STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155730	A. BUILDING 00 B. WING	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN 47031

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaint IN00413804. This visit included a State Residential Licensure Survey. Complaint IN00413804 - No deficiencies related to the allegations are cited. Survey dates: August 15, 16, 17, 18, 21, and 22, 2023 Facility number:000420 Provider number:155730 AIM number:100266230 Census Bed Type: SNF/NF:81 Residential:21 Total:102 Census Payor Type: Medicare:3 Medicaid:54 Other:24 Total:81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.			

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

Trina Johnson | Administrator | 09/08/2023

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

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	Based on observation, record review, and interview, the facility failed to ensure appropriate oversight of a resident's medication during 1 of 11 medication administration observations. (Resident 1) Findings Include: An observation of medication administration with RN 5, on 08/16/23 at 2:41 P.M., of Wing 4 indicated the RN prepared a cup of medications for Resident 1. The cup contained one Gabapentin 100 mg (milligrams) tablet and two Tylenol 325 mg tablets. The RN walked into the resident's room at 2:49 P.M. The resident was brushing her teeth in her bathroom and the nurse asked if she just wanted her medications left at the bedside to take at her convenience and the resident indicated, "Yes." The RN left the medication cup on her over the bed table and exited the room. During an interview on 08/18/23 at 2:18 P.M., the DON (Director of Nursing) indicated she was not aware of any residents on the Health Care side of the facility that self-medicated. During an interview on 08/22/23 at 11:30 A.M., RN 5 indicated there were seven residents on Wing 4 who were independently mobile. The clinical record for Resident 1 was reviewed on 08/22/23 at 12:12 P.M. An Annual MDS assessment, dated 07/05/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anxiety, dysphagia, diabetes, and heart failure. The current physician's orders record was provided by the ADON on 08/22/23 at 12:17 P.M. The record lacked an order permitting the resident	F 0554	On August 23, 2023, Resident 1 was assessed by licensed nurse and was found to have no adverse effects from the medication left at the bedside. On August 24, 2023, the DON & ADON completed rounds of all resident care areas and resident rooms in facility to ensure no medications were left unattended in resident rooms or resident care areas. No medications were identified to be left unattended for resident self-administration. On September 12 & 13, 2023, the Director of Nursing will provide re-education to all licensed nurses on the requirement that medications may not be left at bedside for a resident to self-administer unless the attending physician, in conjunction with the Interdisciplinary Team (IDT) has determined that the resident has the decision-making capacity to do so safely and has a physician order and care plan for self-administration of medications. The Director of Nursing or designee will conduct random audits of medication administration on a minimum of 25% of residents each week for 4 weeks and then 25% each month to ensure that medications are not left at bed-side for self-administration for any resident	09/15/2023

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	to self-medicate or leave medications at the bedside. The complete Care Plan was provided by the MDS Coordinator on 08/22/23 at 1:28 P.M. Care Plans included, but were not limited to, a Focus indicating the resident had a knowledge deficit related to short term memory loss with an initiated date of 02/13/18. The resident record lacked a Care Plan indicating she was assessed or permitted to self-administer her medications. During an interview on 08/22/23 at 2:06 P.M., the DON indicated staff were not allowed to leave residents' medications at the bedside unless they were Care Planned to do so. The current "Administering Medications" policy, with a revised date of April 2019, indicated, "...Medications are administered in a safe...manner, and as prescribed...Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely..." The current "Accidents and Supervision" policy with an implemented date of 09/01/22, was provided by the ADON on 08/22/23 at 1:15 P.M. The policy indicated, "...The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:...Implementing interventions to reduce hazard(s) and risk(s)...Implementation of Interventions-using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes:...Communicating the		not assessed to have the capacity to do so safely. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for six (6) months. The QAPI committee will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	interventions to all relevant staff...Providing training as needed ...Ensuring that the interventions are put into action ..." 3.1-11(a)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or			

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	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify the physician for a change in residents' condition related to the notification of weight changes for 2 of 5 residents reviewed for notification. (Residents 47 and 57) Findings include: 1. The clinical record for Resident 47 was reviewed on 08/21/23 at 3:05 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/29/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, chronic kidney disease, coronary artery disease, peripheral vascular disease, and hypertension. The resident received a diuretic (water pill) medication for seven of the seven days during the review period. The Care Plan, with an initiated date of 06/07/23, indicating the resident was at risk for decreased cardiac output related to chronic kidney disease	F 0580	On September 7, 2023, Resident 47 physician/nurse practitioner was notified of weight changes of three pounds or more that occurred on 6/20/23, 6/30/23, 7/30/23, and 8/16/23. On September 6, 2023, Resident 57 physician/nurse practitioner was notified of weight changes of three pounds or more that occurred on 6/9/23, 6/15/23, 7/15/23, and 8/13/23. On August 31, 2023, the Director of Nursing completed a review of weights obtained for the past month for all current in-house residents to ensure that physician was notified of significant weight changes, including any weights outside of parameters established per physician orders. Attending physicians were notified of all	09/15/2023

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	stage three, peripheral vascular disease, and atherosclerotic heart disease. The interventions included, but were not limited to, "...Daily weights; Notify physician if weight gain is greater than 3 pounds in 24 hours or 5 pounds in a week..." The TAR (Treatment Administration Record) for June, July, and August 2023, were provided by the ADON (assistant director of nursing) on 08/22/23 at 10:09 A.M., and contained the following physician's order: - Obtain daily weight every day shift related to chronic kidney disease stage three and call for three pound weight changes, with a start date of 06/07/23. The records indicated the resident had weight changes of three pounds or more on the following dates: June 2023: - 06/19/23, weight was 258.5, - 06/20/23, weight was 249.5, a change of 9 pounds, and - 06/29/23, weight was 253.5, - 06/30/23, weight was 250, a change of 3.5 pounds. July 2023: - 07/29/23, weight was 246.6, - 07/30/23, weight was 243, a change of 3.6 pounds. August 2023:		significant weight changes identified. On September 12 & 13, 2023, the Director of Nursing will provide re-education to all licensed nurses on the requirement to promptly notify the resident's attending physician of changes in resident condition, including significant weight changes or weights outside of the parameters established per physician order. The Director of Nursing or designee will review weights obtained daily Mon-Fri for 4 weeks then weekly for six (6) months to ensure physician was notified of any identified significant weight changes or weights outside the parameters established per physician order. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review. The QAPI committee will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	- 08/15/23, weight was 244.4, - 08/16/23, weight was 240.3, a change of 4.1 pounds. The Progress Notes for June, July, and August 2023, were provided by the ADON on 08/22/23 at 10:09 A.M. The record lacked documentation the physician had been notified of the changes in the resident's weights. 2. The clinical record for Resident 57 was reviewed on 08/17/23 at 2:42 P.M. An Annual MDS assessment, dated 07/07/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, anemia, heart failure, hypertension, diabetes, anxiety, and depression. The resident received a diuretic medication for seven of the seven days during the review period. The TAR for June, July, and August 2023, was provided by the ADON on 08/22/23 at 10:13 A.M., and contained the following physician's order: - Daily weight at 6:00 A.M. If a weight gain greater than 3 pounds in a day or 5 pounds in a week, Call the MD, with a start date of 08/16/22. The records indicated the resident had weight changes of three pounds or more on the following dates: June 2023: - 06/08/23, weight was 195, - 06/09/23, weight was 198.2, a change of 3.2 pounds, and - 06/14/23, weight was 196.7, - 06/15/23, weight was 200.6, a change of 3.9 pounds.			

