STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST CHARLESTOWN, IN 47111

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00420132, IN00420558, and IN00422795. Complaint IN00420132 - State deficiency related to the allegation is cited at R0149. Complaint IN00420558 - No deficiencies related to the allegation is cited. Complaint IN00422795 - State deficiency related to the allegation is cited at R0064. Survey dates: November 27, 28. 29, 30 and December 1, 2023 Facility number: 012007 Residential Census: 83 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 10, 2023.	R 0000		
R 0040 Bldg. 00	410 IAC 16.2-5-1.2(o)(1-3) Residents' Rights - Noncompliance (o) Residents have the right to form and participate in a resident council, and families of residents have the right to form a family council, to discuss alleged grievances, facility operation, residents ' rights, or other problems and to participate in the resolution of these matters as follows: (1) Participation is voluntary. (2) During resident or family council			

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

RICH PEDERSEN | Executive Director | 12/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	meetings, privacy shall be afforded to the extent practicable unless a member of the staff is invited by the resident council to be present. (3) The licensee shall provide space within the facility for meetings and assistance to residents or families who desire to attend meetings. Based on interview and record review, the facility failed to facilitate and provide assistance for implementation of a resident council for 8 of 9 residents reviewed for resident rights. Findings include: On 12/1/23 at 2:10 p.m., the Executive Director provided a copy of the last Resident Council minutes that he could find, which was dated 5/12/2015. During an interview on 11/27/23 at 1:35 p.m., Resident D indicated she was unaware of a resident council as the facility only had town hall meetings. Resident D felt it would be good to have a resident council as the residents could discuss issues amongst themselves in private. During an interview on 11/28/23 at 9:35 a.m., Resident C indicated the facility did not have a resident council, but they need one. They only have a town hall the the Executive Director runs. Resident C does not attend as they do not listen to what the resident's have to say. During an interview on 11/28/23 at 2:46 p.m.., Resident F indicated the facility did not have a resident council, only town hall meetings. No one had ever mentioned putting together a resident council nor had he been asked. Resident F felt it would be nice to have one.	R 0040	1 All residents were affected. Informational meeting for Resident council scheduled for 12/28/2023 and election of officers scheduled for 1/3/2024 2 All residents are potentially at risk of the same alleged deficient practice. All residents were invited to an informational meeting and asked to inform ED if they are willing to serve as a Resident Council Officer. 3 Activity Department in-serviced on Resident council Process on 12/27/2023 completed minutes turned in to Activity Director. Activity Director will assist council in the initiation of grievance forms. 4 ED will review minutes and grievance forms to ensure identified concerns following meeting are being addressed. Completed minutes and grievance forms are kept in binder in the front office.	01/04/2024

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	During an interview on 11/28/23 at 3:00 p.m., Resident E indicated if there was a resident council, she was unaware of it and no one had ever mentioned starting one up. During an interview on 11/29/23 at 1:50 p.m., Resident H indicated the facility had monthly town hall meetings, but the subject of forming a resident council had never been brought up. She felt a resident council would be a good idea and she would attend. She would love to have one so the residents could get together to discuss concerns and the bring those concerns to the Executive Director. During an interview on 12/1/23 at 8:52 a.m., Resident V indicated there used to be a resident council but died out a while back. The activity director held the meetings. He does not go to the town halls because residents can't voice concerns without some pushback. He had never been asked about starting up a resident council or if he would attend. He would like to have resident council back so the resident's could discuss issues together. During an interview on 12/1/23 at 9:10 a.m., Resident U indicated the facility only has town hall meetings. There was not a resident council and no one had ever discussed having one with him. He went to a town hall once. If you voice a concern, they won't do anything. The one time he did go to a town hall, forming a resident council was never brought up. He though it would be great if they had one so the residents could all discuss issues between themselves in private During an interview on 12/1/23 at 9:17 a.m., Resident G indicated the facility only has town			

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	meetings with everyone. The Executive Director told us here he was the "resident advocate". If we have issues, we should come to him to resolve. He felt it was a conflict of interest being the Executive Director and "resident advocate". He had been to a few town hall meetings, but quit going as nothing got resolved. The facility needed a resident council and he would attend. 11/30/23 at 2:40 p.m., Executive Director indicated renamed from town hall to town hall/resident council as had been trying to get people to join. He had talked to a couple of different residents about being president just recently. The process took over a year and a half as he could not get any resident committed to running the resident council. On 12/1/23 at 1:13 p.m., the Executive Director provided a current, undated copy of the document titled "Resident Council Procedure". It included, but was not limited to, "...A Resident Council allow for residents to identify problems and offer solutions from a resident-perspective, recognize staff for a job well-done, address concerns, and offer feedback on food, life enrichment programming, and other areas of daily life in the community. This council can provide opportunities for resident that support their independence, self-actualization, and provide a social network for residents...Each community should support a Resident Council or establish one if it does not yet exist within the community to provide residents an organized group of peers with which to provide feedback to the community. The Resident Council has the right to meet in private without a staff member if they so choose...."			

