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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUGAR GROVE SENIOR LIVING COMMUNITY	5865 SUGAR LN PLAINFIELD, IN 46168

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00434118. Complaint IN00434118 - No deficiencies related to the allegations are cited. Survey dates: June 26 and 27, 2024. Facility number: 012394 Residential Census: 116 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 5, 2024.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacqueline Mullins	Executive Director	07/19/2024

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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	receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure at least one staff member was present on each shift who was first aide certified to meet the potential needs of the residents for 7 of 21 shifts reviewed. This deficient practice had the potential to affect 116 of 116 residents who resided in the facility. Findings include: On 6/27/24 at 10:00 a.m., the actual worked nursing schedule for June 23rd through the 29th was reviewed. There was no staff member who was first aide certified for the following shifts: June 24th day and evening shift. June 25th day and evening shift. June 26th evening and night shift. June 27th evening shift. On 6/27/24 at 2:07 p.m., the Executive Director (ED) indicated, there was not a specific staffing policy, but the facility followed the Residential Rules which required at least one awake person who was first aide certified. Evidence of coverage for the missing shifts was	R 0117	R117 Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and service provided. The number, qualifications, and training to staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned on those duties for which	08/31/2024

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	not provided by the time of the survey exit conference.		they are trained to be perform. Employee duties shall confirm with written job description. Corrective action: /p> /p> /p> Identification of the other Residents: All residents have the potential to be affected by the alleged deficit practice. First Aid training will be completed with all current nursing and qualified medical aids by 8/31/2024. Measures: Newly hired staff will not be allowed to provide resident care without first aid certification. This will be confirmed by DON or designee during orientation and will be an ongoing process. DON or designee will maintain certifications for clinical staff and monitor monthly to ensure staff stays current. This will be an ongoing process and any discrepancies will be immediately addressed by the ED. Results of audits will be reviewed in routine QAPI meetings. Director of Nursing/Designee will maintain copies of Cardiopulmonary resuscitation (CPR) and First Aid certificates for each staff member. Completion Date: 8/31/2024.	
R 0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency			

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Bldg. 00	(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's environment remained free from the potential for accidents when bedrails were applied but not assessed for appropriateness or monitored for continued safety for 1 of 2 residents reviewed for bed rails (Resident 93). Findings include: On 6/26/24 at 10:34 a.m., Resident 93's bed was observed. Bilateral half side rails were installed to the bed. Although they were close to the mattress, they wobbled loosely up and down when tested. On 6/27/24 at 11:44 a.m., Resident 39's bed was observed. The bilateral half side rails remained as observed the previous day. During an interview on 6/27/24 at 1:11 p.m., the Executive Director indicated bed rails were not	R 0148	R148 Sanitation and Safety Standards The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free from hazards that may adversely affect the health and welfare of the residents or the public. Corrective Action: Director of Nursing and Assistant Director of Nursing were provided with Bed Rail/Enablers Management Policy located in LTC Data. Identification of Other Residents: Hospice residents and all residents have the potential to be affected by the alleged deficit practice. Measures: Director of Nursing and Assistant	07/26/2024

