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	02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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R 0000 Bldg. 00	This visit was for an Initial State Residential Licensure Survey. Survey dates: February 27 and 28, 2020 Facility number: 014548 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 6, 2020.	R 0000		
R 0185 Bldg. 00	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard			

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

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	surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.			
	Based on observation, record review, and interview, the facility failed to ensure an official bed change request had been completed and approved before more than one resident resided in a room licensed to be occupied by only one resident for 2 of 40 rooms reviewed. (Rooms 12 and 19) Findings include: 1. On 2/28/20 at 9:25 a.m., the Administrator indicated the facility had two residents , Residents 13 and 14, that resided in Room 12. The room had one bedroom and was set up	R 0185	R0185 Michelle Sowell, Director of Operations is diligently working with the ISDH in implementing the new bed change licensure. Michelle has been in direct contact with Todd Hite, P.E. at the ISDH and has followed his guidance on completing the addition of bed licensure, which has been submitted, along with payment of new bed additions. This will be implemented as	03/12/2020

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	(licensed) for one resident. The Bed Inventory form indicated the room was licensed for one resident, but since they had two residing in the room, a husband and wife, she wasn't sure how to document that on the bed inventory. 2. On 2/28/20 at 4:18 p.m., the Administrator indicated the facility had two residents, Residents 11 and 12, that resided in Room 19. The room was licensed for one resident only. On 2/28/20 at 4:52 p.m., rooms 12 and 19 were observed with the Administrator. Both rooms had one bedroom and two beds in the bedroom. The Administrator indicated they were requesting a bed change for both rooms. The Bed Inventory form was provided on 2/28/20 at 11:08 a.m. The form indicated rooms 12 and 19 were licensed for one bed.		quickly as the state makes the approval. Please see the Application for Construction Permit (attachment 4) and the Payment Receipt Confirmation (attachment 5). Michelle Sowell, Director of Operations, along with William Utz, Architect, have been working with Walt Perry, ISDH Environmental Engineer, to approve final plans. Upon ISDH decision, admissions will reflect the bed licensure forward. Once ISDH approves bed change licensure, this monitoring can stop.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.	R 0298	R0298	03/02/2020

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	Based on record review and interview, the facility failed to ensure pharmacy reviews were completed every 60 days for 3 of 6 residents reviewed. (Residents 4, 17, and 21) Findings include: 1. Resident 21's record was reviewed on 7/28/20. The record indicated Resident 21 was admitted on 12/18/19 with diagnoses that included, but were not limited to, asthma, depression, chronic kidney disease, and high blood pressure. The Physician's recapitulation orders, dated 2/1/20 through 2/28/20, indicated the resident had the following medication orders: - hydralazine (lowers blood pressure) 50 mg (milligrams) four times a day for high blood pressure - renvela (decreases dietary phosphate) 800 mg by mouth every day with meals - omeprazole (blocks production of stomach acids) 40 mg twice a day before a meal - clopidogrel 75 mg by mouth every day for blood thinner - sertraline (anti-depressant) 100 mg by mouth every day for mood - imdur 60 mg every day in the morning for angina/chest pain - torsemide (diuretic) 40 mg by mouth twice a day for edema - gabapentin 300 mg by mouth three times a day for pain - carvedilol 25 mg by mouth twice a day for high blood pressure - atorvastatin (lowers blood fats) 80 mg by mouth every day at bedtime - aripiprazole (antipsychotic) 5 mg by mouth		Jana Dorsey, Pharmacist at Medworks Pharmacy located in Shelbyville, Indiana had reviews completed on 1/10/2020. Pharmacist stated she gave them to the nurse, Amanda Cuautle, and she never sent them back with a signature. This nurse has been terminated from our facility, effective 2/24/2020. We have a new nurse, Rebecca (Becca) Snider, who has taken her place. Jana Dorsey, Pharmacist, has since given the Administrator, Shannon Logan, copies of the reviews, which were signed 2/28/2020 by the Administrator and placed in the respective resident's charts. A subsequent review was completed on 2/27/2020; these reviews have been reviewed, signed, and placed in resident's charts. We have completed a Pharmacy Review spreadsheet (see attachment 1) that lists the residents name, room number, and all twelve months. Boxes are left blank for signature, under the months in which a review needs to be done. Each month, the nurse and a member of management will verify with signature that each review has been completed. Pharmacy Review will be monitored monthly with attached spreadsheet, by the nurse and a member of management, verifying with signature, that each review	