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R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure misappropriation of resident property did not occur for 1 of 9 residents reviewed for abuse. (Resident G) Findings include: During an interview on 11/29/23 at 1:50 p.m., Resident G indicated after she had returned from LOA (leave of absence) with her family member on 11/25/23, she was informed that someone had stolen her pain medication and had taken the cards and narcotic count sheets. She was LOA with her family member ,from Wednesday (11/22/23) through Saturday (11/25/23) and the facility had sent some with her as she takes them three times a day. She came back to the facility on 11/25/23 and still had her evening dose, which she took that evening. The next morning they went to get her one and discovered they were gone. The clinical record for Resident G was reviewed on 11/29/23 at 11:08 a.m. The diagnoses included, but were not limited to, chronic pain and neuropathy. The November 2023 medication administration record indicated the resident was to receive Hydrocodone (narcotic pain medication) 10-325 mg (milligrams) three times a day as needed for pain.	R 0064	***Corrective action for the resident affected by deficiency:*** Resident's medications were replaced by River Crossing at no cost to resident. ***Other residents that have been identified to have the potential to be affected by deficiency:*** All residents who receive controlled substances from clinical staff have the potential to be affected by deficiency. ***Measures or systems put in place to ensure that the deficiency does not occur:*** 100% audit of narcotic inventory & Proof of Use Sheet reconciliation completed on 12/21/2023 Clinical staff re-educated on resident's rights 12/29/2023 A revised shift to shift inventory count sheet has been developed. In-servicing will be completed by 12/29/2023 A process for storing controlled substances when a resident is out of the building for 24 hours or more has been developed. In-servicing will be completed by 12/29/2023	01/04/2024

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	The incident report, dated 11/26/23 at 6:01 a.m., indicated the resident had three cards of narcotics and the correlating controlled drug records missing. Review of the November 2023 controlled drug record indicated, on 11/17/23 at 2:00 p.m., the resident was administered the medication which brought the count down to zero. Review of the pharmacy delivery packing slip indicated, on 11/17/23, 90 Hydrocodone 10-325 mg were delivered to the facility. On 11/27/23, another 54 Hydrocodone 10-325 mg were delivered to the facility. The clinical record lacked documentation of the controlled drug record for the 90 Hydrocodone -10-325 mg delivered on 11/17/23. During an interview on 11/30/23 at 2:40 p.m., the Executive Director indicated due to the messiness of the card count and the sheets, they could not pinpoint exactly when the medications went missing or who took them, but it was between 11/23/23 and 11/26/23. During an interview on 11/30/23 at 3:02 p.m., the Director of Nursing indicated the controlled drug sheets and the medication cards were both taken and the resident was missing 66 Hydrocodone tablets. On 11/28/23 at 3:25 p.m., the Executive Director provided a current copy of the document titled "Abuse, Prevention and Prohibition Policy" dated 10/22. It included, but was not limited to, "Statement of Intent...Each resident has the right to be free from abuse...Policy...The facility		Comprehensive education on the management of controlled substances was provided by regional nurse. In-servicing will be completed by 12/29/2023 In-house pharmacy has been asked to send no more than thirty pills per narcotic prescription at a time. ***How the corrective actions will be monitored to ensure the deficient practice will not recur:*** Shift to shift inventory count sheets will be turned in to DON every seven days. DON will review the sheets and present them to the ED for storage. ED will ensure that counts are being turned in and address and discrepancies immediately with DON. This will be an ongoing weekly process that will be reviewed at each quarterly QAPI meeting. DON or designee will randomly reconcile 2 Proof of Use Sheets to actual inventory three times a week for 3 weeks and then weekly thereafter. Any discrepancies will be immediately addressed & shared with ED. Results of audits will be shared with QAPI committee, and the committee will determine a stop date. ED or designee will ensure that controlled substances for residents who are out of the building for greater than 24 hours have been delivered to & stored by DON. This will be an on-going	

