STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMONS AT HONEY CREEK, THE	1450 EAST CROSSING BOULEVARD, TERRE HAUTE, , 47802

(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 Complaint IN00443866. Complaint IN00443866 - State deficiencies related to the allegations are cited at R0053 and R0243. Survey date: September 25 and 26, 2024 Facility number: 015282 Residential Census: 64 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 10, 2024.	R 0000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. The Commons at Honey Creek requests that this Plan of Correction be considered an Allegation of Compliance. Compliance is effective 10/30/24.	

R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on record review and interview, the facility failed to protect the residents from verbal abuse causing the residents to experience embarrassment, isolation, and intimidation for 3 of 3 residents interviewed for abuse (Residents (E, B, D, and C). Findings include: 1. On 9/25/24 the record of Resident E was reviewed. The resident was admitted to the facility on 3/27/24. Admitting diagnosis included, but were not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), hypertension (high blood pressure), depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks), and falls. On 9/25/24 at 1:46 p.m., during observation and interview, Resident E was in his room preparing left over chicken to	R 0053	R053 – It is the policy of The Commons at Honey Creek that all residents be free from verbal abuse. 1 What corrective action will be accomplished for those residents found to be affected by the deficient practice? a A meeting was held with Resident B to discuss explicit language alleged by other resident. Resident B alleges that no explicit language was ever used and understands expectations regarding resident rights and communication. 2 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 a Resident interviews were completed using the Resident Abuse Questionnaire as a screening tool. No additional residents were	11/05/2024

	give to the puppies residing at the facility. He was alert and oriented. The resident indicated he was well taken care of at the facility and needed assistance for care. He indicated he had a "run in" with another resident, Resident B. He indicated Resident B asked Resident E if he would be interested in relationship with him. Resident E asked Resident B to leave him alone and told Resident B that he loved his wife and was not interested in men. He told Resident B "no" and reported the incident to the Administrator. He indicated he was not afraid of Resident B, but it upset him to talk about it and had made him have increased anxiety. He indicated around 5 or 6 residents had complained to him about Resident B approaching them as well. 2. On 9/25/24 the medical record of Resident D was reviewed. The resident was admitted to the facility on 5/22/24. Admission diagnosis included but were not limited to, HTN (high blood pressure), anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), Dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily		identified. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur a The Administrator was granted permission by the Resident Council President to present at the Resident Council meeting on 11/5/24. The Administrator provided verbal communication and education regarding communication between residents, as well as provided Ombudsman contact information. b Abuse Policy and Reporting education for all staff by 10/30/24 4 How the corrective action will be monitored to ensure the deficient practice will not recur a Administrator or designee will	

	life and activities), and Stage 2 kidney disease (also known as chronic kidney disease (CKD), is a stage of mild kidney damage where the kidneys are still working well). On 9/26/24 at 9:15 a.m., during observation and interview, Resident D indicated he was sitting on the front porch and Resident B came out and asked to sit down. Resident B sat down next to him, and Resident B patted him on his upper inner thigh. He indicated Resident B did not touch him in the groin area or fondle him. Resident B then began asking inappropriate sexual questions. He asked him how his third leg was doing and if he "played" with himself. Resident B told him he liked to go to the exercise group and watch the ladies lift their legs because he knew it would get "hot and sweaty down there", and he wondered if they went back to their rooms and "played" with themselves. He then asked the resident if his wife "played" with herself. The resident told Resident B to "shut up." Resident B continued to make sexual comments to him and asked if the resident would like a "blow job" because he liked to give "blow jobs." He told the resident to "shut up" and leave and the resident left. He indicated he still had not "gotten over" the incident.		complete the Abuse Prohibition and Investigation Quality Assurance Tool. 5 By what date systemic changes will be completed a 10/30/24 IDR is requested to dispute the allegation the facility failed to protect the residents from verbal abuse causing the residents to experience embarrassment, isolation, and intimidation for 3 of 3 residents	