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July 2023:

- 07/14/23, weight was 200.2,
- 07/15/23, weight was 204.5, a change of 4.5 pounds.

August 2023:

- 08/12/23, weight was 199.7,
- 08/13/23, weight was 203.2, a change of 3.5 pounds.

The Progress Notes for June, July, and August 2023, were provided by the ADON on 08/22/23 at 10:13 A.M. The record lacked documentation the physician had been notified of the changes in the resident's weights.

During an interview on 08/21/23 at 2:33 P.M., LPN (Licensed Practical Nurse) 2 indicated when a resident was to have a daily weight, the resident would be weighed as soon as they awoke for the morning. If the physician needed notified due to a weight gain, they would call the physician. If no one answered she would leave a message. When the physician was notified a progress note would be entered that they had been notified.

The current facility policy titled, "Change in Resident's Condition or Status", with a revised date of February 2021, was provided by the ADON on 08/22/23 at 1:15 P.M. The policy indicated, "...promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.)...The nurse will notify the resident's attending physician or physician on call

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	when there has been a(an):...specific instruction to notify the physician of changes in resident's condition..." 3.1-5(a)(3)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) 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 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			

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	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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure a care plan was initiated for a resident with an intravaginal device for 1 of 20 residents reviewed for care plans. (Resident 53) Findings include: During an interview on 08/16/23 at 1:41 P.M., Resident 53 indicated she took water pills and had to go to the bathroom often. The resident's clinical record was reviewed on 08/21/23 at 10:01 A.M. An Admission MDS (Minimum Data Set) assessment, dated 06/12/23, indicated the resident was moderately cognitively impaired. The resident required limited staff assistance for most ADLs (Activities of Daily Living), including toileting, but required extensive staff assistance with personal hygiene. The resident was occasionally incontinent of urine, and frequently incontinent of bowel. The diagnoses included, but were not limited to, congestive heart failure, atrial fibrillation, uterovaginal prolapse, and the presence of	F 0656	On August 24, 2023, Resident 53's comprehensive care plan was updated to reflect the use of the pessary device and orders for the vaginal gel. On August 24, 2023, members of nursing administration completed audit of the physician orders of all in-house residents to identify residents with an intravaginal device and the comprehensive care plans for residents identified to have intravaginal devices were reviewed to ensure the use of intravaginal device is care planned appropriately for all residents with intravaginal devices. No other devices were identified. On September 12 & 13, 2023, all nursing staff, will be re-educated by nursing administration on the requirement to ensure a comprehensive person-centered care plan is developed for each	09/15/2023

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	urinogenital implants. A facility "Admission Assessment", dated 06/05/23, indicated the resident was incontinent of bladder. A note in the genitourinary section of the assessment indicated "pessary maintenance". During an interview on 08/21/23 at 10:59 A.M., LPN (Licensed Practical Nurse) 7 indicated the resident did have a pessary (a device placed in the vagina to support the uterus or bladder and rectum that helped decrease urine leakage). The resident went to her Gynecologist in June 2023, and had a follow up appointment in four months. There were no issues with the pessary. There was a vaginal gel that was administered on night shift. A "REPORT OF CONSULTATION", dated 06/26/23, indicated the resident's physician changed and cleansed her pessary device. The resident was to follow up in four months and nursing staff were to continue administering the vaginal gel twice a week. The resident's current MD orders included, but were not limited to, an open-ended order, with a start date of 06/30/23, for Oxyquinolone Sulfate vaginal gel, insert one application vaginally at bedtime every Tuesday and Friday for pessary maintenance. The resident's complete "Care Plan" was provided by the MDS Coordinator on 08/22/23, at 9:35 A.M. There was no indication the resident had a pessary, and there was no plan of care related to the resident's pessary device. During an interview on 08/22/23 at 10:19 A.M., the DON (Director of Nursing) indicated the resident did have a pessary and had MD orders for the		resident that addresses resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, including the use of intravaginal devices. All new admissions will be reviewed by the IDT daily Mon-Fri to ensure that care plans are implemented to address identified resident needs that are identified in the resident admission assessment and admission physician orders, including the use of intravaginal devices. New orders will be reviewed daily Mon-Fri by the IDT to ensure care plans are updated, as necessary, to address newly identified resident needs, including the use of intravaginal devices. The Director of Nursing or designee will conduct random audits of comprehensive care plans for 5 residents each week for 4 weeks and then 5 each month for six (6) months to ensure that the care plan addresses identified resident needs, including the use of intravaginal device, as indicated. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for six (6) months. The QAPI committee will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	vaginal gel. The resident should have a care plan that indicated she had a pessary device. The current facility policy, titled "Care Plans, Comprehensive Person-Centered", with a revised on date of 12/2016, was provided by the ADON (Assistant Director of Nursing) on 08/22/23 at 1:15 P.M. The policy indicated, "...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's...needs is developed and implemented for each resident..." 3.1-35(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage for 1 of 11 residents reviewed for Quality of Care. (Resident 135) Findings include: Medication administration was observed on 08/17/23 at 11:33 A.M., on Wing 5 with RN 3. The RN prepared to check the blood sugar level of Resident 135. The nurse took a basket of supplies, donned clean gloves, and checked the resident's	F 0684	On August 23, 2023, Resident 135 was assessed by licensed nurse and was found to have no adverse effects related to the failure to follow manufacturer's guidelines related to insulin pen usage. RN 3 was provided education by the Director of Nursing on the requirement to clean the hub of the insulin pen prior to applying the needle and to prime the pen before use. On August 30, 2023, the Infection	09/15/2023

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	blood sugar level. The level was 204. The nurse unlocked the medication cart, removed a bag containing a Lispro insulin pen, indicated the resident was to receive two units of insulin, used hand sanitizer, removed the pen from the bag, removed the pen cap, applied the needle to the end of the insulin pen, turned the dose knob to two units, and administered the insulin. The nurse did not clean the hub of the pen prior to applying the needle, nor did she prime the pen before use. During an interview on 08/17/23 at 11:44 A.M., RN 3 indicated she was not trained to clean the hub of the insulin pen before applying the needle. She looks at the pen to see if there was air in the pen. She did not prime the pen before each dose. During an interview on 08/22/23 at 2:02 P.M., the DON indicated insulin pens should be cleaned with alcohol before applying the needle to the pen. She had no comment regarding priming the insulin pens. The Medication Review Report was provided by the DON on 08/22/23 at 2:56 P.M. The report indicated the resident was to receive two units of Lispro insulin, subcutaneously, in the afternoon for diabetes. The Lispro insulin pen package insert was provided by the DON on 08/22/23 at 2:56 P.M. The directions for use indicated, "...Pull the Pen Cap straight off...Wipe the Rubber Seal with an alcohol swab...Push the capped Needle straight onto the Pen...Prime before each injection...Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures the Pen is working correctly...If you do not prime before each injection, you may get too much or too little insulin...To prime your Pen, turn		Preventionist completed observation of insulin administration for all diabetic residents requiring insulin administration to ensure that manufacturer's guidelines related to insulin pen usage were followed. Indicate if any issues were identified and corrective action taken for any issues. On September 12 & 13, 2023, the Director of Nursing will provide re-education to all licensed nurses on the requirement that manufacturer's guidelines related to insulin pen usage must be followed, including cleaning the hub of the insulin pen prior to applying the needle and priming the pen before use. Competency evaluations were completed on all licensed nurses, using return demonstration to validate competency in the use of insulin pens. The Director of Nursing or designee will conduct random audits of medication administration on a minimum of 25% of diabetic residents each week for 4 weeks and then 25% each month to ensure that manufacturer guidelines are followed related to insulin pen usage. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for six (6) months. The QAPI committee will	

