STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK INDIANA, LLC	1941 W US HIGHWAY 40, BRAZIL, , 47834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00357009 and IN00357118. Complaint IN00357009 - Substantiated. State deficiencies related to the allegations are cited at R0095. Complaint IN00357118 - Substantiated. State deficiencies related to the allegations are cited at R0095 and R0304. Survey dates: July 6 and 7, 2021 Facility number: 013946 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 22, 2021.	R 0000		

R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2) (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to	R 0095	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - We had Gaddis Baysinger ED take 6 more hours of dementia training, which put him over the minimum of 12 hours of dementia-specific training. He has at least 1 year of work experience in the past 5 years with dementia/alzheimer's residents and has over the 12 hours of dementia-specific training. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; - The director of the memory care unit will be more suitable to oversee the care needs of the residents in the unit. Having the necessary knowledge needed to oversee the unit will allow the director to better educate staff working in the unit as well. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not occur? - The building will continue to in-service staff to ensure these deficient practices do not occur.	07/22/2021

	designate a director for the Alzheimer's and dementia special care unit in accordance with requirements under IC12-10-5.5 in that the designated director did not have a minimum of 12 hours of dementia-specific training. This had the potential to affect 9 of 9 residents residing on the Memory Care unit. (RE, RD, RF, RG, RH, RJ, RO. RP. and RQ) Finding includes: During the entrance conference with the Facility Director and Wellness Director (Registered Nurse) on 7/6/21 at 9:45 a.m., the staff indicated they both served as the directors for the Memory Care (Alzheimer's and Dementia) unit. The Director indicated he began employment in the facility in January of 2021, and the Wellness Director in October of 2020. During a telephone interview on 7/8/21 at 4:58 p.m., with the faciity Director, the director indicated the Wellness Director had not had one year of work experience with dementia or Alzhheimer's residents. At that time the facility Director indicated he guessed he was the Director and disclosed he had 7.66 hours of dementia training. A list of residents in the facility was provided on 7/6/21 at 10:30		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - Will assure that the director of the unit continues education annually by getting 6 hours of dementia-specific training.	

	a.m. It included names of 9 residents living on the Memory Care Unit. A form titled "Reflections Memory Care - Disclosure Statement," (no date) provided by the Director on 7/6/21 at 10:34 a.m., included but was not limited to: "I. Enriching Lives through Person-Centered Care at Reflections Memory Care. We are providing a home-like environment offering holistic treatment and a positive atmosphere. Reflections Memory Care's specially trained staff and activity program that focuses on the resident's abilities,allowing them to function at their highest capability...." The Director indicated the facility did not have a policy that addressed the position of Director of Memory Care Unit. This state residential finding relates to Complaints IN00357009 and IN00357118. Based on interview and record review, the facility failed to designate a director for the Alzheimer's and dementia special care unit in accordance with requirements under IC12-10-5.5 in that the designated director did not have a minimum of 12 hours of dementia-specific training. This had the potential to affect 9 of 9 residents residing on the			

Memory Care unit. (RE, RD, RF, RG, RH, RJ, RO. RP. and RQ)

Finding includes:

During the entrance conference with the Facility Director and Wellness Director (Registered Nurse) on 7/6/21 at 9:45 a.m., the staff indicated they both served as the directors for the Memory Care (Alzheimer's and Dementia) unit. The Director indicated he began employment in the facility in January of 2021, and the Wellness Director in October of 2020.

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	at Reflections Memory Care. We are providing a home-like environment offering holistic treatment and a positive atmosphere. Reflections Memory Care's specially trained staff and activity program that focuses on the resident's abilities,allowing them to function at their highest capability...." The Director indicated the facility did not have a policy that addressed the position of Director of Memory Care Unit. This state residential finding relates to Complaints IN00357009 and IN00357118.			
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on interview and record review, the facility failed to ensure Schedule II narcotics (pain medications) were stored in a substantially constructed box, under double locks for 1 of 2 residents reviewed with	R 0304	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; . We had an in-service with all of our nursing staff that handle medications about the correct way of storing meds and the process for disposing of them. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; .	07/08/2021

discontinued narcotics. (Resident RN).

Finding includes:

On 7/7/21 at 10:39 a.m., Resident RN's closed clinical record was reviewed. Documentation was noted that the resident went on medical/therapeutic leave 8/9/20 related to fall with fracture and transferred to skilled facility for rehabilitation. The resident was discharged from the facility on 8/31/20.

A "Medication Destruction Log," for June 2021, provided by the Wellness Director on 7/7/21 at 12:42 p.m., included but was not limited to, a log of schedule II medications and amounts destroyed on 6/21/21. The destructions of each medication was signed by two licensed nurses. The Wellness Director indicated she had begun employment in the facility in October of 2020. On 6/21/21, while straightening her office she found a cardboard box on top of a filing cabinet. When the box was opened she found opened multiple medication bottles that contained narcotics prescribed for Resident RN. The Schedule II narcotics inside of the box were: Liquid Morphine Sulfate 20 mg [milligrams] per milliliter [ml],- 25.5 ml; Liquid Morphine Sulfate 100 mg/5 ml, - 30 ml;

We will assure that any Schedule II drugs administered by the facility are kept in individual containers under a double lock. This will assure that only the necessary personnel are having access to these medications and will ensure the safety of the residents.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

The building will continue to in-service its staff to ensure these deficient practices do not occur.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and

.
The wellness director will do a weekly count audit of narcotics with another nurse, which will be documented.

Oxycodone/Acetaminophen - 59 tablets (tabs); and Morphine Sulfate ER (extended release])15 mg - 48 tabs.

The Wellness Director on 7/7/21 at 12:42 p.m., indicated a medication count had been done and there were no discrepancies found.

The DON indicated the nurses' destroyed the medications in accordance with the facility's policy. The facility's policy titled 'The VOHB/Reflections Policies and Procedures," no date, provided by the Director on 7/7/21 at 12:44 p.m., included but was not limited to, "Disposal of Medication: 1. When a resident's medication is changed, expired, discontinued, or following a resident's transfer, discharge, or death, all unused medication will be recorded on a Medication Release/Disposal Log form and ideally returned to the issuing pharmacy for disposal. 2. If the pharmacy will not accept medications for some reason, an alternate drug disposal system may be used (i.e.. Drug Buster).

This state residential finding relates to complaint IN00357118.

Based on interview and record review, the facility failed to ensure Schedule II narcotics

(pain medications) were stored in a substantially constructed box, under double locks for 1 of 2 residents reviewed with discontinued narcotics. (Resident RN).

Finding includes:

On 7/7/21 at 10:39 a.m., Resident RN's closed clinical record was reviewed. Documentation was noted that the resident went on medical/therapeutic leave 8/9/20 related to fall with fracture and transferred to skilled facility for rehabilitation. The resident was discharged from the facility on 8/31/20.

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Sulfate 20 mg [milligrams] per milliliter [ml],- 25.5 ml; Liquid Morphine Sulfate 100 mg/5 ml, - 30 ml; Oxycodone/Acetaminophen - 59 tablets (tabs); and Morphine Sulfate ER (extended release])15 mg - 48 tabs.

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	This state residential finding relates to complaint IN00357118.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE