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	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KEEPSAKE VILLAGE OF COLUMBUS	2564 FOXPOINTE DR COLUMBUS, IN 47203

(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 the Investigation of Complaint IN00440216. Complaint IN00440216 - State deficiencies related to the allegations are cited at R0036 and R0305. An unrelated deficiency cited. Survey dates: August 20, and 21, 2024 Facility number: 010680 Residential Census: 38 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 23, 2024.	R 0000	**/b> ="" span="">**	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to follow the physician's order in a timely manner related to obtaining a urine specimen for a UA (Urinalysis) for 1 of 4 residents reviewed. (Resident B) Findings include: The clinical record for Resident B was reviewed on 08/20/24 at 11:38 A.M. The resident's diagnoses included, but were not limited to, dementia, behavioral disturbances, and anxiety. A "Lab Order", dated 04/06/24, indicated the resident was to have a UA and reflex culture	R 0036	**R036** 1.Resident B is no longer residing at the facility. 2. The community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The charge nurse has reviewed and confirmed that all physician orders are being followed as written. In addition, all licensed nurses and med techs were in-serviced to ensure all physician orders are followed per company	09/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Angel	Executive Director	09/05/2024

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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	completed. A faxed physician's order, dated 04/06/24, for Resident B was provided by the Charge Nurse on 08/21/24 at 11:38 A.M. The physician's order contained the following: - Check UA/culture, - Haldol (an antipsychotic medication) 2.5 mg (milligrams), every six hours as needed, repeat one time if no improvement for severe agitation, times two days, and - Ativan (an antianxiety medication) 0.5 mg, every six hours as needed for agitation. The ETAR (Electronic Treatment Administration Record) for April 2024, was provided by the Charge Nurse on 08/21/24 at 1:09 P.M. The record indicated the following: - The order to obtain a UA for a diagnosis of "Confusion", was not put in the resident's chart to be collected until 04/10/24, four days after the facility received the order from the lab and the physician. The end date of the order was 05/09/24. - Haldol 2.5 mg was administered IM (via intramuscular injection) on 04/08/24, and, (according to the Charting [Nurse] Notes) it was administered a second time on 04/17/24. The Haldol was to be discontinued on 04/08/24 per the physician's order. The "Charting (Nurses) Notes" from the EHR (Electronic Health Record) from 02/22/24 through 07/23/24, were provided by the Charge Nurse on 08/21/24 at 11:38 A.M. The record included, but was not limited to, the following: - An LPN (Licensed Practical Nurse) note, dated		policy. The charge nurse or designee will validate each physician order entered by other nursing staff members daily. 4. The charge nurse or designee will audit daily logs for the next six months to ensure physician orders are per company policy and as written by the physician. 5. The systemic changes will be completed by 9-21-2024.	

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	04/06/24 at 4:20 P.M., indicated the resident became aggressive while staff were assisting her to change soiled clothes and was threatening other residents. - An LPN note, dated 04/08/24 at 1:43 P.M., indicated the resident was having behaviors of going into other residents' rooms, taking meals from them, yelling, and hitting staff members. A Haldol injection was administered. - An LPN note, dated 04/10/24 at 1:25 P.M., indicated staff had made two attempts to collect urine but the resident was incontinent each time. - An LPN note, dated 04/17/24 at 1:48 P.M., indicated staff administered Haldol IM 2.5 mg for aggressive behaviors. - An LPN note, dated 04/22/24 at 9:33 P.M., indicated staff were unable to obtain the UA (Urinalysis sample) and would pass it on the next shift. - An LPN note, dated 04/23/24 at 9:33 P.M., indicated staff were unable to obtain the UA and would pass it on the next shift. The notes from February and March did not indicate the resident had aggressive behaviors towards staff or residents prior to 04/06/24. The notes from May and June indicated the resident continued to receive the antianxiety medication, Lorazepam/Ativan, 0.5 mg, as needed. On 05/12/24, the notes indicated the resident received the medication at 4:53 P.M. and at 7:59 P.M., only three hours and six minutes apart, not the prescribed six hours apart.			

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	The notes lacked documentation the physician had been notified regarding to the staff's inability to obtain the urine specimen nor were there any notes identifying any responses or ongoing guidance from the physician. A note, dated 07/21/24, indicated the resident's temperature was 100.6. The resident was sent to the local hospital. The resident was admitted with a UTI and was treated with IV (Intravenous) antibiotics. During an interview on 08/20/24 at 1:50 P.M., CNAs (Certified Nurse Aides) 3, 4, and 5, indicated they had behavior sheets they filled out if a resident had a behavior. They gave the sheet to the nurse after they filled them out. Resident B was a good resident, really sweet, friendly to everyone, and liked to walk a lot. If she was tired or if staff were doing patient care, she would show aggression and that was normal for her. It was usually just during patient care. The resident was usually happy, smiling, and singing. So, if she was aggressive at any other time, that would be a behavior for her. Any time a resident showed aggression they filled out a behavior form, even if it was their normal. There was a question at the bottom of the form asking if it was a repeat behavior. During an interview on 08/20/24 at 2:08 P.M., the Charge Nurse indicated there should be a Nurse (Chart) Note in the record when the physician was notified. During an interview on 08/21/24 at 1:24 P.M., the Charge Nurse indicated when they received an order for a UA, they faxed it to the pharmacy, then they attempted to get a clean catch (uncontaminated urine sample). The facility had			