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	the Dose Knob to select 2 units...hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top..." The current Facility Insulin Pen policy, with an implemented date of 03/2023, was provided by the DON on 08/22/23 at 2:56 P.M. The policy indicated, ...Procedure...Remove the pen cap from the insulin pen...Wipe the rubber seal with an alcohol pad...Screw the pen needle onto the insulin pen...Twist open and remove outer cover from the pen needle...Prime the insulin pen...Dial 2 units...With the needle point up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle..." 3.1- 37(a)		review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	
F 0689 SS=D 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 record review, interview, and observation, the facility failed to ensure a resident's safety during bus transport (Resident 15), follow and implement fall interventions (Resident 57) for 2 of 6 residents reviewed for accident hazards. Findings include: 1. Resident 15's clinical record was reviewed on	F 0689	On August 3, 2023, Resident 15 was evaluated at the ER and found to have no injuries related to the van incident and physician and responsible were notified of the incident. A non-slip mat was placed in Resident #15's wheelchair seat on August 24, 2023. CNA 10 was to be reeducated regarding requirement	09/15/2023

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	08/21/23 at 2:32 P.M. A Quarterly MDS (Minimum Data Set) Assessment, dated 07/15/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, hypertension, hemiplegia, and anxiety. The resident required extensive staff assistance with bed mobility and transfers. The resident's functional range of motion was impaired on one side of their upper and lower extremities. A Health Status Note, dated 08/02/23 at 6:18 P.M., indicated the FBD (Facility Bus Driver) indicated the resident was currently at the hospital. On the way to a dental appointment that afternoon a vehicle pulled out in front of her as she was driving, and she had to " slam on her brakes". The resident was in a wheelchair and slid under her safety belt and was sitting on the wheelchair leg rests. The resident complained of leg pain, so the FBD called 911 and the resident was transported by stretcher to the local hospital ER for evaluation. A Health Status Note, dated 08/02/23 at 8:30 P.M., indicated the resident was evaluated and there were no injuries related to the incident. During an interview on 08/17/23 at 2:27 P.M., the resident indicated she did have an incident on the bus. When the bus stopped, she thought the whole wheelchair moved on the bus. The wheelchair was locked in place, but it moved. Her legs hurt, she thought she was injured. She would not ride in the bus again. During an interview on 08/21/23 at 11:39 A.M., the FBD indicated the resident had a dentist appointment on 08/02/23. She took her to the appointment, but when they got there, they realized it was the wrong location. They called the		to use 2-person transfer when transferring Resident #57 but no longer works here. On September 6, 2023, all staff working on unit in which Resident #57 resides, were re-educated that Resident #57 is to be transferred with two assist. On August 29, 2023, all residents who may require wheelchair transport were reviewed to ensure they are able to sit up in wheelchair during transport with the wheelchair secured in the vehicle per manufacturer recommendations. Those residents that are unable to sit up securely during transport will not be transported in the facility van but by stretcher. On August 29, 2023, the Assistant Director of Nursing completed review of fall care plans for all in-house residents to identify care planned fall interventions and ensured all fall interventions, including level of assistance required for transfers were provided as care planned. On September 12 & 13, 2023, all nursing staff will be re-educated by the Director of Nursing regarding the requirement to follow fall care plan interventions, including ensuring that appropriate level of assistance is provided per the care plan for all transfers. Indicate specific education provided related transportation safety and any system changes you made to ensure residents are securely	

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	dentist's office and since they weren't very far away, they could still go to the appointment. The bus driver loaded the resident back into the bus and headed toward the correct location. The road was being worked on and traffic was a little backed up. Suddenly, she saw a van coming across her lane, so she hit the brakes. The resident's wheelchair was reclined, and her leg was up on the foot pedal. The resident slid down in her wheelchair, and she couldn't get her up. The resident's leg slid, and she hit her leg on the back of the front passenger seat. At first the resident said she was ok, but then she said her hip hurt. The FBD called 911 and the resident was transported to a local ER to be evaluated. When she put the resident in the van, she put the wheel locks in place and cranked them to make sure they were tight. She fastened the seat belt around the resident and the wheelchair. She was not sure how tight the seatbelt was since it went around resident and the wheelchair. Usually everyone sits up in their wheelchair, but this wheelchair was in a reclined position and the resident was half laying down. It was a high backed wheelchair, she had been driving the bus for a year, and this was the only resident that she transported in a wheelchair that was reclined. She left the wheelchair reclined because staff said the resident would slide out of the wheelchair if it was not reclined. During an interview on 08/22/23 at 10:06 A.M., CNA (Certified Nurse Aide) 6 indicated she was working on the day the resident went out for her dental appointment. The resident had a standard wheelchair in her room that she used when she got out of bed. Her feet were always elevated in the wheelchair, especially her bad leg. The day of the appointment, they put her in her regular wheelchair, but she kept sliding out, so they put her in another resident's high backed wheelchair.		fastened. The Director of Nursing or designee will conduct random audits on 5 residents each week for 4 weeks and then 5 each month to ensure that fall interventions are implemented in accordance with the plan of care. The Assistant Director of Nursing will validate that all wheelchairs are secured appropriately in the vehicle, for all residents transported per facility vehicle, prior to departure from the facility for 2 weeks, then random audits will be conducted on a minimum of 5 transports per month. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for six (6) months. The QAPI committee will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	They reclined the wheelchair, and her legs were resting on the extended foot pedals. The facility bus was observed with the FBD on 08/22/23 at 11:44 A.M. The FBD brought a regular wheelchair to demonstrate how the resident was positioned in the bus. They could not locate a highbacked wheelchair to use that was not already being used by another resident. The FBD locked the wheelchair wheels in place on the bus. The seatbelt came out from the floor and was attached around from the back to the front of the wheelchair. The FBD indicated on 08/02/23, the resident's wheelchair was reclined, but the seatbelt was in place. When she hit the brakes, the resident slid down the wheelchair and the resident's buttocks were sitting on the padded leg rests that were located at the top of the wheelchair foot pedals. The resident's right leg hit the back of the front passenger seat. During an interview on 08/22/23 at 1:55 P.M., the Administrator indicated she did investigate what happened. She made sure the bus equipment was functioning properly and that the FBD knew how to properly secure residents on the bus, and there were no issues. The resident suffered no injuries. At the time, they considered transporting the resident via stretcher, but the resident's husband wanted the resident to go in the facility bus. The current facility "TRANSPORTATION" job description, dated 2022, was provided by the Administrator on 08/21/23 at 1:02 P.M. The form indicated, "...Additional Assigned Tasks...Follows appropriate safety and hygiene measures at all times to protect residents..." The current, undated facility policy, titled "Vehicle Lift Safety", was provided by the Administrator			

