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	155820	A. BUILDING 00 B. WING	08/01/2022

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00375365. Complaint IN00375365- Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: July 25, 26, 27. 28, 29, August 1, 2022. Facility number: 000443 Provider number: 155820 AIM number: 100289580 Census Bed Type: SNF/NF: 42 Total: 42 Census Payor Type: Medicare: 8 Medicaid: 27 Other: 7 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 9, 2022.	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility respectfully requests the 2567 plan of correction to be considered our allegation of compliance **effective August 19, 2022** to the State findings of the Annual/Complaint survey conducted on August 1, 2022. We respectfully request a desk review in lieu of a post-survey review.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons			

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

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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	and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to honor rights of the	F 0550	*This facility will be submitting an IDR related to F550 and supporting documents and*	08/19/2022

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	residents. The chapel was closed and residents were restricted to certain areas of the facility for 6 of 6 days of the survey. (Resident 37) Findings include: On 7/25/22 at 9:15 a.m., the chapel on the 100 unit was observed to have a chain and padlock attached to both entry doors with a sign that stated "Due to being in outbreak status related to COVID -19 the Chapel will be CLOSED until further notice!" On 7/26/22 at 8:44 a.m., the same was observed. On 7/27/22 at 8:33 a.m. the same was observed. On 7/28/22 at 10:10 a.m., the same was observed. On 7/29/22 at 8:45 a.m., the same was observed. On 07/26/22 at 9:22 a.m., Resident 37 indicated the facility had chains on the doors to the chapel, mass was not being offered, residents were told to stay on the floor where they resided, they thought the chains were extreme and residents in the facility were upset about it. On 7/27/22 at 10:29 a.m., an anonymous resident interview described the following, went for bible study and no one was there, no communion was offered, chains on the chapel doors are terrible, they could lock it, didn't have to put chains on the door, the residents could not go to the second floor or ground floor, we were told that by staff, and were unable to go downstairs to mail letters. On 7/27/22 at 10:35 a.m., an anonymous resident interview indicated they had a concern with the chapel being closed, there was no place else to go		*summary will be added to POC .* *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Resident 37 and the three anonymous residents mentioned were not adversely affected by the alleged deficient practice. All residents and families, along with the independent apartment residents of the campus, were notified of the closing of the chapel on 7-18-22 due to the outbreak status of Covid on the 2nd floor and the subsequent staff positives who worked the 1st floor on 7-21-22 and 7-22-22. All residents and families along with the independent apartment residents of the campus, were made aware of the re-opening of the chapel on 7-29-22 following no additional positive Covid tests since 7-22-22. During this closure, no outside religious visitation to residents were restricted and Activities offered devotional and bible study. Administrator will meet with all residents willing to discuss their concerns and answer questions related to the reasoning behind shared chapel closure.** *How will other residents with the potential to be affected by the same alleged deficient practice be*	

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	for services. On 7/27/22 at 10:40 a.m., an anonymous resident interview indicated they had a concern with the chapel being closed, signs were on the doors about positive cases of COVID. On 7/28/22 at 10:23 a.m., signs were observed on all doors and outside of the elevators asking residents not to use elevators or leave their floors until further notice. The signs were observed from 7/25/22 through 7/29/22. On 7/29/22 at 9:30 a.m., the activity calendar for July 2022 was reviewed. Mass was scheduled daily at 11:00 a.m. in the chapel, Rosary was scheduled daily in the chapel at 3:45 p.m. No alternative location was listed on the calendar. On 7/28/22 at 11:16 a.m., the Administrator indicated the chapel was closed when the facility outbreak started, would reopen it if over the weekend when the last COVID positive resident was taken off precautions, she told the residents that she did not want them to come down from the second floor to the first floor for the chapel, it was closed to all residents, no mass while it was closed, but able to do communion on the first floor. On 8/01/22 at 10:32 a.m., the Administrator indicated there had been no COVID positive residents since 7/19/22, the chapel had been closed after the first positive residents, she told the second floor residents to stay on the second floor and first floor residents not to go to the second floor for safety reasons. The first positive resident came from the hospital positive on 7/16/22, all residents were tested on 7/16/22 and no positives, retested on 7/17/22 due to close		*identified and what corrective action(s) will be taken?* **Any resident involved in religious activities has the potential to be affected by the closure of the chapel. Administrator will meet with all residents willing to discuss their concerns and answer questions related to the reasoning behind shared chapel closure and Covid outbreak regulations.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **In-service on current CMS guidelines related to isolation of residents during an outbreak will be completed with Administrator by Regional Director of Operations. Residents and families will be made aware of what to expect for any future outbreak occurrences.** *How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur i.e., what quality assurance program will be put into place?* **Administrator will monitor for outbreak concerns and complete audit tool as warranted for showing CMS-guided follow up for residents religious opportunities. This will be in effect for six months. The outcome of this tool will be reviewed at the Quality**	