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	prohibits...abuse of residents...The facility...prohibits misappropriation of resident property...Misappropriation of Resident Property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...." This citation relates to Complaint IN00422795		system check that will be discussed during daily census review	
R 0149 Bldg. 00	410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the facility was free of gnats for 4 of 4 observations for pest control. (Residents E, G, M apartments and 100 Hall Library) Findings include: On 11/28/23 at 9:50 a.m., upon entrance to Resident G's apartment, there were a multitude of gnats flying in the resident's living room where he was seated. There were several gnats on the fly trap hanging by the cabinet area. Multiple gnats were observed on the cabinets and walls, flying around the kitchen sink, and on the ceiling in the bathroom. Resident G indicated gnats had been an issue for over 4 months. He had reported to everyone, maintenance, management, and nursing staff. He has vascular wounds to his lower legs and concerned that if not covered, the gnats could land on the wounds and cause issues. They gave him a gnat trap and it did not work. It's been an ongoing issue and a shame had to live like this.	R 0149	1 What corrective actions: All affected rooms drains flushed with solution of bleach and water as recommended by Pest Control. 2 Maintenance Director or Designee will inspect all resident rooms for signs of Gnats on 12/27/2023 and any other identified rooms will receive the same drain treatment of hot water and bleach. 3 Housekeeping and Maintenance staff in-service on drain maintenance on 12/27/2023 4 Resident rooms will be inspected for presence of Gnats: a 6/wk for 2 weeks b 4/week for 2 weeks c 2/week for 4 weeks d 1/week for 4 weeks	01/04/2024

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	On 11/28/23 at 10:25 a.m., upon entrance to Resident E's apartment, several gnats were observed flying over the kitchen sink; one resting on kitchen wall; multiple gnats were observed flying in the bathroom, on the wall and ceiling. The resident indicated she had a gnat issue and they gave her a gnat trap. The trap had helped some, but there was still an issue with them. On 11/28/23 at 10:35 a.m., there were 2 gnats observed flying in the 100 HallLlibrary area. On 11/29/23 at 10:02 a.m., upon entrance to Resident M's apartment, a multitude of gnats were observed flying in the kitchen and living area. The resident indicated gnats had been an issue for awhile but not sure how long. She was given a gnat trap to help with them but it had not help much. During an interview on 11/30/23 at 2:40 p.m., the Executive Director indicated they could not identify the source of the gnat problem. The sinks were treated, gnat traps were placed, and they checked for food in cupboards. He had been aware of the gnat issue for about a month, however the maintenance director had been working on the problem prior to that. 12/1/23 at 9:32 a.m., the Maintenance Director indicated there had been a gnat problem, mainly in the 7 shaped quadrant on the 300 hall. They had put out traps and put enzyme treatments in the drains. He also had them in his office. The cannot find the source of the problem which had been an Issue since early September 2023. Pest Control had been in and told him the gnats should clear after the first freeze. This State citation relates to Complaint		ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Any presence of gnats will result in extension of audits	

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R 0154 Bldg. 00	IN00420132 410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the ceilings and light fixtures in the kitchen and dining area were maintained for 1 of 1 kitchen and dining rooms observations. Findings include: On 11/29/23 at 10:50 a.m., upon kitchen entrance, the following was observed: - Dust, gray in color, was observed on the light fixture with a 2 inch strand swaying back and forth in front of the ice machine - The light fixture directly in front of the food prep table was observed with dust on the sides - The light fixture above the refrigerator was observed with dust particles on it - Gray dust particles were observed on the ceiling between the vent above the food serving area and extended back to the light fixture to the left of the dry storage area - The vent to the left of the food prep table was observed to be chipped and peeling with a 6-7 inch split - There was a 24 inch crack observed in the ceiling above the food prep table	R 0154	1. outside contractor contacted to make repairs to ceiling, 2. All residents are potentially at risk of same alleged deficient practice. 3. Executive Director and Dietary Manager inserviced dietary and maintenance staff on cleaning procedures for ceiling in kitchen and reporting of needed repairs on 12/21/2023. 4. Kitchen Sanitation will be audited for cleanliness 3/week for 4 weeks, 2/week for 4 weeks, 1/week for 2 months, then monthly ongoing by Dietary Director. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Kitchen sanitation audit must score 85% or better to reduce to monthly.	01/10/2024