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	on 08/21/23 at 1:40 P.M. The policy indicated, "...All wheelchairs must be secured in the vehicle..." 2. The clinical record for Resident 57 was reviewed on 08/17/23 at 2:42 P.M. An Annual MDS assessment, dated 07/07/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, anemia, heart failure, hypertension, diabetes, anxiety, and depression. The resident required extensive assistance of two staff members for transferring and toileting. A Progress Note, dated 12/26/22 at 8:55 P.M., indicated the resident was lowered to the floor that evening at 8:25 P.M. There were no visible injuries. A Late Entry Progress Note, dated 12/26/22 at 8:35 P.M., indicated an after fall investigation was completed. The resident was being transferred by a CNA from the toilet to his wheelchair when he lost his balance, resulting in a fall/assist to the floor. There were no injuries at the time of the fall. A new intervention was put into place, the staff were educated on following the recommended number of staff needed for resident's transfers. A Progress Note, dated 03/29/23 at 7:44 A.M., indicated an after fall investigation was completed. The resident's foot slipped when a CNA was assisting with a transfer from the toilet to the wheelchair that resulted in a witnessed fall. The resident was lowered to the floor by the CNA. There were no injuries noted. A new intervention was put into place to offer the resident a urinal or bedpan when needing to use the bathroom until two staff were available for safe transfers. The Care Plan for the resident was provided by			

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	the ADON (Assistant Director of Nursing) on 08/22/23 at 10:13 A.M. The care plan contained the following: - Activities of Daily of Living Self Care Performance Deficit related to right sided hemiplegia with a start date of 08/22/22. The care plan inventions included, but were not limited to, extensive assist of 2 staff for toileting, with a start date of 08/16/22, and extensive assist of 2 staff for transfer with a start date of 08/16/22. - Potential for injuries/falls related to right sided hemiplegia with a start date of 08/22/22. The care plan interventions included, but was not limited to, staff (CNA) educated on following number of staff needed for resident's transfers. During an interview on 08/21/23 at 10:27 A.M., QMA (Qualified Medication Aide) 11 indicated the resident was to have two staff assistance for transfers. He had been a 2 person transfer since she had been working in the facility for the last 6 months. During an interview on 08/22/23 at 9:38 A.M., CNA 10 indicated the resident was impatient when wanting to get off the toilet at times. When the resident fell in March, the other aide on the wing was getting someone up out of bed and the resident was getting agitated, so she transferred him by herself. She had to lower him to the floor. The resident was supposed to be a two person transfer at the time of the fall. During an interview on 08/21/23 at 1:13 P.M., the DON (Director of Nursing) indicated the CNA did not follow the intervention from the previous fall and she should have gotten assistance to transfer the resident.			

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	The current "Accidents and Supervision" policy with an implemented date of 09/01/22, was provided by the ADON on 08/22/23 at 1:15 P.M. The policy indicated, "...The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:...Implementing interventions to reduce hazard(s) and risk(s)...Implementation of Interventions-using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes:...Communicating the interventions to all relevant staff...Providing training as needed ...Ensuring that the interventions are put into action ..." 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;			

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	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to acknowledge a nutrition recommendation and document meal consumption for 1 of 2 residents reviewed for nutrition. (Resident 6) Findings include: 1a. During an interview on 8/15/23 at 12:06 P.M., LPN (Licensed Practical Nurse) 7 indicated the resident lost weight and had a poor appetite. They had increased her health shakes and she had a lot of snacks in her room. The resident had a stable weight at the time of 115 pounds. She was only 5 foot tall. She had a stroke recently and thought it might have affected the part of the brain the had to do with hunger because she just wasn't hungry anymore. During an observation and interview on 08/18/23 at 12:43 P.M., Resident 6 was sitting in her recliner in her room. She indicated she was a picky eater. She ate oatmeal every morning for breakfast. The facility was accommodating if she didn't like what was being served. She believed she had lost weight because she wasn't as active as she used to be. The Quarterly MDS (Minimum Data Set) assessment, dated 05/16/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, diabetes, anxiety, and depression. The resident required supervision with eating, she weighed 114 pounds, and had weight loss and was not on a prescribed weight loss regimen.	F 0692	1. On September 7, 2023, Resident 6 physician was notified of the RD recommendation to add fortified cereal with breakfast and an order was obtained. On August 30, 2023 the Nutrition at Risk Committee, consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Social Worker, and Dietary Manager, reviewed resident 6 intake records, weight records, nutrition care plan, and dietary recommendations to ensure that appropriate nutritional interventions are implemented and the physician was notified of the lack of documented meals for the identified dates and meals. 2. On August 30, 2023, the Nutrition at Risk (NAR) committee reviewed all dietician recommendations made in the past 3 months to ensure that all recommendations were communicated to the physician and appropriate follow-up occurred for each recommendation and reviewed meal intake records for past 3 months for all in-house residents to ensure meal intake documented for each meal. Any residents identified to have missing documentation of meal intake were evaluated by the NAR team to ensure no weight loss or	09/15/2023

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	The resident admitted to the facility on 02/07/23. The following weights were documented: - On, 02/08/23 the resident weighed 122.6 pounds, - On, 02/13/23 the resident weighed 117.9 pounds, - On 02/18/23 the resident weighed 121.5 pounds, - On 03/18/23 the resident weighed 118.1 pounds, - On 04/18/23 the resident weighed 119.4 pounds, - On 05/10/23 the resident weighed 114.0 pounds, - On 06/10/23 the resident weighed 114.0 pounds, - On 07/10/23 the resident weighed 115.7 pounds, - On 08/10/23 the resident weighed 112.0 pounds, and - On 08/20/23 the resident weighed 114.0 pounds. The resident had the following physician orders: - A current physician's order, with a start date of 03/09/23, indicated the resident was on a regular texture diet, - A current physician's order, with a start date of 02/13/23, indicated the resident was to receive four ounces of a health shake, three times a day, and - A current physician's order, with a start date of 02/21/23, indicated the resident was to receive 120 milliliters of Med Pass (a fortified nutritional supplement) in the morning and at bedtime. A Nutrition/Dietary Progress Note, dated 05/12/23 at 12:50 P.M., indicated the resident was being monitored for weight loss weekly. Her most recent weight of 114 pounds, showed a loss of 7.9% in 3 months. The resident received health shakes, three times a day. She consumed 50-100% of most meals. Dietary would continue to monitor the resident weights and intakes. She would be referred to the RD (Registered Dietician) as needed.		signs of nutritional impairment exist. 3. On September 12 & 13, 2023, the Director of Nursing will provide re-education to all nursing staff on the requirement that RD recommendations must be communicated to the physician and followed-up on promptly and that meal intake must be documented for all residents for all meals consumed in the facility. 4. The Director of Nursing or designee will conduct random audits of meal intake records on a minimum of 25% of residents each week for 4 weeks and then 25% each month to ensure that meal intake is documented for all meals for 4 weeks. All dietary recommendations will be reviewed in the weekly NAR meeting to ensure appropriate follow-up occurred for each recommendation; this will be ongoing. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for six (6) months. The QAPI committee will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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A Nutrition/Dietary Progress Note, dated 05/16/23 at 12:10 P.M., indicated the resident was being monitored for weight loss weekly. The most recent weight of 114 pounds, showed a loss of 5.2% in 20 days. The resident received health shakes, three times a day. She consumed 50 to 100% of most meals. Dietary would continue to monitor the resident weights and intakes. She would be referred to the Registered Dietician as needed.