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	exposure and additional cases found. All COVID -19 residents resided on the second floor. On 8/1/22 at 10:56 a.m., the Administrator indicated it was her decision to close the chapel because the residents who resided in the apartments (independent living apartments adjoining the building), will not stay out of the chapel and they visit residents in the facility, it was done as a precaution to help contain the outbreak, communion was offered on the first floor, she had informed the residents and their representatives. On 8/1/22 at 12:24 p.m., the Administrator provided the current policy on resident rights with a revision date of December 2016. The policy included, not limited to, Federal and state laws guarantee basic rights to all residents of this facility. These rights include the residents rights to: communication with and access to people and services, both inside and outside of the facility, exercise his or her rights as a resident of the facility and as a resident or citizen of the United States. 3.1-3(a) 3.1-3(g)(6)		**Assurance monthly meeting to determine if any additional action is warranted.**	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the			

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	comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to ensure a plan of care was implemented to address the resident's medical and physical needs for 1 of 2 residents reviewed for pressure ulcers. A resident did not receive weekly skin assessments, and a dressing was not	F 0656	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Resident 11 was not adversely affected by the alleged**	08/19/2022

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	changed per the physician's order. (Resident 11) Finding includes: On 7/28/22 at 10:28 A.M., Resident 11's clinical record was reviewed. The most recent significant change MDS (minimum data set) Assessment, dated 5/13/22, indicated Resident 11 was currently receiving hospice services, was at risk for pressure ulcers, and a had a moderate cognitive impairment. Current physician's orders included, but were not limited to, the following: Cleanse on and around below coccyx, apply med honey and cover with foam dressing, once a day, dated 7/14/22 Weekly skin assessments, dated 1/31/22 A current risk for skin impairment care plan, dated 1/27/22, indicted interventions, but were not limited to, weekly skin assessments, dated 1/27/22. Weekly skin assessments were completed on the following dates from 6/7/22 through 7/26/22: 6/7/22 6/14/22 6/21/22 6/28/22 7/5/22 7/19/22 7/26/22 There was no weekly skin assessment completed the week of 7/12/22. On 7/27/22 at 1:38 P.M., LPN 3 was observed to apply a dressing for Resident 11's pressure area on her coccyx. LPN 3 wiped the area with skin prep, let dry, and covered with a dressing. Medihoney was not used for the new dressing.		**deficient practice. Resident 11's physician orders for wound orders and skin assessment were audited by DON to show correct and LPN 3 was in-serviced on following orders as directed. DON completed skin assessment on resident 11 and no additional concerns noted.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* **All residents have the potential to be affected by alleged deficient practice. All current residents orders for skin assessments and wound care were audited by DON to show completion of orders correctly.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **In-service will be held with all nursing staff by DON/designee regarding the importance of following physician orders and completed skin assessments as directed.** *How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur i.e., what quality assurance program will be put into place?* **An audit tool will be put in place to monitor wound orders and**	