	The resident indicated he reported the incident to the Administrator and was told Resident B had "rights." He indicated the Administrator asked if he wanted to move to another facility. He contacted the police and was instructed to file an assault report with the Sheriff, but he had not filed a report. He indicated he was not afraid of Resident B, and indicated Resident B had not approached him since the first incident. He believed the resident was trying to taunt him by walking up to him and behind him and sitting on the porch when he was outside. He indicated he believed his rights were being violated and he was now isolated and could not freely leave his apartment due to the incident. He indicated they no longer attend activities due to Resident B's behavior. He indicated he had been verbally abused by Resident B and indicated he was told by the Administrator they can't talk to the family due to Resident B's right to privacy. 3. On 9/25/24 the medical record of Resident C was reviewed. The resident was admitted to the facility on 5/22/24. Admission diagnosis included, but were not limited to, stage 3 kidney failure also known as chronic kidney disease (CKD), (a stage of mild kidney damage where the			

	kidneys are still working well), hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream), depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks), COPD (chronic obstructive pulmonary disease, a group of diseases that cause airflow blockage and breathing-related problems). On 9/26/24 at 9:23 a.m., during observation and interview Resident C indicated she was very upset about the incident that had occurred between her husband and Resident B. The resident indicated she had developed headaches and other medical issues since the incident due to increased anxiety and stress. She indicated she was afraid Resident B would come into her apartment, because their apartment was right next to his. She was afraid she was going to be punished by the Administrator and be made to move to another facility for complaining. She no longer attended activities or exercises because Resident B was there, and she did not want him watching her. She indicated she felt isolated and was unable to			

	leave her apartment except for meals and appointments. On 9/26/2024 at 1:35 p.m., the Administrator provided a document titled, "Resident Bill of Rights" dated 11/04, and indicated it was the policy currently being used by the facility. The policy indicated, "...Title: Resident Bill of Rights ...(a) The resident has the right to have his/her rights recognized by the community ...(c) The resident has the right to exercise any or all of the enumerated rights without restraint, interference, coercion, discrimination, or threat of reprisal by the community ... d) The resident has the right to be treated with consideration, respect and recognition of their dignity and individuality ...(v) Residents have the right to be free from sexual, physical, mental abuse, corporal punishment, neglect, and involuntary seclusion ...((w) Residents have the right to be free from verbal abuse ...." This citation relates to Complaint IN00443866. Based on record review and interview, the facility failed to protect the residents from verbal abuse causing the residents to experience embarrassment, isolation, and intimidation for 3 of 3 residents interviewed for abuse (Residents (E, B, D, and			

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Findings include:

1. On 9/25/24 the record of Resident E was reviewed. The resident was admitted to the facility on 3/27/24. Admitting diagnosis included, but were not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), hypertension (high blood pressure), depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks), and falls.

On 9/25/24 at 1:46 p.m., during observation and interview, Resident E was in his room preparing left over chicken to give to the puppies residing at the facility. He was alert and oriented. The resident indicated he was well taken care of at the facility and needed assistance for care. He indicated he had a "run in" with another resident, Resident B. He indicated Resident B asked Resident E if he would be interested in relationship with him. Resident E asked Resident B to leave him alone and told Resident B that he loved his wife and was

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R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to	R 0243	R243 – It is the policy of The Commons at Honey Creek that all nurses and QMA's sign out medications at the time of administration. 1 What corrective action will be accomplished for those residents found to be affected by the deficient practice? a Residents G and H were not adversely affected. All licensed nurses and QMAs re-educated by	10/30/2024