A Nutrition/Dietary RD Progress Note, dated 05/31/23 at 9:56 P.M., indicated the resident was on a regular diet with shakes three times a day and Med Pass 2.0, twice a day. She fed herself and her seven-day meal consumption average was 61%. The resident's weight on 05/10/23 was 114 pounds and reflected an insidious weight loss of 4.2% for 1 month and significant weight loss of 7.9% in 2 months, and 13.8% in 6 months. A recommendation was made to add fortified cereal with breakfast for added calories and protein to aid in weight loss prevention.

A Nutrition/Dietary Note, dated 06/07/23 at 11:41 A.M., indicated the resident was being monitored for weight loss weekly. The most recent weight of 114 pounds, showed a loss of 5.6% in 2 months and 13.6% in 6 months. The resident received health shakes, three times a day. She consumed 50 to 100% of most meals. See RD recommendations from 05/31/23. Dietary would continue to monitor the resident weights and intakes.

A Nutrition/Dietary Note, dated 07/20/23 at 12:37 P.M., indicated the resident was being monitored for weight loss weekly. The most recent weight of 110.5 pounds, showed a loss of 6.5% in 3 weeks, and 8.1% in 3 months The resident had a gradual decline in weight. The resident received health

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN 47031

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	shakes, three times a day. Her appetite varied. Dietary would continue to monitor the resident weights and intakes. She would be referred to the RD as needed. A Nutrition/Dietary Note, dated 08/07/23 at 8:15 A.M., indicated the resident received a regular diet. Her most recent weight was 114 pounds and was stable at that time. The resident's appetite varied. She received health shakes three times a day. Dietary would continue to monitor the resident weights and intakes. The NAR (Nutritionally At Risk) Master List, were provided by the ADON (Assistant Director of Nursing), on 08/22/23 at 9:45 A.M. The forms indicated the following for Resident 6: - dated 05/02/23, the resident was a watch for weight decrease of 6.1 pounds in 9 days and was fairly stable for 3 months, - dated 05/09/23, the reason for NAR was the resident was down 7.9% of weight in 3 months. The interventions included, to request oatmeal at breakfast, health shakes three times a day, - dated 05/15/23, the reason for NAR was the resident was down 5.2% of weight in 20 days. The interventions included, to request oatmeal at breakfast, health shakes three times a day, - dated 05/22/23, the reason for NAR was the resident was down 5.2% of weight in 20 days and 13.8% of weight in 5 months. The interventions included, health shakes three times a day, and Med Pass twice a day, - dated 05/29/23, the reason for NAR was the resident was down 5.2% of weight in 1 month and down 7.9% in 3 months. The interventions included, daily weights, health shake three times a day, and Med Pass twice a day, - dated 06/05/23, the reason for NAR was the			

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	resident was down 5.6% of weight in 2 months and down 13.8% in 6 months. The interventions included, health shake three times a day, Med Pass twice a day. An intervention was listed for an RD recommendation of fortified cereal on 05/31/23 with a question mark beside it. The resident weight was stable for 1 month, and - dated 07/17/23, the reason for NAR was the resident had decline in weight. The interventions included Med Pass twice a day, and health shakes three times a day. The resident was not listed on the NAR notes for 06/12/23, 06/20/23, 06/26/23, 07/10/23, 07/31/23, 08/07/23, 08/14/23, and 08/21/23. The clinical record lacked documentation the resident's physician was notified of the RD recommendation to add fortified cereal with breakfast. During an interview on 08/18/23 at 9:04 A.M., LPN 7 indicated the resident really liked oatmeal with brown sugar for breakfast. She was a "sweets" eater. She received house shakes and Med Pass. She had never received fortified foods. During an interview on 08/21/23 at 10:38 A.M., CNA (Certified Nurse Aide) 12 indicated the resident would feed herself. The resident always ate oatmeal for breakfast. She liked to snack a lot. The resident always ate regular oatmeal at breakfast. She had never gotten fortified oatmeal. If the resident was to have fortified oatmeal it would be indicated on her meal card. During an interview on 08/21/23 at 10:51 A.M., the Dietary Manager indicated when the RD made a recommendation it would be written on the NAR and then sent to the DON (Director of Nursing),			

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	ADON, and the Administrator. They would then be sent to the physician. The physician would then agree or disagree with the recommendation. If the physician agreed with the recommendation the order would be implemented and if they disagreed, they would let the DON know why the disagreed and it would be documented in a progress note. She wasn't sure what happened with the fortified cereal recommendation. The resident had received health shakes and was on a regular diet. During an interview on 08/21/23 at 11:30 A.M., the DON indicated if the NP (Nurse Practitioner) disagreed with an RD recommendation a progress note would have been created. She didn't see anything on the physician visit note on 05/31/23 that it was addressed. During an interview on 08/21/23 at 1:14 P.M., the DON indicated she wasn't sure what happened to the RD recommendation. It should have been documented that the physician agreed or disagreed with the recommendation. The current facility policy titled, "Nutritional Management", with an implemented date of 09-01-2022 was provided by the ADON on 0822/23 at 1:15 P.M. The policy indicated, "...The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition..." The current, undated, facility policy titled, "CONSULTING REGISTERED DIETICIAN REPORTS", was provided by the DON on 08/22/23 at 1:42 P.M. The policy indicated, "...A record of the consultant dietician's observations and recommendations is made available in an			

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	easily retrievable for to nurses, physician's and the care planning team...Recommendations are acted upon and documented by the facility staff and/or prescriber. If the prescriber does not respond to the recommendations within a reasonable timeframe, the Director of Nursing and/or the consultant registered dietician may contact the medical director, as needed..." 1b. The Amount Eaten Record for Resident 6 was provided by the ADON on 08/21/23 at 4:17 P.M. The record lacked documented meals for the following dates and meals: - On 05/02/23 at breakfast, - On 05/13/23 at dinner, - On 05/22/23 at breakfast and lunch, - On 05/25/23 at dinner, - On 05/28/23 at dinner, - On 06/03/23 at breakfast, - On 06/04/23 at breakfast, - On 06/19/23 at dinner, - On 07/02/23 at breakfast, - On 07/03/23 at breakfast, - On 07/08/23 at dinner, - On 07/17/23 at dinner, - On 07/20/23 at breakfast, - On 07/22/23 at dinner, - On 07/23/23 at dinner, - On 08/05/23 at dinner, - On 08/06/23 at dinner, and - On 08/14/23 at dinner. During an interview on 08/22/23 at 9:34 A.M., CNA 10 indicated the amount of food the resident ate was entered in the computer system at the end of each shift. It should be documented for each meal. The supplements the residents received were not to be entered into the computer with the meals.			