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	once daily for mood - azelastine 0.1% (137 mcg) spray, 1 spray in each nostril twice a day for allergies - levothyroxin 150 mcg, take 2 tablets (300 mcg) by mouth once daily for thyroid - levocetirizine 5 mg by mouth every day in the evening for allergies The clinical record failed to indicate Resident 21 had a pharmacy review since admission. On 2/27/20 at 2:15 p.m., LPN (License Practical Nurse) 1 indicated the facility had been open since November 2019, and the Pharmacist's understanding was that she had to do a review quarterly, and she hasn't done a pharmacy review yet. On 2/28/20 at 11:08 a.m., the Administrator indicated the facility admitted their first resident on 11/29/19. 2. Resident 4's record was reviewed on 2/27/20 at 1:20 p.m. The resident was admitted on 12/16/19, and his diagnoses included, but were not limited to, depression, dementia, and hypothyroidism. The Physician's recapitulation orders indicated the resident had the following medication orders: - mirtazapine 30 mg every evening, at bedtime - citalopram 10 mg every day at bedtime - aspirin-dipyrid er 25-200 mg 2 times a day - dorzolamide-timolol eye drops 1 drop each eye 2 times a day - rouvastatin 5 mg every day at bedtime - tamsulosin 0.4 mg every day in morning - therapeutic-m 1 cap every day in morning - propranolol 40 mg three times a day - primidone 50 mg take 2 tablets four times a day		has been completed. This practice will continue indefinitely.	

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	- levothyroxin 50 mcg once daily in the morning - levetiraceta 500 mg 2 times a day - lantanoprost 0.005% 1 drop in both eyes every day at bedtime - doneperil 10 mg every day at bedtime - docusate 100 mg every day at bedtime as needed for constipation - acetaminophen 325 mg 2 tablets every 4 hours as needed. Review of the pharmacist drug regimen review indicated a review was not completed for this resident. 3. Resident 16's record was reviewed on 2/28/20 at 10:30 a.m. The resident was admitted on 11/29/19, her diagnoses included, but were not limited to, sepsis, urinary tract infection, syncope and collapse. The physician's recapulation orders indicated the resident had the following medication orders: - amlodipine 2.5 mg every day - oyster shell/d calcium 500 mg every day - therapeutic-m 1 cap every day - citalopram 20 mg every day - aspirin 325 mg every day - alendronate 70 mg once weekly on Monday at least 30 minutes before food/medication - remain stand/sit, atorvastatin 10 mg take 1/2 tablet every day at bedtime - ammonium lactate 12% lotion apply 2 times a day as needed for dry skin. Review of the pharmacist drug regimen review indicated a review was not completed for this resident. A policy for "Pharmaceutical Services" was			

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	provided by the Administrator on 2/28/20 at 4:15 p.m. The policy indicated: "A Pharmacy must be contracted with. They shall review the drug handling and storage practices in the facility, provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping...They should review the drug regimen of each resident receiving these services at least once every 60 days."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency files contained the resident's phone number and/or a clear identifiable photograph in the event of an emergency for 14 of 19 emergency files reviewed. (Residents 2, 3, 4, 6, 7, 8, 9, 10, 15,	R 0356	R0356 New face sheets (see attachment 2) have been created and completed for ALL residents. New Pictures of ALL residents have been taken and placed with new	03/18/2020