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	used unless a resident was on Hospice but only with certain permissions. On 6/27/24 at 2:15 p.m., Resident 93's medical record was reviewed. She was an Assisted Living resident who resided on the secured memory care unit with a diagnoses of Alzheimer's dementia (an irreversible degenerative brain disease which affects memory and cognitive function) and generalized anxiety. The record lacked documentation of an assessment to confirm the reason and appropriateness of the side rails. The record lacked documentation of a risk assessment for entrapment. The record lacked documentation of a description of the device with specific and appropriate instructions for their use. Resident 93's most recent Service Plan indicated she was at risk for falls and used assistive devices, but the devices were not specified. The Service Plan lacked documentation of her need/preference for the bed rails. During an interview on 6/27/24 at 2:51 p.m., the Director of Nursing (DON) indicated the side rails had been removed until all appropriate assessments and evaluations were obtained. On 6/27/24 at 2:05 p.m., the ED provided a copy of current facility policy titled, "Bed Rail/Enablers Management," reviewed 2/2023. The policy indicated, "Prior to bedrail installation the resident will be assessed for the use of the bed rails/enablers, including the risk of entrapment,		Director of Nursing will provide resident/resident representatives with the Resident Bed Rail/Enabler Consent Form to be signed and kept at the facility as well as perform Device/Restraint Evaluation – V5 to be completed and kept at the facility. 1 resident with bed rail in place has the Bed Rail/Enabler Consent Form completed and signed by POA in Point Click Care and a as hard copy placed in residents' hard chart well as the Device/Restraint Evaluation – V5 completed in Point Click Care as well as hard copy placed in residents' hard chart, these forms were completed and placed in Point Click Care and the residents' hard chart on 6/14/2024. 100% audit of resident beds to identify anyone who is using assistive devices for their beds will be completed by DON or designee. This audit will be completed by 7/21/2024. 100% audit of required documentation for those who have assisted devices for their beds will be completed by DON or designee. This audit will be completed by 7/21/2024. 100% audit of Hospice residents to ensure their beds are free from siderails will be completed by DON or designee. This audit will be completed by 7/21/2024. 100% of service plans for those	

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	and informed consent is obtained from the resident or resident's representative. Even when bed rails/enablers are properly designed to reduce the risk of entrapment or falls, are compatible with the bed and mattress, and are used appropriately, they can present a hazard to certain individuals, particularly people with physical limitations or altered mental status, such as dementia or delirium ... Prior to installing bedrails/enablers, the following will occur: Resident assessment to confirm the device is not a restrain and to determine the purpose of the bedrail/enabler and the resident's ability to safely use the device. Entrapment risk assessed. If the purpose is to assist with transfers the functional capacity screen should document the resident's functional ability based on the use of the assistive device. Include a description of the device, it's purpose, and any special instructions on use and monitoring in the resident's negotiated service agreement/health care service plan. Informed consent is obtained from the resident or the resident's representative."		who are using assistive devices on their bed to ensure a description, purpose, and any special instructions are documented will be conducted by DON or designee. This audit will be completed by 7/21/2024. ED or designee will communicate the policy & process for assistive devices, the two types that are allowed, and the no restraint policy to residents and families. To be completed during resident assessment for admission. Monitored: Director of Nursing and Assistant Director of Nursing will provide resident/resident representatives with the Resident Bed Rail/Enabler Consent Form to be signed and kept at the facility as well as perform Device/Restraint Evaluation – V5 to be completed and kept at the facility. Device/Restraint Evaluation to be completed every 6 months when the (ALF) Resident Functional Capacity Screen NSP & HSP – V7 is due.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the			

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	activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure assessments were completed for residents who self-administer their medication for 6 of 6 residents reviewed for medication self-administration (Resident 6, 10, 11, 16, 18, and 22). Findings include: 1. On 6/26/24 at 12:40 p.m., Resident 6's record was reviewed. She was admitted on 3/31/19. Her self-administration medication assessment was dated 3/20/23. Her diagnoses included, but were not limited to, Sjogren syndrome (causes dry eyes and mouth), cerebral palsy (condition that affects movement and posture), and gastro-esophageal reflux disease (GERD). The medications observed on top of her microwave and on her kitchen counter were: a Children's acetaminophen (for pain relief). b. Pilocarpine 5 mg (milligram), take 3 times a day for glaucoma (eye disease). c. Cephalexin 500 mg, take twice a day for 7 days (antibiotic). It was dispensed on 3/18/24. The bottle was observed on its side with no lid, one pill was inside the bottle. The lid was observed on top of the microwave. d. Equate laxative (for constipation).	R 0216	The scope and content of the evaluation shall be delineated in the facility policy manual, but at minimum the needs the assessment shall include an evaluation of the following: The resident's ability to self-administer medications. The evaluation shall be documented in writing and kept in the facility. Corrective Action: DON and ADON will perform self-administering of medication assessment, including semi-annual evaluations and service plan in a timely manner. Identification of Other Residents: All residents have the potential to be affected by the alleged deficient practice. An audit of residents will be completed within 30 days to ensure that all resident self-administration of medication assessments are completed by 8/31/2024. Measures: An audit tool will be completed for each resident that is self-medicated to ensure that residents will have assessments completed in a timely manner.	08/31/2024

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	e. Ex-lax (for constipation). 2. On 6/26/24 at 1:02 p.m., Resident 10's record was reviewed. She was admitted on 3/31/19. Her diagnoses included, but were not limited to, hypertension (high blood pressure), atrial fibrillation (heart flutter), heart failure, and atherosclerotic heart disease (narrowing of coronary arteries). The medications observed in her closet were: a Eliquis 2.5 mg, take 1 tablet twice daily (anticoagulant). b. Furosemide 40 mg, take 1 tablet daily (diuretic). c. Potassium chloride ER (extended release) 20 mEq (milliequivalent) daily (supplement). d. Amlodipine 5 mg, daily (for hypertension). e. Spironolactone 25 mg, take ½ tab per day (diuretic for edema). f. Primidone 50 mg, take twice a day (for tremors: involuntary quivering movement). g. Acetaminophen ER 650 mg, twice daily as needed (pain relief). h. Digoxin 125 mcg daily for atrial-fibrillation. i. Metoprolol succinate ER 50 mg, take one tablet daily (for hypertension). Her self-administration medication assessment was dated 6/27/24. 3. On 6/27/24 at 12:15 p.m., Resident 11's record was reviewed. She was admitted on 1/10/18. Her diagnoses included, but were not limited to, hypertension (high blood pressure), gastro-esophageal reflux disease, chronic kidney disease, hyperlipidemia (increased fats in the blood), atherosclerotic heart disease (coronary artery disease), and angina pectoris (chest pain).		DON/designee will monitor the self-medicated log every 2 weeks to ensure all assignments related to self-medication are completed in a timely manner. Monitored: Executive Director/Designee, in collaboration with DON/Designee will review audits during morning meeting every two weeks for the duration of the extended timeframe.	

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	Her June MAR indicated her physician medication orders: a Lipitor 40 mg by mouth at bedtime (for high cholesterol). b. Torsemide 20 mg, ½ tablet daily by mouth (diuretic to treat edema). c. Iron 65 mg, 1 tablet by mouth (supplement). d. Diclofenac sodium, topical gel (treats rheumatoid arthritis). e. Tylenol arthritis ER 650 mg, take 2 tablets by mouth once daily (pain relief). f. Aspirin 81 mg chewable tablet, take 1 tablet by mouth daily. g. Metoprolol tartrate 25 mg, take 1 tablet by mouth twice daily. Her self-administration medication assessment was dated 6/27/24. 4. On 6/27/24 at 12:21 p.m., Resident 16's record was reviewed. She was admitted on 3/31/19. Her diagnoses included, but were not limited to, hypertension, fibromyalgia (nerve pain), NSTEMI (hypoxic heart attack), and anxiety disorder. Her June MAR indicated her physician medication orders: a Isosorbide mononitrate 30 mg by mouth, daily (to prevent chest pain). b. Vitamin D3 daily (supplement). c. Restasis multidose 0.05% eye drops, instill 1 drop into both eyes 2 times a days (for dry eyes). d. Valsartan 160 mg tablet, take 1 tablet by mouth twice daily (high blood pressure). e. Aspirin 81 mg chewable tablet, taken 1 tablet by mouth daily. f. Acetaminophen 325 mg tablet, take 2 tablets by mouth every 4 hours as needed (PRN) for pain.			