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	During an interview on 08/22/23 at 10:19 A.M., the Dietary Manager indicated resident meal consumptions were reviewed for NAR and by the RD. The current facility policy titled, "Recording Percent of Meal Consumed", dated 2021, was provided by the DON on 08/22/23 at 1:42 P.M. The policy indicated, "...Staff will document the percentage of each meal consumed for each individual on a daily basis..." 3.1-46(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services			

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	in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to accurately monitor the disbursement of a controlled substance (Resident 24) and follow pharmacy recommendations (Residents 15 and 44) for 3 of 16 residents reviewed for pharmacy services. Findings include: 1. Medication administration was observed on Wing 3 on 08/17/23 at 10:20 A.M. LPN (Licensed Practical Nurse) 4 was giving Resident 24 liquid morphine prior to pericare. The label on the bottle indicated there was 100 mg (milligrams) of morphine in every 5 ml (milliliters) of fluid. The resident's dose was 0.25 ml (5 mg) sublingually (under the tongue). The LPN drew the morphine out of the bottle using a small easy to read syringe. After the nurse administered the morphine, she rinsed the syringe in the sink, placed the syringe in a new plastic bag used for crushing medications, and placed it in the dark plastic bag with the bottle of morphine. She documented on the paper "Controlled Drug Record for Liquids" form following the administration. The drug record indicated the resident should have had 1.5 (six doses) ml left in the bottle. The LPN drew up the liquid morphine left in bottle and the amount was between 0.25	F 0755	1. Resident #24 did not go without a dose as medication was PRN. On August 22, 2023 Resident 15's order for Colestid was updated to be administered at 10am and 3pm and the directions for administration were updated to state that other medications should be administered at least an hour before or at least 4 hours after the Colestid. Resident 44 Bupropion order was updated to reflect the appropriate order, as the correct medication was administered the order was transcribed incorrectly in computer. There were no adverse effects related to Bupropion transcription error. 2. On August 17, 2023, the DON and Consulting Pharmacist conducted an inventory of all liquid narcotics in the facility to ensure that the count accurately reflects the remaining amount of liquid in each bottle. No additional discrepancies were identified. On August 22, 2023, the Director of Nursing and Assistant Director of	09/15/2023

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	and 0.5 ml (less than two doses) . The narcotics count book indicted the resident should have had 1.5 ml left in the bottle following the administration of the dose of morphine. The LPN indicated she would contact the DON (Director of Nursing) in regard to the discrepancy. On 08/17/23 at 10:38 A.M., LPN 4 contacted the DON from the unit phone. On 08/17/23 at 10:39 A.M., the DON arrived at the medication cart on Wing 3. The LPN explained the bottle of Morphine contained between 0.25 and 0.5 ml and the Controlled Substance Log indicated the resident should have had 1.5 ml left in the bottle. On 08/17/23 at 10:41 A.M., the bottle of morphine was observed and indicated it had contained 15 ml upon delivery from the pharmacy. The LPN indicated the resident had been on 0.25 ml since she had started on the medication. The dose had not changed. During an interview on 08/17/23 at 11:56 A.M., the DON indicated there was spillage in the plastic bags, of which she indicated there were two, within the plastic bag with the morphine bottle. During an interview on 08/18/23 at 12:35 P.M., LPN 4 indicated when the bottle of liquid morphine would get below the last line it was hard to tell how much was in the bottle. The Controlled Drug Record for Liquids was provided by the DON on 08/17/23 at 10:42 A.M. The record indicated the resident had received 53 doses of 0.25 ml. The bottle contained 15 ml (60 doses). The resident should have had seven doses left in the bottle. Less than two doses		Nursing reviewed all pharmacy recommendations made in the past 3 months to ensure that all recommendations are being followed. 3. On September 12 & 13, 2023, the Director of Nursing will provide re-education to all licensed nursing staff on the requirement that all controlled substances administration and remaining doses must be accurately documented on the narcotic count sheet and any discrepancies must be immediately reported to the DON and that pharmacy recommendations must be followed. All new pharmacy recommendations will be reviewed in daily IDT meeting to ensure appropriate follow-up occurred for each recommendation. 4. The Director of Nursing or designee will conduct random audits of narcotic counts on a minimum of 25% of residents each week for 4 weeks and then 25% each month to ensure that remaining doses are correct for controlled substances. The Director of Nursing or designee will conduct random audits on a minimum of 25% of the monthly pharmacy recommendations for 6 months to ensure recommendations are followed. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review	

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	remained in the bottle. During an interview on 08/17/23 at 10:58 A.M., the DON indicated staff were supposed to document on the Controlled Drug Record when a dose was administered. The current facility policy title, "MEDICATION STORAGE IN THE FACILITY-CONTROLLED SUBSTANCE STORAGE", with a revision date of 02/2023, was provided by the DON on 08/17/23 at 3:39 P.M. The policy indicated, "...Schedule medications and other medications subject to abuse or diversion are stored in a permanently affixed, [double-locked] compartment separate from all other medications or per state regulations...At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented...Any discrepancy in controlled substance counts is reported to the director of nursing immediately...Liquid narcotics will be overfilled in comparison to the quantity written on the label. This is a pharmacy industry standard. To account for excess amount, the nurse checking in the bottle of liquid controlled substance, should eliminate the quantity by using the measurement grid, located on the bottle...This amount should be recorded as the starting quantity..." 2. Resident 15's clinical record was reviewed on 08/21/23 at 2:32 P.M. A Quarterly MDS Assessment, dated 07/15/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, hypertension, hemiplegia, and personal history of other diseases of the digestive system. A "Consultant Pharmacy Communication to		at least monthly for six (6) months. The QAPI committee will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	Nursing" form, dated 02/25/23, indicated the resident received Colestid (Colestipol, a cholesterol medication that was used to treat diarrhea), 1 gram, once in the morning and again at bedtime. Clinical Pharmacology sources indicated other medications the resident took should be administered at least an hour before or at least 4 hours after the Colestipol. Based on administration times for the resident's other medications, the Colestipol could be administered at 11:00 A.M. and 4:00 P.M. The response section of the form, signed by the ADON (Assistant Director of Nursing) and dated 03/01/23, indicated the Colestipol medication administration times were adjusted to 11:00 A.M. and 4:00 P.M. The March 2023 EMAR (Electronic Medication Administration Record) included, but was not limited to the following MD orders: - An MD order, with a start date of 03/02/23, to administer Colestid, 1 gram, by mouth, in the morning for diarrhea. The administration time was 11:00 A.M. The medication was administered as ordered until the order was discontinued on 03/06/23. - An open ended MD order, with a start date of 03/07/23, to administer Colestid, 1 gram, by mouth in the morning for diarrhea. The administration time was "UPON" (upon rising). The resident's EMARs from March 2023 to August 2023 indicated the resident received a morning dose of Colestid with all her other morning medications and an evening dose of the medication at 4:00 P.M. During an interview on 08/22/23 at 10:13 A.M., RN 4 indicated the resident received the Colestid with			