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	- The vent above the refrigerator was observed with chipped plaster peeling back. - The vent above the deep fryer was observed with chipped plaster around the edges - In the dining room, 4 of the 5 ceiling vents were observed with water stains around them. During an interview on 11/29/23 at 10:55 a.m., Staff Member 4 indicated it had been over a month since maintenance had cleaned the light fixtures and management was aware of the ceiling issues. During an interview on 12/1/23 at 11:13 a.m., the Executive Director indicated the there was not a kitchen policy which related to the ceilings and light fixtures and they currently did not have a maintenance policy as it was in the process of being written.			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to ensure a resident (Resident H) received the correct dosage of medication for 1 of 3 residents reviewed for medication errors. Findings include: The clinical record for Resident H was reviewed on 11/29/23 at 9:41 a.m. The diagnoses included, but were not limited to, depression and anxiety.	R 0247	***Corrective actions for resident that was affected by the alleged deficient practice:*** Resident is a discharged resident. ***Other residents having the potential to be affected by the alleged deficient practice:*** All residents that receive medication management services	01/04/2024

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	The physician's order, dated 2/22/23, indicated the resident was to start Diazepam 5 mg (milligrams) every morning at 6:00 a.m. and 10 mg at 2:00 p.m. and 10:00 p.m. The progress note, dated 5/22/23 at 9:15 p.m., indicated it was discovered that the previous shift shift administered the incorrect dose of Diazepam. Review of the May 2023 controlled drug record indicated the resident received the 5 mg dose a 2:00 p.m. instead of the ordered 10 mg. The physician's order, dated 6/28/23, indicated the resident was to receive Diazepam 5 mg at 6:00 a.m. and 9:00 p.m., and 2.5 mg at 2:00 p.m. The progress note, dated 7/5/23 at 8:00 a.m., indicated during an audit of narcotics, it was discovered that a medication error had occurred and the resident received Diazepam 5 mg at 2:00 p.m. rather than the 2.5 mg as ordered. Review of the July 2023 controlled drug record indicated, on 7/4/23, the resident received 5 mg of Diazepam at 2:00 p.m. During an interview on 12/1/23 at 1:35 p.m., LPN (Licensed Practical Nurse) 14, indicated the five rights of medication administrated included the right dose and the right time. On 12/1/23 at 2:10 p.m., the Director of Nursing provided a current copy of the document titled "Medication Administration - General Guidelines" dated 1/17. It included, but was not limited to, "Policy...Medications are administered as prescribed in accordance with good nursing principles and practices...FIVE RIGHTS...right		from clinical staff have the potential to be affected. ***Measures put into place to ensure that the alleged deficient practice does not recur:*** Clinical staff were re-educated on the 5 rights of medication administration by 12/29/2023 All clinical staff will complete a written quiz regarding medication administration. by 12/29/2023 Clinical staff will be re-educated on process for medication errors. by 12/29/2023 Education regarding preventing med errors was provided to the DON by Regional Nurse. 12/21/23 Audit of medication errors from the last 30 days to validate that MD was informed was completed on 12/29/2023 ***How the corrective actions will be monitored to ensure the alleged deficient practice will not recur:*** DON or designee will administer medication administration competencies to those who pass medication upon hire, quarterly, and PRN beginning 12/29/23 DON will monitor incident reports five times a week. If a medication error occurs DON will ensure that all steps in the documentation & reporting process were completed. This will be an on-going process and results will be shared at routine QAPI	

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	dose...right time...."		meetings.	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (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 observations, interview and record review, the facility failed to ensure medications carts were locked for 1 of 3 observations and failed to ensure medications were dated and expired medications were removed for 2 of 3 carts observed for medication storage. Findings include: 1. On 11/29/23 at 2:30 p.m., the 300 hall medication cart was observed to be unlocked with the cart keys in the lock and unattended. During an interview on 11/29/23 at 2:33 p.m., Licensed Practical Nurse (LPN) 8 indicated medications carts should not be left unlocked with the keys in the lock unattended. LPN 8 indicated he usually locks his cart but had forgotten. 2. During an observation of the 200 medication cart #1, with LPN 12 on 11/30/23 at 8:47 a.m., the following was observed: -Resident N - Azelastine eye drops, Artificial Tears eye drops, and Anora Ellipta inhaler were not dated when opened -Resident O - Trelegy Ellipta inhaler was not dated when opened	R 0304	***Corrective actions for residents that were affected by the alleged deficient practice*** Expired medications were destroyed, & medications that were undated were destroyed and replaced at the expense of the facility for the identified residents. ***Other residents having the potential to be affected by the alleged deficiency.*** All residents who have medication managed by clinical staff have the potential to be affected. ***Measures put into place to ensure that the alleged deficient practice does not recur*** 100% audit of all six medication carts completed by pharmacy on 12/12/2023. Education regarding storage and parameters for inhalers, nebulizers, opthalmics, insulin, and other medications that require discarding before listed expiration dates. In-servicing for all staff	01/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST CHARLESTOWN, IN 47111

