PRINTED: 01/08/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/17/2024				
NAME OF F	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP COD	12/11/2021			
CHARLES FORD MEMORIAL HOME INC				920 S MAIN ST NEW HARMONY, IN 47631				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG R 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00440674. Complaint IN00440674 - No deficiencies related to the allegations are cited. Survey dates: December 17, 2024 Facility number: 001123 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 18, 2024.		R 0000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submit the responses pursuant to our regulatory obligations. The farequests the plan of correction considered our allegation of compliance effective January 2025, to the state findings of the State Residential Licensure we Complaint (IN00440674) Survivinducted on December 17, 20	fic e of hese cility n be 10, he ith ey			
R 0247 Bldg. 00	410 IAC 16.2-5-4 Health Services -							
	interview, the facil insulin per manufa residents reviewed (Resident 10) Finding includes: On 12/17/2024 at 1 (RN) 2 administere Resident 10. RN 2 prior to administrat	on, record review, and ity failed to properly administer cturer's instructions for 1 of 5 for medication administration. 1:51 A.M., Registered Nurse ed 4 units of insulin lispro to failed to prime the insulin pention. 2:00 P.M., Resident 10's clinical	R 0247	R 247 The corrective action taken for those residents found to have been affected by the deficient practice is that Registered Nur. 2 was provided with in-service training on the proper technique for priming insulin to ensure correct administration. Reside identified as resident 10 is now receiving their insulin in accordance with acceptable standards of practice of insulin administration.	rse e ue nts v			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE			