	ensure medications were administered according to administration schedule and physician order for 2 of 2 residents reviewed for medication administration. (Residents G and H) Findings include: On 9/25/24 at 10:25 a.m., during a confidential interview Employee 4, indicated the Qualified Medication Aides (QMAs) had been instructed to sign off medications as being given though they were not in the facility at the time of scheduled administration. On 9/25/24 at 1:58 p.m., during an interview with the Administrator and Director of Nursing (DON) indicated they had residents who were administered medications from 9:00 p.m. to 12:00 a.m. They had a nurse in the facility 24 hours a day 7 days a week to ensure medications were administered as ordered. The DON indicated the facility had specific medication times, and the last scheduled time was 8 p.m. She indicated the facility policy was, a medication may be given for up to one hour before and up to one hour after the scheduled medication administration time. On 9/26/24 at 11:00 a.m., the Medication Administration		10/30/24 on the policies and procedures of medication administration, to include documentation of the medication administration at the correct time of administration as well as the 5 rights of medication administration. 2 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 a All residents have the potential to be affected; however no residents were affected by the deficiency. All licensed nurses and QMAs re-educated by 10/30/25 on the policies and procedures of medication administration, to include documentation of the medication administration at the correct time of administration as well as the 5 rights of medication administration. Medication administration times were reviewed by 10/1/24 to ensure administration times are appropriate to ensure compliance.	

	Record (MAR) of Residents G and H were reviewed. The documentation on the MAR of each resident indicated medications were scheduled to be administered at 8 p.m., and were administered at the scheduled time and signed as administered by QMA 5. The staffing schedule indicated QMA 5 was scheduled on the following dates in September from 6:00 a.m. to 6:00 p.m. September 1, 7, 8, 14, 15, and 22. QMA 5 left the facility each day prior to 7:00 p.m. On 9/26/24 at 11:55 a.m., during interview, the DON indicated QMA 5 was scheduled but she would have to check the timecard to see what time the employee left the facility. On 9/26/24 during interview with the DON, she indicated QMA 5 left the facility prior to 8 p.m. and acknowledged the medications were signed off before she left. She indicated the pharmacy recommendations were to change the evening medication pass to earlier times; however, she had not yet changed the times on the MAR. On 9/26/2024 at 1:35 p.m., the Administrator provided a document, titled, "Medication administration times," dated 9/1/10, and indicated it was the policy currently being used by		3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur a Medication administration times were reviewed by 10/1/24 to ensure administration times are appropriate to ensure compliance. All licensed nurses and QMAs were re-educated on the Medication Administration policy by 10/30/24. 4 How the corrective action will be monitored to ensure the deficient practice will not recur a The DON or designee will be responsible to audit medication pass on different shifts, with different nurses and QMA’s on scheduled days of work 5 days a week x 4 weeks, then 2 days a week x 4 weeks, then weekly for 4 weeks to ensure documentation of medication administration is done timely and accurately, per	

	the facility. The policy indicated, "...Procedure ...1. The community should ensure that authorized personnel ...assist with administration or observation of medications according to times of administration as determined by the community ...2. The community should commence medication administration, assistance or observation within sixty (60) minutes before the designated times of administration and sixty (60) minutes after the designated times of administration ...." This citation relates to Complaint IN00443866. Based on interview and record review, the facility failed to ensure medications were administered according to administration schedule and physician order for 2 of 2 residents reviewed for medication administration. (Residents G and H) Findings include: On 9/25/24 at 10:25 a.m., during a confidential interview Employee 4, indicated the Qualified Medication Aides (QMAs) had been instructed to sign off medications as being given though they were not in the facility at the time of scheduled administration. On 9/25/24 at 1:58 p.m., during		policy. Observations will be documented on a medication administration monitoring tool. Any noted documentation concerns will be addressed through employee education and counseling. b The DON or designee will review the outcomes of the audits with the QA committee. Monitoring will continue until 100% compliance is achieved 5 By what date systemic changes will be completed a 10/30/24	

an interview with the Administrator and Director of Nursing (DON) indicated they had residents who were administered medications from 9:00 p.m. to 12:00 a.m. They had a nurse in the facility 24 hours a day 7 days a week to ensure medications were administered as ordered. The DON indicated the facility had specific medication times, and the last scheduled time was 8 p.m. She indicated the facility policy was, a medication may be given for up to one hour before and up to one hour after the scheduled medication administration time.

On 9/26/24 at 11:00 a.m., the Medication Administration Record (MAR) of Residents G and H were reviewed. The documentation on the MAR of each resident indicated medications were scheduled to be administered at 8 p.m., and were administered at the scheduled time and signed as administered by QMA 5.

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This citation relates to Complaint IN00443866.

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