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	16, 17, 19, 20, and 21) Findings include: During the review of the Residential Emergency Files on 2/28/20, the following was identified: 1. Resident 2's phone number was not in her emergency file. 2. Resident 3's phone number was not in the emergency file. The photograph in her emergency file was dark and blurred and unable to accurately identify the resident. 3. Resident 4's phone number was not in the emergency file. 4. Resident 6's phone number and photograph were not in his emergency file. 5. Resident 7's phone number was not in his emergency file. 6. Resident 8's phone number was not in her emergency file. 7. Resident 9's phone number was not in her emergency file. 8. Resident 10's phone number was not in her emergency file. 9. Resident 15's phone number was not in her emergency file. 10. Resident 16's phone number was not in her emergency file. 11. Resident 17's phone number was not in her		face sheets, in both the Emergency File and Resident Chart. This was completed 3/18/2020. Required information was added to new face sheet. The administrative assistant will review each new residents chart upon admission. This practice will continue indefinitely.	

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	emergency file. 12. Resident 19's phone number was not in his emergency file. 13. Resident 20's phone number was not in her emergency file. 14. Resident 21's phone number was not in her emergency file. On 2/28/20 at 4:07 p.m., the Administrator indicated not all residents had a phone in their room. A list of residents who did not have a phone in their room was provided. Residents 2, 3, 4, 6, 7, 8, 9, 10, 15, 16, 17, 19, 20, and 21 were not on the list and had a room phone or a cell phone in their room. A Procedure for "Resident Emergency Information" was provided by the Administrator on 2/28/20 at 4:15 p.m. The Procedure included, but was not limited to: "An emergency file shall be immediately accessible for each resident, in case of emergency, that contains the following: 1. Resident's name, sex, room or apt number, phone number, age or DOB [date of birth]...."			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12)			

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	months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure the two step tuberculin skin tests were given timely after admission for 2 of 6 residents reviewed for tuberculin skin tests. (Residents 17 and 16) Findings include: 1. Resident 17's record was reviewed on 2/28/20 at 10:15 a.m. The record indicated Resident 17 was admitted on 11/29/19 and had diagnoses that included, but were not limited to, anxiety, arthritis, high blood pressure, and chronic kidney disease. Resident 17's "Mantoux (tuberculin skin test) Report" indicated she had been given a first step tuberculin skin test on 11/19/19, which was read on 11/21/19 and was negative. The "Mantoux Report" indicated: "One step TB Test required if resident has documented negative TB test within preceding 12 months. Two step TB Test required if resident has NOT had a documented TB Test within preceding 12 months. (If first test is negative, then 2nd test should be preformed within 1 to 3 weeks after first test.)	R 0410	R 0410 Facility nurse, Rebecca (Becca) Snider, is in the process of obtaining her TB certification. For an immediate correction, nurse, Marilee Evans from the local Shelby County Health Department will come and place TB tests on residents in need and will return within 48-72 hours to read the results. The two-step process will be completed by 4/30/2020. We have completed a TB Administration spreadsheet (see attachment 3) with resident's names and when their next PPD is due. The facility nurse will track this each month to monitor those residents that are due. Upon admission, new residents will be added to the list, including the next date due. The local Shelby County Health Department Nurse, Marilee Evans committed to come to the facility to place TB test on residents in need. Due to COVID-19, Ms.	04/30/2020

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	No documentation was in the medical record that indicated a second step tuberculin had been given, or that she had received a tuberculin skin test within the past 12 months. On 2/28/20 at 3:30 p.m., the Administrator indicated they only have a one step tuberculin skin test for Resident 17. 2. Review of resident 16's record on 2/28/20 at 10:30 a.m., indicated her diagnoses included, but were not limited to, sepsis, urinary tract infection, syncope and collapse. The tuberculin test forms indicated the resident's step one of the PPD test was completed, but step two was not completed. On 2/28/20 at 4:20 p.m., the Administrator indicated the resident "...received the step two PPD the day she moved in, but the facility she came from did not tell us she had received it, so we didn't know to read it and we missed doing the second step PPD on this resident."		Evans had to place a hold on completing this task. Ms. Evans has stated that as soon as COVID19 restrictions are lifted, and she is permitted, she will be in to complete this task for us. The attached TB Administration spreadsheet will be monitored monthly by the facility nurse. This practice will continue indefinitely.	