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	g. Fioricet 50-300-40 mg capsule, take 1 tablet by mouth 2 times a day PRN for pain. Her self-administration medication assessment was dated 6/27/24. 5. On 6/27/14 at 12:27 p.m., Resident 18's record was reviewed. She was admitted on 12/17/17. Her diagnoses included, but were not limited to, hypertension and hypothyroidism (decreased thyroid hormone). Her June MAR indicated her physician medication orders: a Norvasc 5 mg, take 1 tablet by mouth daily (for hypertension). b. Synthroid 75 mcg (micrograms), take 1 tablet by mouth daily (for hypothyroidism). c. Magnesium oxide 250 mg, take 1 tablet by mouth daily (supplement). d. Questran packet, take 1 packet by mouth 2 times a day (for loose stools). e. Muro-128 2% eye drops, place 1 drop in each eye three times daily (reduces eye swelling). Her self-administration medication assessment was dated 6/27/24. 6. On 6/27/24 at 12:33 p.m., Resident 22's record was reviewed. She was admitted on 12/20/22. Her self-administration medication assessment was dated 2/8/23. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), osteoporosis (thinning of bone), osteoarthritis, hyperlipidemia, iron deficient anemia (decreased absorption of iron).			

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	Her June MAR indicated her physician medication orders: a Aspirin 81 mg, take 1 tablet by mouth daily. b. Zetia 10 mg tablet, take 1 tablet by mouth daily (treats high cholesterol). c. Acetaminophen 500 mg, take 1 tablet by mouth every 4 hours PRN. A current policy, titled, "Self-Administration of Medication," with no date, was provided by the ED, on 6/27/24 at 2:44 p.m. A review of the policy indicated, " ...If a resident wishes to self-administer medications, an assessment must be performed to ensure that the resident can safely self-administer medications ...The assessment must be performed on admission, readmission, every 6 months, with significant changes and as needed ...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure all foods were labeled and dated, hair restraints were worn by kitchen staff near food, internal thermometers were inside coolers, thermometers were cleaned appropriately for taking temperatures of the food, and frozen meats were thawed appropriately for 1 of 1 observation of the kitchen with the potential to affect 116 of 116 residents who consumed food from the kitchen. Findings include:	R 0273	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement or correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the	08/31/2024

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	During an interview, on 6/26/24 at 9:46 a.m., Head Cook 5 indicated the Dietary Manager (DM) was out of the building and would be unable to complete the kitchen tour. She indicated the drawers under the stove were freezer drawers. During an interview, on 6/26/24 at 9:48 a.m., Cook 6 indicated there were no thermometers inside freezer drawers, she indicated the kitchen staff would just feel whether the foods felt frozen or not. The items observed in the freezer drawers were chicken tenders, pork tenderloins, country fried chicken, hash brown, onion rings, and french fries. No dates were observed. On 6/26/24 at 9:51 a.m., Line Cook 7 was observed without a beard cover. He was standing in front of the breakfast serving line, breakfast was still being served. On 6/26/24 at 9:52 a.m., Line Cook 7 retrieved a thermometer to provide temperatures for the breakfast foods. He indicated the kitchen was out of thermometer sanitizing wipes. He was observed to run tap water over the thermometer and dry it with a paper towel before provided the temperature of the scrambled eggs. Between each food, he wiped the thermometer with the same paper towel. He also provided temperatures for sausage links and sausage patties, oatmeal, and sausage gravy. On 6/26/24 at 9:54 a.m., Line Cook 7 indicated the salad bar cooler had a container of undated German potato salad, an unlabeled and undated plastic bag of tuna salad, and a small container of sliced lemons that had no date and were observed to have gone bad.		alleged deficiencies in lieu of any revisit. Alleged Deficiency: R 273 Food Preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Corrective Action: Dietary Manager/Designee will provide all new/current dietary staff in-services using the policies including hair restraints, appropriate cleaning/usage of thermometers, food labeling/storage safety, food safety, and refrigerator and freezer temperature by 8/31/2024. The Dietary Manager will ensure that thermometer sanitizing wipes are in stock in the facility, thermometer sanitizing wipes have been ordered. Identification of Other Residents: All residents have the potential to be affected by the alleged deficient practices in food storage/labeling/safety. Measures: In services will be provided to all new/current dietary staff using the policies in place, thermometers will be placed/maintained in each area identified in the policy, Dietary Manager to ensure that thermometer sanitizing wipes are	