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	all her other morning medications upon rising, and received an additional dose of the medication by itself at 4:00 P.M. During an interview on 08/22/23 at 10:29 A.M., the DON indicated the facility switched pharmacies in March. The order for the morning dose of the medication should have been entered into the computer to reflect the 11:00 A.M. administration time. The medication should have been administered at 11:00 A.M., not upon rising and not with the other medications. 3. Resident 44's clinical record was reviewed on 08/21/23 at 10:26 A.M. A Quarterly MDS assessment, dated 06/07/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, stroke, hypertension, anemia, diabetes, anxiety, and depression. A "Consultant Pharmacy Communication to Nursing" form, dated 05/23/23, indicated the resident's order from the recent hospital discharge was for Bupropion XL (An antidepressant). This medication was entered in the EMAR as Bupropion SR which was not the same dosage form. The response section of the form, signed by the DON and dated 05/25/23, indicated the medication had been changed to XL. The hospital discharge orders, dated 05/20/23, indicated the resident was to continue Bupropion XL (150 mg/24 hours) one oral tablet every 24 hours. The May 2023 EMAR included, but were not limited to the following orders: - A MD order, with a start date of 04/30/23, for Bupropion HCL (hydrogen chloride) ER (extended			

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	release) (XL) oral tablet, Extended Release 24 hour 150 mg. Give one tablet in the morning for depression. The medication was administered as ordered until the order was discontinued on 05/18/23. - A MD order, with a start date of 05/21/23, for Bupropion HCL ER (SR) oral tablet, Extended Release 12 hour 150 mg. Give one tablet in the morning for major depressive disorder. The medication was administered as ordered until the order was discontinued on 05/24/23 at 4:23 P.M. - An open-ended MD order, with a start date of 05/25/23, for Bupropion HCL ER (XL) oral tablet extended release 24 hour. Give one tablet in the morning for major depressive disorder. During an interview on 08/22/23 at 10:15 A.M., RN 5 indicated when a resident came back from the hospital with orders, the orders were written on an order form in the chart and written in the computer as a new order. The orders were faxed to the pharmacy and would be delivered either the same day or the next day depending on the time the orders were faxed. The current "Administering Medications" policy, with a revised date of April 2019, indicated "...Medications are administered in a safe and timely manner, and as prescribed...Medications are administered in accordance with prescriber orders, including any required time frame..." 3.1-25(b)(3) 3.1-25(b)(5) 3.1-25(e)(2) 3.1-25(e)(3) 3.1-25(m) 3.1-25(n)			

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F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately for 2 of 3 medication carts reviewed. (Wing 1 and Wing 3 medication carts) Findings include: 1. The medication cart on Wing 1 was observed on 08/21/23 at 3:42 P.M., with LPN 7. The top drawer of the cart contained several medication cups containing pills nested together. The LPN	F 0761	1. On August 24, 2023, LPN 7 was reeducated by the Administrator and Director of Nursing on the requirement that medications cannot be prepared in advance of medication administration and must be administered at the time they are removed from packaging. Resident 29 vial of Lantus with open date of 7/22 was discarded	09/15/2023

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	155730	A. BUILDING 00 B. WING	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN 47031

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	indicated it was medications for the 4:00 P.M. medication pass. The cups were labeled with the residents' initials only. She was unaware of the facility policy. The cups contained the following medications for the following residents as described by the LPN: - Resident 14, bupropion (antidepressant), - Resident 42, Protonix, Gabapentin (a nerve medication), - Resident 58, Xanax (antianxiety medication, a controlled substance), - Resident 13, two Metformin tablets, - Resident 6, two Tylenol, Metformin, Buspar (antianxiety medication), - Resident 22, Metformin, - Resident 49, two Tylenol, 1.5 tabs of Lasix, - Resident 39, two Demadex (a diuretic medication), two Tylenol, - Resident 3, two Tylenol, and - Resident 63, Buspar (an antidepressant). The LPN indicated she gets the pills out so she can help with the supper trays. She thought she could prepare for one medication pass. During an interview on 08/22/23 at 2:06 P.M., the DON (Director of Nursing) indicated staff were not allowed to preset medications. During an interview on 08/22/23 at 2:47 P.M., the		on 8/22/23. On August 22, 2023, Resident 70's Tramadol was counted by 2 licensed nurses and all doses were accounted for. LPN 9 was re-educated on requirement to count all pills present when conducting shift to shift narcotic count. 2. On August 24, 2023, the Infection Preventionist conducted an audit of all medication carts in the facility to ensure that no medications were prepared in cups in advance of administration, that all opened insulin is discarded within 28 days of opening, and that the narcotic count is accurate for all narcotics. 3. On September 12 & 13, 2023, the Director of Nursing will provide education to all licensed nurses d on the facility policy for medication storage, including controlled substance storage and competency of each nurse was validated by conducting medication pass observations of each nurse. 4. The Director of Nursing or designee will conduct random audits of medication carts on each unit each week for 4 weeks and then monthly to ensure that medications are stored properly. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for six (6) months. The QAPI committee will	

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	DON indicated antianxiety and antidepressant medications were not kept in the double locked narcotics box in the medication carts if they were routinely scheduled medications. The were kept in the locked narcotics box only if they were ordered "as needed". Xanax and Buspar were not narcotics. During an observation and interview on 08/22/23 at 2:51 P.M., the medication cart on Wing 1 was reviewed with RN 8. The RN indicated Xanax was kept in the narcotics drawer. Resident 58's card of Xanax pills was observed and in the double locked narcotics box. The medication was a routinely scheduled medication. Xanax should be double locked per the RN. The "Controlled Drug Record" for Resident 58's Xanax (alprazolam) was provided by RN 8 on 08/22/23 at 2:55 P.M. The record indicated the medication was scheduled, and the resident was to take one tablet by mouth twice a day. 2. On 08/22/23 at 2:21 P.M., Wing 3's Medication Cart was observed with LPN 9. The following was observed: - A vial of Lantus (insulin) for Resident 29, that was 1/4 full had an open date of 7/22. LPN 9 indicated the medication was good for 28 days after it was opened and should have been discarded. During a Narcotic Count with the LPN the following was observed: - Resident 72 had 28 lorazepam (an antianxiety medication) tablets. Tablet 28 in the narcotic blister pack had been punched out and taped back into place. The LPN indicated the pill had probably been removed by accident and a staff		review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	member taped it back into the blister pack. If a pill had been removed from the blister pack, then it should be discarded appropriately. - Resident 70 had a bottle of Tramadol (a pain medication). The narcotic count sheet indicated the resident should have had 58 tramadol tablets. Inside the bottle of medication was a plastic pill crusher package that had whole pills inside. The package was stapled shut and had "30" written on the outside of it. There were other loose pills inside the bottle. LPN 9 indicated she didn't have a pill counter to be able to count the pills and had not counted them that morning. After a few seconds she retrieved a clean plastic spoon and clean plastic cup and started counting the loose pills. The loose pills totaled 28. She did not count the pills inside the plastic package. She indicated she did not count them that morning when she took over the medication cart from the other nurse. All narcotic medications should be counted at each shift change and the 30 tablets inside the plastic package should have been counted every shift. The current facility policy title, "MEDICATION STORAGE IN THE FACILITY-CONTROLLED SUBSTANCE STORAGE", with a revision date of 02/2023, was provided by the DON on 08/17/23 at 3:39 P.M. The policy indicated, "...Schedule medications and other medications subject to abuse or diversion are stored in a permanently affixed, [double-locked] compartment separate from all other medications or per state regulations...At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented...Any discrepancy in controlled			