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	-Resident P - Albuterol HFA inhaler dated 12/5/22 was not bagged or in a box -Resident Q - Symbicort inhaler and Erythromycin eye drops was not dated when opened -Resident R - Nicotine Trandsdermal Patch was discontinued 10/25/23 and still in cart -Resident T - Ventolin HFA inhaler expired 5/6/23 -Resident S - Nitroglycerin 0.4 mg expired 9/21/23 and still on cart On 11/30/23 at 9:23 a.m., during an observation of the 100 hall medication cart #1, with LPN 13, the following was observed: -Resident X - Incruse Ellipta Inhaler and Symbicort inhaler were not dated when opened -Resident Y - Fluticasone nasal spray and Eye itch relief eye drops were not dated when opened -Resident Z - Incruse Ellipta inhaler was not dated when opened -Resident BB - Anora Ellipta inhaler was not dated when opened During an interview on 11/30/23 at 2:30 p.m., LPN 11 indicated when inhalers, eye drops or nasal sprays should be dated when opened. All expired medications and discontinued medications should be removed from the cart at the time of discontinuation or expiration. On 11/29/23 at 12:20 p.m., the Executive Director provided a current copy of the document titled "Medication Storage in the Facility" dated 1/17. It included, but was not limited to, "Procedures...Expiration Dating...When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated...All expired medications will be removed from the active supply...."		that administer medications will be completed by 12/29/2023 Medication storage and parameter manuals have been created and placed in readily accessible locations to serve as a resource for those who administer medications. Those who administer medications were re-educated on the importance of locking med carts and removing their keys every time they walk away by 12/29/2023 ***How the corrective actions will be monitored to ensure the alleged deficient practice will not recur:*** Pharmacy will conduct routine medication cart Any expired medications will be given to the DON to be destroyed according to facility policy. DON will ensure that all six med carts are audited three times a week for six weeks and then two carts weekly to check for expired medications and to ensure the appropriate storage of ophthalmic, inhalers, nebulizers, injectables, and other medications that are required to be dated upon opening. Expired or undated medications will be removed from the carts and destroyed per facility policy. Auditing two med carts per week will become an on-going process unless otherwise determined by QAPI committee. DON and ED will observe med	

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			carts daily during med pass times and routinely as they make their rounds throughout the building. Unlocked carts or carts with keys in the lock will be immediately addressed and counseling will be provided to the clinical staff member. Ensuring med carts are secured will be an on-going process for DON and ED and results will be shared at routine QAPI meetings.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure a residents (Resident H) clinical record was complete for 1 of 9 records reviewed for medical records. Findings include: The closed clinical record for Resident H was reviewed on 11/29/23 at 9:41 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, insomnia, encephalopathy, depression and anxiety. On 11/29/23 at 2:40 p.m., the July, August and	R 0349	***Corrective actions for resident that was affected by the alleged deficient practice:*** The records request was for a discharged resident. Medication Administration Records have not been located. ***Other residents having the potential to be affected by the alleged deficient practice:*** All residents with a Medication Administration Record have the potential to be affected.	01/04/2024

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	September 2023 medication administration records for the resident were requested for review. On 11/30/23 at 2:42 p.m., the Director of Nursing indicated they could not locate the July through September 2023 medication administration records for Resident H. On 12/1/23 at 2:28 p.m., the Executive Director provided a current copy of the document titled "Health Information Management Manual" dated 1/17. It included, but was not limited to, "Retention of Medical Records...The retention system is designed and implemented to provide...accuracy of health records...."		***Measures put into place to ensure that the alleged deficient practice does not recur:*** The record retention room has been secured. 12/19/2023 Facility will be transitioning to Electronic Medical Administration Record in early 2024. During monthly change over of paper Medication Administration Records, all completed MARs will be cross checked against resident roster, scanned into PCC and stored in record retention room in residents extended files. ***How the corrective actions will be monitored to ensure the alleged deficient practice does not recur:*** Access to record retention room will be granted at the discretion of the ED. Each month old and new Medication Administration Records will be reconciled. The old MARs will be given to the DON who will reconcile them using a resident roster and then place them in the record retention room. Any missing records will be immediately brought to the attention of the ED for follow up. This process will be ongoing until EMAR conversion is completed.	