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	During an interview on 8/1/22 at 10:06 A.M., the DON (Director of Nursing) indicated she was unsure why Resident 11's weekly skin assessment was missed on 7/12/22, but that is was required. She further indicated the dressing on Resident 11's coccyx should have been medihoney and a foam dressing. A policy related to following care plans and/or physician's orders was requested, and not provided. 3.1-35(g)(1)		**skin assessment frequency. This tool will be used Monday to Friday daily for 4 weeks, weekly for 8 weeks and monthly for 3 months. It will be implemented and monitored by the DON or designee. This outcome of this audit tool will be reviewed at monthly Quality Assurance meeting to determine if any additional action is warranted.**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review the facility failed to provide showers/baths for 2 of 3 residents reviewed. Residents were not given showers or baths. (Resident C, Resident D) Findings include: 1. On 7/25/22 at 10:41 a.m., Resident C indicated she was not getting a shower twice a week, the staff turned her side to side and cleaned her up. On 7/27/22 at 9:05 a.m., Resident C's clinical record was reviewed. Resident C had diagnoses that included, not limited to, Hypertension, chronic kidney disease stage 3, spondylolistheses, multiple sites in spine. An MDS (Minimum Data Set) quarterly assessment dated 7/25/22, indicated	F 0677	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice*? **Resident C and D were reviewed for their preferences in bathing. Residents will have their preferences met and offered bathing as requested; with refusals for care documented appropriately by staff.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* **All residents have the potential to**	08/19/2022

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	C's cognition was intact, physical help in part of bathing, one person assist. Care plans were reviewed and included, not limited to, Resident preferences for daily care and care planning include: Shower: 2x weekly, bathing time of day: no preference, revision on 1/19/22. Bathing documentation was revived for June and July of 2022 and contained the following: 6/3- bed bath 6/7- bed bath 6/14- bed bath 6/17- bed bath 6/21- not applicable 6/28- bed bath 7/1- bed bath 7/5- bed bath 7/15- bed bath 7/19- bed bath 7/24- not applicable 7/26- bed bath No refusals were documented in Resident C's clinical record. 2. On 7/27/22 at 8:48 a.m., Resident D's clinical record was reviewed. Resident D had diagnoses that included, not limited to, schizoaffective disorder, bipolar type, cognitive communication deficit, dementia in other diseases classified elsewhere with behavioral disturbance. An MDS (Minimum Data Set) quarterly assessment dated 6/10/22, indicated Resident D's cognition was moderately impaired, physical help in part of bathing one person assist. Care plans were reviewed and included, not limited to, Resident preferences for daily care and care planning include:; Shower: Yes 2x weekly, bathing time of day: AM, interventions included,		**be affected by this alleged deficient practice. An audit of all residents to note current bathing preferences will be completed by Social Services.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?***. An in-service will be completed with all nursing staff by DON related to appropriate documentation of refusals and practice of returning to offer assist more than once.** *How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur i.e., what quality assurance program will be put into place?* ***An audit tool will be used to monitor that resident bathing schedules are followed and the correct documentation of refusal for bathing is in place.*** **This tool will be used Monday to Friday daily for 4 weeks, weekly for 8 weeks and monthly for 3 months. It will be implemented and monitored by the DON or designee. The outcome of this tool will be reviewed at monthly Quality Assurance meeting to determine if any additional action is warranted.**	

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	not limited to, ask resident about preferences regarding activities of daily living> dressing, bathing, grooming, time of day, frequency, etc., initiated 8/5/19. The resident has an ADL self care performance deficit r/t her diagnosis of Multiple Sclerosis, interventions included, not limited to, bathing: the resident is able to with cuing wash face and upper body, initiated on 7/10/17. Bathing: the resident is totally dependant on staff to provide a bath at least 2x wk and as necessary, initiated 3/20/20. Bathing documentation was reviewed for June and July of 2022 and contained the following: 6/3- shower 6/7- shower 6/14- shower 6/17- shower 6/21- shower 6/24- bed bath 6/28- shower 7/5- bed bath 7/12- resident not available 7/22- resident refused 7/26- shower 7/29- bed bath No refusals were in the clinical record except 7/22. On 7/29/22 at 9:04 a.m., CNA 1 indicated if a resident refuses bathing they try to come back later, let the charge nurse know the resident refused, should be documented. On 8/1/22 at 12:24 p.m., the Administrator provided a document titled " Shower/Tub Bath" with a revision date of October 2010. The document included, not limited to -Documentation- If the resident refused the shower/tub bath, the reason(s) why and the			

