STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155490	A. BUILDING 00 B. WING	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00443195 and IN00447316. Complaint IN00443195 -- Federal/state deficiency related to the allegations are cited at F755. Complaint IN00447316 -- Federal/state deficiency related to the allegations are cited at F755. Survey dates: December 4, 5, 6 and 9, 2024 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census Bed Type: SNF/NF: 104 Total: 104 Census Payor Type: Medicare: 19 Medicaid: 70 Other: 15 Total: 104 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 11, 2024.	F 0000	Plan and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of the truth of facts alleged or the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by Federal and State law. This provider maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before 12/31/2024. Ambassador Healthcare respectfully requests that a "desk" review be conducted and accepted. Additional documentation will be sent upon request.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview, and record review, the facility failed to ensure medication administration was conducted in a safe manner and did not include leaving medication at a	F 0755	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	12/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jared Glaub	Executive Director	12/19/2024

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	resident's bedside unattended for 1 of 25 residents rooms observed for unattended medications. (Resident G) Findings include: During random observations of 25 resident rooms for unattended medications on 12/4/24, between 12:58 p.m. and 2:00 p.m., with the facility's Director of Nursing (DON), one resident room was observed with two medication cups of two similar-looking white oblong tablets and observed in close proximity to Resident G. Resident G was observed seated in his recliner with his rollator located adjacent to the recliner. On the rollator, one pill cup containing two large, white oblong tablets were observed, with a second pill cup containing two large, white oblong tablets were observed on his overbed table. All four tablets appeared to resemble each other. Resident G indicated he had asked the nurse who provided the medication to him to leave the meds for him to take later. During the conversation, the resident was observed to pick up the pill cup on the rollator and take both pills. Resident G was unable to identify what the medications were or what they were to be taken for. The DON was immediately informed of the situation and was observed to immediately enter the room to speak with the resident and shortly thereafter, she indicated she had spoken with the nursing staff. In an observation, on 12/5/24 at 9:04 a.m., of Resident G's room, no medications were observed to be unattended in his room. In an interview with the DON, on 12/5/24 at 1:30 p.m., she indicated she had addressed Resident G's medication being unattended with the nurse involved. She shared the nurse indicated the resident had requested for the nurse to leave his		Immediately removed all unsecured medications from the affected resident's room. Conducted a physical audit of the resident's room and surrounding areas to ensure no additional medications were left unsecured. Assessed the resident for any adverse effects or incidents related to the unsecured medication. No adverse outcomes were identified. Reviewed the resident's care plan to determine any contributing factors and revised as necessary. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Conducted a full facility audit to inspect all resident rooms and common areas for unsecured medications. Identified any residents with similar risks and implemented appropriate interventions if needed. No additional instances of unsecured medications were identified during the audit. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Policy Update: Revised the facility's Administering Medications Policy to explicitly prohibit leaving	

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	medication for him to take shortly afterward and she honored his request. In an interview with the DON, on 12/9/24 at 11:00 a.m., she indicated when she was informed of the unattended medications, on 12/4/24, she only observed one pill cup with two similar-looking pills and did not realize Resident G had already consumed a different cup of pills in the presence of the state surveyor. She indicated in either situation, the nursing staff should not leave medication unattended for a resident to consume, unless the resident has been assessed to be able to do so safely. She indicated Resident G had not been assessed for consumption of medications independently. The DON was observed to view the nursing schedule for the date, of 12/4/24, and determined the two nurses who provided medication she assumed to be sevelamer 800 milligrams (mg), (a medication used for persons with chronic kidney disease to lower the phosphate levels in their blood) to determine the 12/4/24, 6:00 a.m., dose was provided by Licensed Practical Nurse (LPN) 3 and the 11:00 a.m. dose was provided by Registered Nurse (RN) 4. The clinical record review for Resident G was conducted on 12/9/24 at 9:45 a.m. His diagnoses included, but were not limited to, stage 5 chronic kidney disease, end-stage kidney disease, dependence on dialysis and Alzheimer's disease. His most recent Minimum Data Set assessment, dated 10/26/24, indicated he was moderately cognitively impaired and received dialysis treatment. Resident G's most current physician recapitulation orders, for December 2024, indicated he was		medications unattended for a resident to consume, unless the resident has been assessed to be able to do so safely. Staff Training: Provided mandatory education to all nurses and QMAs regarding: Proper medication administration protocols. Risks and consequences of unsecured medications. Routine Audits: Instituted weekly audits of resident rooms to ensure compliance with administration protocols performed by the Director of Nursing (DON), or designee, to oversee compliance and address any identified issues immediately. 4 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? DON, or designee, will audit policy compliance weekly for 3 months, then monthly for an additional 3 months to ensure ongoing compliance. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 12/31/2024	

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	ordered, on 8/3/24, to receive sevelamer carbonate 800 mg, two tablets orally, before meals. His associated medication administration record (MAR) for this same order, indicated the administration times were 6:00 a.m., 11:00 a.m. and 4:00 p.m. On 12/4/24, the MAR indicated this medication was administered, at 6:00 a.m., by LPN 3, and the 11:00 a.m. dose was administered by RN 4. A review of the nursing progress notes, for 12/4/24, did not reflect any notations by the nursing staff regarding any medication related information. On 12/9/24 at 3:13 p.m., the DON provided a copy of a document entitled, "Medication And/Or Treatment Incident Report." This document indicated Resident G had received the 12/4/24, doses of the 6:00 a.m., and 11:00 a.m., of sevelamer 800 mg, two tablets, at "the wrong time," as the medications had been "left at resident [sic] bedside. Resident took one dose on own, RN watched resident 11am dose." It indicated the resident was not sent out to the hospital, but the resident was made aware of the incident, on 12/4/24 at 12:20 p.m., and the physician was notified of the incident on 12/9/24 at 3:00 p.m. The document was signed as completed, on 12/9/24 at 3:08 p.m., by the DON. On 12/9/24 at 1:32 p.m., the DON provided a copy of a facility policy entitled, "Administering Medications." This policy had a revision date of December 2012. It indicated its policy statement was, "Medications shall be administered in a safe and timely manner, and as prescribed." In an associated interview with the DON, on 12/9/24 at 2:35 p.m., she indicated her expectations related to medication administration included, but were not limited to, the staff member administering the medication to each resident would remain with the			

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	resident until the medication is taken in order to observe the resident consuming the medication. This citation relates to Complaints IN00443195 and IN00447316. 3.1-25(b)(1) 3.1-25(b)(3) 3.1-25(b)(9)			