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	substance counts is reported to the director of nursing immediately...Liquid narcotics will be overfilled in comparison to the quantity written on the label. This is a pharmacy industry standard. To account for excess amount, the nurse checking in the bottle of liquid controlled substance, should eliminate the quantity by using the measurement grid, located on the bottle...This amount should be recorded as the starting quantity..." 3.1-25(b)(5) 3.1-25(e)(3) 3.1-25(m) 3.1-25(n)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

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	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to follow appropriate infection control guidelines during medication administration for 1 of 11 residents observed. (Resident 57) Findings include: Medication administration was observed on Wing 4 on 08/17/23 at 11:03 A.M., with LPN (Licensed Practical Nurse) 2. The nurse was preparing to check the blood sugar of Resident 57 and indicated he was to receive six units of scheduled insulin before meals. The nurse donned gloves, then dropped the packet containing an alcohol wipe to be used for the procedure on floor. The LPN picked the alcohol wipe packet up with her gloved hand and went to check the resident's blood sugar. The resident was sitting at a table in the dining area. The nurse laid her supplies on the table and was preparing to open the packet she had just picked up off the floor. When asked what she should do since she dropped the alcohol wipe packet on the floor, she said she should get another one. She doffed her gloves and threw away the alcohol wipe, used hand sanitizer, got keys out of her pocket, got a new alcohol wipe packet out of the medication cart, donned clean gloves, and proceeded to check the resident's blood sugar level. Following the procedure, the nurse wiped down the blood sugar checking machine with an alcohol wipe. The LPN indicated the blood sugar machine was used for the whole	F 0880	1. On September 8, 2023, LPN 2 was reeducated on infection control guidelines during medication administration, including the requirement that dropped items must be discarded or disinfected prior to use and the procedure for cleaning and disinfecting glucometers. A new alcohol wipe was used to administer Resident 57's insulin on 8/17/23. 2. Med pass observations were conducted on August 25, 2023, by the Director of Nursing on all licensed nurses to ensure that infection control guidelines are followed during medication administration. 3. On September 12 & 13, 2023, the Director of Nursing will provide re-education to all licensed nursing staff on infection control guidelines that must be followed during medication administration and the procedure for cleaning and disinfecting the glucometer. 4. The Director of Nursing or designee will conduct random med pass observations of 5 nurses each week for 4 weeks and then 5 monthly to ensure that infection	09/15/2023

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	wing. The Medication Review Report was provided by the DON (Director of Nursing) on 08/22/23 at 2:56 P.M. The report indicated the resident was to receive Novolog insulin, six units, subcutaneously before meals. The current Administering Medications policy, with a revised date of April 2019, was provided by the DON on 08/17/23 at 3:39 P.M. The policy indicated, "...Medications are administered in a safe and timely manner...Staff follows established facility infection control procedures (e.g., handwashing, antiseptic [sic] technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable..." The current Infection Prevention and Control Program policy, with a reviewed date of 05/12/23, was provided following the Entrance conference. The policy indicated, "...facility...maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment..." 3.1-18(a)		control guidelines are followed during medication administration. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for six (6) months. The QAPI committee will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00413804. Complaint IN00413804 - No deficiencies related to the allegations are cited. Survey dates: August 15, 16, 17, 18, 21, and 22,	R 0000		

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	2023 Facility number:000420 Residential Census: 21 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on August 28, 2023.			
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to follow a physician's recommendations related to hold parameters for 1 of 7 residents reviewed for pharmacy services. (Resident 305) Findings include: The clinical record for Resident 305 was reviewed on 08/22/23 at 1:45 P.M. The diagnoses included, but were not limited to, hypertension, and diabetes. A current physician's order, with a start date of 01/22/23, indicated the resident was to take amlodipine, 2.5 mg (milligrams), every morning, for hypertension. The medication was to be held when the blood pressure was less than or equal to 110/60 or the heart rate was less than or equal to 60. The August 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the	R 0299	1. On September 7, 2023, Resident 305's physician was notified of that resident received Amlodipine 2.5mg on the following dates 08/02/23, 8/4/23 -8/8/23, 8/10/23, 8/15/23, and 8/19/23-8/20/23 when the blood pressure was less than or equal to 110/60 or the heart rate was less than or equal to 60. Resident was assessed and found to have no negative effect from receiving the medication. 2. On September 5, 2023, nursing administration reviewed the physician orders and MARs for the past 30 days for all current in-house residents to ensure that physician recommendations related to hold parameters for medications were followed and resident attending physicians were notified of any identified instances	09/08/2023

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	resident had received the medication on the following dates and times when the blood pressure was less than or equal to 110/60 or the heart rate was less than or equal to 60: - On 08/02/23 upon rise, the blood pressure was 110/60, - On 08/04/23 upon rise, the blood pressure was 132/60, - On 08/05/23 upon rise, the heart rate was 60, - On 08/06/23 upon rise, the heart rate was 60, - On 08/07/23 upon rise, the heart rate was 60, - On 08/08/23 upon rise, the heart rate was 60, - On 08/10/23 upon rise, the heart rate was 60, - On 08/15/23 upon rise, the blood pressure was 132/60, - On 08/19/23 upon rise, the heart rate was 60, and - On 08/20/23 upon rise, the heart rate was 60. During an interview on 08/22/23 at 2:43 P.M., LPN (Licensed Practical Nurse) 13 indicated if a resident had parameters in the physician's order for a blood pressure medication the blood pressure and heart rate should have been taken before the medication was administered. The medication should have been held if outside of the parameters. The medication, blood pressure, and heart rate would be documented in the EMAR. The current undated facility policy titled, "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES" was provided by the DON (Director of Nursing) on 08/22/23 at 2:59 P.M. The policy indicated, "...Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration ..."		when physician recommendations related to hold parameters were not followed. 3. On September 5, 2023, licensed nursing staff were re-educated on the requirement to follow physician recommendations related to hold orders based on parameters. On September 12 & 13 2023, the Director of Nursing will provide education to all licensed nursing staff on the requirement to follow physician recommendations related to hold orders based on parameters. 4. The Director of Nursing or designee will conduct random audit of MARs 5 days a week for 4 weeks and then weekly to ensure that physician recommendations related to hold parameters are followed. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for six (6) months. The QAPI committee will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	