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	On 6/26/24 at 10:03 a.m., a plastic tub of frozen riblet meat and 2 tubes of ground beef were observed in a sink. Cold water was being run over the frozen riblet meat. The tubes of ground beef were long enough that 1/3 of the tubing was protruding from the plastic bin with no cold water running on them. During an interview, on 2/26/24 at 10:11 a.m., Cook 6 indicated the pass-thru cooler had no internal thermometer. The items observed inside the pass-thru cooler were several different juices, milk, and whipped cream. A current policy, titled, "Food Storage (Dry, Refrigerated, and Frozen)," with no dated, was provided by the ED, on 6/27/24 at 9:55 a.m. A review of the policy indicated, " ...General storage guidelines to be followed: ...All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded ...discarded food that has been prepared the in the facility after seven days of storing under proper refrigeration ...Left over contents of cans and prepared food will be stored in covered, labeled and dated containers in refrigerators and / or freezers ...." A current policy, titled, "Labeling and Dating Foods (Date Marking)," with no date, was provided by the Executive Director (ED), on 6/27/24 at 9:55 a.m. A review of the policy indicated, " ...All foods stored will be properly labeled according to the following guidelines ...Once a case is opened, the individual, refrigerated food items are dated with the date the item was received into the facility ...Once opened,		in stock in facility. Monitored: Dietary Manager/Designee will complete in services with all new/current dietary staff, dietary staff to discuss thermometer sanitizing wipe stock weekly for duration of extended timeframe. Completion Date: 8/31/2024	

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	all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturers expiration date ...Frozen food packages, removed from the case will be dated with the date the item was received into the facility ...Once package is opened, it will be re-dated with the date the item was opened ...Prepared food or opened food items should be discarded when: ...The food item does not have a specific manufacturer expiration date and has been refrigerated for 7 days ...." A current policy, titled, "General HACCP Guidelines for Food Safety," with no date, was provided by the ED, on 6/27/24 at 12:30 p.m. A review of the policy indicated, " ...Safe Thawing Practices ...Completely submerge the item in clean running water (<70 degrees F) that is running fast enough to agitate and float off loose ice particles ...Food temperatures for Meal Service ...Check to be sure the staff actually takes food temperatures and takes them correctly ...Refrigerator/Freezer Temperatures ...Take the internal temperatures of each unit ...." A current policy, titled, "Refrigerator and Freezer Temperature Checks," with no date, was provided by the ED, on 6/27/24 at 9:55 a.m. A review of the policy indicated, " ...Temperatures are taken from the thermometer located inside the unit ...." A current policy, titled, "Hair Restraints," with no dated, was provided by the ED, on 6/27/24 at 10:09 a.m. A review of the policy indicated, " ...Beard guards shall be used to prevent hair from contacting exposed food ...."			
R 0306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance			

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Bldg. 00	(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.			
	Based on observation and interviews, the facility failed to date eye drops, insulin, and failed to label over the counter (OTC) from the 100 and 300 hall medication carts for 2 of 5 medication carts reviewed. Findings include: On 6/27/24 at 11:14 a.m., the 100-hall medication cart was observed with Licensed Practical Nurse (LPN) 12. Resident 8 had latanoprost on the medication cart and was not dated when opened. Resident 2 had a pen of Tresiba on the medication cart and it was not dated to indicate when it was opened. On 6/27/24 at 11:30 a.m. the 300-hall medication cart was observed with Qualified Medication Aide (QMA) 11. The following medications were found to lack a label and/or date to indicate when opened.	R 0306	Deficiency: The community failed to date eye drops, insulin, and failed to label o ver the counter for the 100 and 300 hall medication carts. R8 had a bottle of Latanaprost that was not dated when opened. R2 had a Tresiba pen that was not dated when opened Corrective Action for residents that were affected by the alleged defici ency: R8; Latanoprost was removed from cart and replaced at	08/31/2024