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	intervention taken. Reporting - notify the supervisor if the resident refuses the shower/tub bath. This Federal tag relates to Complaint IN00375365. 3.1-38(a)(1)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide an environment free of accident hazards for 2 of 4 residents reviewed. A cognitively impaired resident had medications in their room, unlocked and unattended. Resident 24 had six falls in two months, one resulted in a fracture to the left hip with one additional fall after the fracture. (Resident 24, Resident 13) Findings include: 1. On 7/29/22 at 9:07 A.M., Resident 24's clinical record was reviewed. Diagnosis included, but were not limited to, depression, dementia, and osteopenic bones. The most recent significant change MDS (minimum data set) Assessment, dated 6/2/22, indicated Resident 24 required extensive assistance of two staff with bed mobility, transfers, and toileting, and was	F 0689	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Resident 13 had all medications removed from her room that were not authorized by physician order and a self-administration of medications assessment was completed. Physician orders were gathered for those medications she wished to continue using and the Social Service Director spoke with family about guidelines not allowing for outside medications to be brought in for residents without physician order. Resident 24 had all care**	08/19/2022

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(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
	completely dependent on one staff for bathing. The MDS indicated Resident 24 had a moderate cognitive impairment. A current care plan for risk for falls, dated 6/25/21, included the following interventions: anti rollback to wheelchair, dated 5/16/22 anticipate and meet needs, dated 6/25/21 call light within reach and encourage to use, dated 6/25/21 follow facility fall protocol if fall occurs, dated 6/25/21 non-skid strips to left side of bed, dated 5/23/22 notify family and physician of falls, dated 6/25/21 therapy evaluations and treatments as ordered and as needed, dated 6/25/21 resident not to be left in wheelchair in room alone, dated 6/20/22 Falls included the following: Fall 1 4/24/22 at 2:00 A.M. Staff heard a loud crash from the resident's room and calls for help. Resident was found on the floor lying on her left side. Resident was helped to bed and given pain medication. The resident had a bruise to the back of the right hand, and an abrasion on the left buttock. An IDT (interdisciplinary team) note, dated 4/25/22, indicated the new intervention related to the fall was to have staff ensure that walker was within reach at all times. The falls care plan was not updated with the new intervention. Fall 2 5/12/22 at 9:45 P.M. Resident was standing in the doorway holding onto the bed trying to reach the nurse. Nurse attempted to reach the resident, when the resident sat down on the floor.		**plan interventions assessed and updated to reflect current interventions and updated access to information for all staff to follow appropriately.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* **All residents have the potential to be affected by the alleged deficient practice. All nursing staff will be in-serviced on reporting to the charge nurse any meds observed in residents' rooms so appropriate follow up with physician orders can occur. All nursing staff will be in-serviced on the importance of following interventions that are current. Administrator will remind all families of residents that they are not allowed to bring in outside medications to their residents and must inform the nursing staff of need to get order for any new medication items they desire.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **All facility staff will be in-serviced on the importance of sharing with nursing supervision any observation of hidden medications in resident room. MDS will be in-serviced**	

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	155820	A. BUILDING 00 B. WING	08/01/2022

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	An IDT note, dated 5/13/22, indicated the new intervention related to the fall was to place wheelchair in locked position next to the bed. The falls care plan was not updated with the new intervention. Fall 3 5/13/22 at 8:49 P.M. Resident fell while attempting to transfer self from the wheelchair to the bed. Resident was found lying on her right side beside the bed. An IDT note, dated 5/16/22, indicated the new intervention related to the fall was to place anti roll backs on wheelchair. Fall 4 5/15/22 at 2:44 P.M. Resident was found on the floor on back without socks or shoes in front of recliner. The resident indicated to staff she was going to the bathroom and fell. Walker was not in reach, and the resident's wheelchair was in the bathroom. An IDT note, dated 5/16/22, indicated the new intervention related to the fall was to re-educate staff to ensure wheelchair is kept locked and next to the resident. The falls care plan was not updated with the new intervention. Fall 5 5/20/22 at 4:30 P.M. Resident was found in room lying on the right side with a wheelchair next to her. The resident indicated she was trying to get to the chair. At that time, the resident complained of left hip pain. A left hip x-ray was ordered the same day, and results showed a left hip fracture. An IDT note, dated 5/23/22, indicated the new intervention related to the fall was to place non skid strips to floor on left side of bed.		**on importance of appropriate review and update of all care plan intervention changes and related IDT notes by Regional MDS Director.** *How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur i.e., what quality assurance program will be put into place?* **An audit tool to monitor for changes in interventions, updated CNA sheets, nursing review every shift of safety measures for #24 as a high risk for falls and completion of an updated care plan review will be put into place and monitored by MDS/designee. An audit tool to monitor resident rooms for unauthorized medications will be put into place and monitored by DON/designee. Both of these tools will used daily Monday to Friday for 4 weeks, weekly for 8 weeks and monthly for 3 months. The outcome of these tools will be reviewed at the Quality Assurance monthly meeting to determine if any additional action is warranted.**	