Amy Knopf Koch HFA, Executive Director 12/31/2024

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING 12/17/20		2024		
				CTD FFT A	ADDRESS OF A STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
CHARLES FORD MEMORIAL HOME INC					MAIN ST		
CHARLE	S FORD MEMORIA	AL HOME INC		NEW H	ARMONY, IN 47631		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	record was reviewe	d. Resident 10 had diagnosis			The corrective action taken for	the	
	that included, but w	as not limited to, diabetes			other residents that have the		
	mellitus type II.			potential to be affected by the			
					same deficient practice is that	_	
	Physician orders for	r Resident 10 included, but			residents currently receiving		
	were not limited to:				insulin are at risk of being		
	Insulin Lispro Injec	tion Solution 100 unit/mL			affected by this deficient pract	ice.	
		- Inject as per sliding scale: if			Registered Nurse 2 and all nu		
	141 - 200 = 4 units;	201 - 250 = 6 units; 251 - 300 =			staff received in-service trainir		
	8 units; $301+=10$ u	units. If above 301, recheck in 2			on the correct method for prim	_	
	hours. Do not repea	t insulin & call physician if			insulin to prevent potential erro	•	
	still above 301 after	the 10 units, subcutaneously			in insulin administration. All		
	before meals and at	bedtime, dated 8/7/24			residents who have orders for		
					insulin are now receiving their		
	On 12/17/2024 12:1	10 P.M., RN 2 indicated they			insulin in accordance with		
	never primed insulin pens.				acceptable standards of practi	ce	
					of insulin administration.		
	On 12/17/2024 at 2	:00 P.M. the Director of Nursing					
	(DON) provided an	insulin administration policy.			The measures that have been	put	
	This policy did not	address the use of insulin			into place to ensure that the		
	pens only insulin gi	ven with a syringe.			deficient practice does not rec	ur is	
					that the facility has reviewed ti	heir	
	On 12/17/2024 at 2	:09 P.M., the manufacturer's			insulin administration policy ar	nd	
	insert for Insulin Li	spro KwikPen was reviewed. It			procedure to ensure it meets		
	indicated "if you do	not prime before each			acceptable standards of practi	ce.	
	injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to				Nursing staff have been in		
					serviced on the updated insuli	n	
	select 2 units. Hold your pen with the needle				administration policy and		
	pointing up. Tap the	e cartridge holder gently to			procedure.		
	collect air bubbles a	at the top. Continue holding					
	your pen with need	le pointing up. Push the dose			The corrective action taken to		
	knob in until it stop	s, and "0" is seen in the dose			monitor to ensure that the		
	window. Hold the d	lose knob in and count to 5			deficient practice will not recui	is	
	slowly. You should	see insulin at the tip of the			that we have developed a Qua	ality	
	needle. If you do not see insulin, repeat priming				Assurance tool to ensure		
	steps 6 to 8, no mor	re than 4 times. If you still do			compliance. This tool will be		
		nge the Needle and repeat			completed by the Director of		
	priming steps 6 to 8	3."			Nursing and or their designee.		
					Nursing staff will be monitored	for	
					compliance on a weekly basis	for	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/17/2024	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD MAIN ST	
CHARLE	S FORD MEMORIA	L HOME INC		HARMONY, IN 47631	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
			TAU	the first month. After the initial month, monitoring will be conducted monthly for the following three months. Quart monitoring will then be implemented and maintained one year to ensure ongoing compliance.	er
R 0273	410 IAC 16.2-5-5.	• •			
Dida 00	Food and Nutrition	nal Services - Deficiency			
Bldg. 00	review, the facility of policy by dating for packaging according handling standards observations. (Kitch Finding includes: During an observation the following items freezer, removed from lacked any labeling of items inside the bag of waffles bag of chicken patting of strawberries bag of grapes bag of french fries bag of blueberries bag of potato cubes During an interview dietary director inditell when an item was	on on 12/17/24 at 9:35 A.M., were observed in the walk-in om original packaging, and including dates or description pag:	R 0273	R 273 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey all residents staff and visitors have the potential to be affected by this deficiency. All undated items items without label that were identified in the walk-in freeze were promptly removed and disposed of to ensure resident safety and compliance with purification for the corrective action taken for other residents that have the potential to be affected by the same deficient practice is although no specific residents were identified during the survall residents, staff and visitors have the potential to be affect by this deficiency. All undated items and items without label	ied s, s and r t topper r the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 12/17/2024			
NAME OF PROVIDER OR SUPPLIER CHARLES FORD MEMORIAL HOME INC			STREET ADDRESS, CITY, STATE, ZIP COD 920 S MAIN ST NEW HARMONY, IN 47631					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE		
	provided an undate Dating Policy" that safety for residents it is dated with the is open it gets an op	d policy titled "Opening and indicated "To ensure food Once the product is received receiving date. Once a product pen date. Once opened and date product must have an		were identified in the weare freezer were promptly and disposed of to ensist safety and compliance food handling practices. Additionally, the walk-in was inventoried to identified address all items missist open date, or expiration. The measures that have into place to ensure that deficient practice does that the FOOD SAFET STORAGE OF FOOD has been amended to acceptable standards if safety practices (attack dietary staff have received in-service training on the FOOD SAFETY: STOFFOOD POLICY in acceptable standard handling. The corrective action to monitor to ensure that a Quality Assurance been developed and in to monitor the safe food in the dietary department of the interest of the properly wrapped/cover dated with open dates/dates in accordance we food practices. This to completed by the Dietal and/or their designee we four weeks, then monthing.	removed rure resident with proper s. In freezer ntify and ing a label, In date. We been put at the not recur is for food ned). All ived he amended RAGE OF ordance with rds for food he at the ot recur is ce tool has he plemented d practices ent to ms are fored and fexpiration ith safety of shall be ary Manager fiveekly for			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/17/2024	
NAME OF PROVIDER OR SUPPLIER CHARLES FORD MEMORIAL HOME INC			STREET ADDRESS, CITY, STATE, ZIP COD 920 S MAIN ST NEW HARMONY, IN 47631				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	F	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
					months and then quarterly for three quarters to ensure on-go compliance. Any discrepancie will be immediately corrected to ensure food safety.	s	

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