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	a.) Resident 71 had a bottle of vitamin D3 that lacked a label. b.) Resident 77 had a bottle of CoQ10 that lacked a label. c.) Resident 73 had a bottle of vitamin B12 1000 mcg, Tylenol 500 mg and vitamin D3 that lacked a label. d.) Resident 78 had a bottle of calcium with vitamin D3 and vitamin B12 that lacked a label. e.) Resident 63 had a bottle of latanoprost that lacked a date to indicate when it was opened. A policy titled; "Medication Administration Policy for Senior Living" was provided by the Executive Director (ED) on 6/27/24 at 2:05 p.m. It indicated, " ...Proper storage must be ensured for each medication (insulin, eye drops, ointments, etc.) ...All medications must be labeled correctly with the resident's name, medication name, dosage, and administration instructions ...."		the cost of the facility. R2; Tresiba was removed from the cart and replaced at the cost of th e facility. Medication labels were placed OT C medications for residents 71, 77 , 73, 78, & 63 Other residents having the potenti al to be affected by the alleged def iciency: All residents who receive medicati ons that must be dated and discar ded before listed expiration date h ave the potential to be affected. All residents who receive OTC me dications that are ordered by MD a nd provided by family have the pot ential to be affected. Measures put in place to prevent r ecurrence of alleged deficient prac tice: · 100% audit of injectables, oral so lutions/suspensions, ophthalmic, otic, and topical medications, will be completed by DON or designee to ensure that medication has not	

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			expired based upon its date open ed. Any of the abovementioned m edications that are found to be ope ned and not dated will be consider ed expired and discarded and repl aced at the community's expense. 8/31/2024 100% audit of OTC medications th at were ordered by the MD and pro vided by residents' families. Any medications that are found without a label will have one applied using the standard format for medicatio n orders, resident name, medicati on, dosage, and directions. 8/31/ 2024 DON or designee will provide in-se rvicing to clinical staff that pass m edications to review medications t hat must be dated upon opening a nd their expiration DON or designee will provide inser vicing on labeling OTC medication s that are brought in by family me mbers in response to an MD order 8/31/2024 How measures will be monitored: DON or designee will conduct rand om audits on each medication cart	

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			& medication refrigerator to check for proper storage & dating of injectables, ophthalmics, otics, topicals, and oral suspensions. Medications that are found to be opened but not dated will be disposed of and immediately reordered at the cost of the community. Each cart will be audited twice a day three times a week for three weeks, and daily three times a week times three weeks, & will become an ongoing routine weekly audit, then daily once a week for three weeks. Results will be shared with ED and reviewed during the next QAPI meeting. DON or designee will conduct random audits on each medication cart to check for proper labeling of OTC medications that were brought in by families. Any discrepancies will be immediately addressed and an appropriate label containing residents name, medication, dosage, and directions, will be applied. Each medication cart will be audited daily three times per week times three weeks and will become an ongoing routine monthly audit. Results will be shared with the ED and reviewed during the next QAPI meeting.	

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			Director of Nursing and Asisstant Director of Nursing will provide an i n-service including printed Medicat ion Administration Policy for Senio r Living as well as perform monthly audits on each Medication Cart Identification of Other Residents: All residents have the potential to be affected by the alleged deficient practice. An audit will be perform ed on all Medication Carts monthl y to ensure proper labeling is com pleted per Medication Administrati on Policy by 8/31/2024. Measures: Director of Nursing and Assisted D irector of Nursing will provide an inservice on Medication Administration Policy and an audi t will be completed on each Medic ation Cart month to ensure that all medication is labeled and labeled correctly per Medication Administr ation Policy.	

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