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	Fall 6 618/22 at 1:56 P.M. Resident was found lying on her buttocks and left elbow on the bedroom floor. The resident was between the wheelchair and recliner, and indicated at that time she was trying to transfer self to the recliner. An IDT note, dated 6/20/22, indicated the new intervention related to the fall was to educate staff to not leave resident in her wheelchair in her room alone. On 7/27/22 at 1:21 P.M., Resident 24 was observed lying awake in bed. The call light was on the floor between the wall and the bed, and the resident's walker was observed on the other side of the room. On 7/28/22 at 9:04 A.M., Resident 24 was observed sitting in a recliner in her room with her feet up. The resident's walker was observed on the other side of the room. On 7/29/22 at 10:56 A.M., Resident 24 was observed sitting in a recliner in her room with her feet up. The resident's walker and wheelchair were observed in the bathroom with the door closed. On 8/1/22 at 9:57 A.M., Resident 24 was observed lying in bed with a call light on the floor between the wall and the bed. The resident's walker was observed on the other side of the room. At that time, QMA (Qualified Medication Aide) 5 indicated Resident 24 should have the call light in reach at all times. 2. On 7/26/22 at 9:41 A.M., a bottle of Omega 3 and a bottle of B Complex were observed in Resident 13's room. At that time, Resident 13 indicated she had several bottles of "vitamins" in			

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	her room, including a box of them in her closet. Resident 13 also indicated she had taken the medications in her room all her life. On 7/28/22 at 1:34 P.M., Resident 13's clinical record was reviewed. Diagnosis included, but were not limited to, depression and PTSD (post-traumatic stress disorder). The most recent quarterly MDS Assessment, dated 5/17/22, indicated a moderate cognitive impairment. The clinical record lacked a self-administration of medications assessment. The clinical record lacked a physician's order for self-administration of medications or storage of medications in room. During an interview on 7/29/22 at 10:35 A.M., LPN (Licensed Practical Nurse) 7 indicated she was unaware of any medications in Resident 13's room. At that time, LPN 7 gathered all medications from Resident 13's room, which included the following: a bottle of B Complex (supplement) two bottles of Omega 3 (supplement) Icy Hot spray and bottle a box of Banophen (allergy medication) 25mg (milligram) tablets a tub of Desitin (cream) three bottles of Advanced D (supplement) four bottles of Primal Force curcumin triple burn (dietary supplement) a bottle of Krill omega 50+ a bottle of Ginko Biloba two bottles of meclizine 25mg (antihistamine) a tub of chest rub a bottle of Apple Cider vinegar seven tubs of Capsaicin 0.05% (pain relief cream) a bottle of Trexar nerve sensation (dietary supplement)			

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	At that time, LPN 7 indicated Resident 13 was not supposed to have any medications in her room. Resident 13's clinical record lacked any orders for the medications found in her room except the following: meclizine HCl tablet 25mg as needed, dated 4/28/22 During an interview on 7/29/22 at 11:35 A.M., the Administrator indicated it was Resident 13's sister that was bringing in medications to her, and the sister had also brought medications to another resident in the past. The issue of bringing in medications was addressed with the sister, and she had voiced understanding. The Administrator further indicated she was unaware that any other medications had been brought in to Resident 13 due to the fact Resident 13 was cognitively impaired, and did not understand to notify staff. On 8/1/22 at 12:24 P.M., a current care plans policy, revised September 2010, was provided and indicated "Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change ... The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans" On 8/1/22 at 12:24 P.M., a current self-administration of drugs policy, revised August 2006, was provided and indicated "Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for bedside storage, for return to the family or responsible party" 3.1-45(a)(1)			

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	3.1-45(a)(2)			