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	standing orders that any of the nurses could put in place at any time. Other staff were made aware of the need for a UA by passing the information on in the 24-hour report. If they were unable to obtain the specimen they notified the physician after three attempts. They fax the physician and report to them their inability to obtain the specimen and place the fax in the hard chart. They also put a note in the computer in the nurse notes. They document the physician's response in the nurse notes. The physician's response on the faxed form will go into the chart as well. If they don't get a response from the physician after they fax them three times, they give them a call. They did not straight cath here at this facility. They had asked for the order because of the resident's behaviors, that's when the physician informed them it was a standing order. On 08/21/24 at 2:24 PM, the Charge Nurse looked through the binder of 24-hour nurse report notes and indicated she could not find any other dates beside 04/16/24 and 04/22/24, where it mentioned that Resident B needed a UA. During an interview on 08/21/24 at 2:31 P.M., the Charge Nurse indicated they were unable to obtain the urine specimen for Resident B, and provided a physician notification, dated 04/22/24, indicating the physician had been notified of the staff's inability to obtain the specimen. The current Resident Rights policy, with a revised date of 09/28/20, was provided by the Charge Nurse on 08/21/24 at 1:53 P.M. The policy indicated, "...Residents have the right to a dignified existence...and communication with and access to persons and services inside and outside the facility..."			

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R 0304 Bldg. 00	This citation relates to complaint IN00440216. 410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to store medications in a safe and secure manner for 1 of 3 medication carts reviewed. (Medication Cart 1) Findings include: During an observation on 08/21/24 at 1:36 P.M., three medication carts were lined up next to each other sitting against a wall in a back hallway next to residents' rooms. One of the carts was unlocked and contained the following loose pills: - One half (1/2) of a small round red pill, - One small round yellow pill marked with the number "81", - One small round brown pill marked with "T5", - One small round white pill marked with a "U" on one side and a "5" on the other side, - One small oval tan pill marked with "M126", and - One small oval white pill marked with "91". No staff were in the immediate area or within sight of the medication cart. The medication cart was empty other than the loose pills. At 1:39 P.M., one male resident walked past the cart who had been observed earlier pouring a packet of sugar in his mouth while walking down the hallway. At 1:41 P.M., one female resident walked up to the cart and started a conversation about what a job it was to bury people. The resident was confused. During an interview and observation at 1:44 P.M., the Charge Nurse indicated medication carts	R 0304	**R304** 1. No residents were affected by the alleged deficient practice. 2. The community reviewed each medication cart to determine if any residents could be affected by the alleged deficient practice. 3. The charge nurse and the executive director have reviewed and confirmed that all medication carts are free and clear of any loose medications and are always locked. Any additional medication carts that are awaiting pick up from the pharmacy are stored in a locked office with the carts locked. In addition, all licensed personnel with access to the medication cart have been in-serviced on State Reg 410 IAC 16.2-5-6 (e). 4. The charge nurse or designee will complete random daily audits for the next six months to ensure all medication carts meet the regulations. 5. The systemic changes will be completed by 9-21-2024	09/21/2024

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	should be locked at all times, they were waiting for the pharmacy to pick up the cart, and she proceeded to lock the cart. During an interview on 08/21/24 at 2:49 P.M., the Administrator indicated they did not have a policy related to the storage of medications.			
R 0305 Bldg. 00	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance Based on record review, interview, and observation, the facility failed to provide a resident's medication in a timely manner related to antibiotics for 1 of 3 residents reviewed for antibiotic use. (Resident C) Findings include: The clinical record for Resident C was reviewed on 08/20/24. The resident's diagnoses included, but were not limited to, dementia, anemia, and depression. The resident was on a pureed diet and took their medications crushed. The resident was sent out to the local hospital on 08/02/24, following a fall from their wheelchair at 6:47 P.M. The resident returned to the facility on 08/03/24 at 5:58 A.M. The Emergency Room "AFTER VISIT SUMMARY", dated 08/02/24, indicated the resident had been injured when they were pushed from their wheelchair by another resident. The resident was to apply ice to the bruised areas to help with the swelling. The hematoma would take weeks to resolve. The resident was not to blow their nose because their nasal bones were fractured, and it could lead to a deeper tissue infection. The resident was prescribed antibiotics to take as a preventative measure and was to start	R 0305	**R305** 1. Resident C clinical record was reviewed. The resident record is in accordance with all physician and pharmacy recommendations. 2. The community reviewed each resident's record to determine if any other residents could be affected by the alleged deficient practice. 3. The charge nurse has reviewed and confirmed that all resident records, all medication recommendations, and orders, have been acted upon within a reasonable time frame. In addition, all nursing staff were in-serviced on how to properly handle medication recommendations and orders. 4. The charge nurse or designee will complete daily checks to ensure the EDK is fully stocked, and all medication ordered is received by family members or the facility pharmacy within the appropriate time frame. 5. The systemic changes will be completed by 9-21-2024	09/21/2024

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	taking Cephalexin (Keflex), 500 mg (milligrams) twice a day for five days. The medication was available to be picked up at a local pharmacy for two dollars. The EMAR (Electronic Medication Administration Record) for August 2024, was provided by the Charge Nurse on 08/21/24 at 11:38 A.M. The record indicated staff members had documented the Cephalexin medication was not available from 08/04/24 thru 08/06/24. The resident was not started on the antibiotic until the morning of 08/07/24. During an interview and observation on 08/21/24 at 1:24 P.M., the Charge Nurse indicated if a resident did not have a medication readily available, they could have the physician send prescriptions to a local pharmacy. The facility pharmacy could deliver medications every night. The facility had some antibiotics available in their EDK (Emergency Drug Kit). The EDK was observed and noted to contain the antibiotic Cephalexin 250 mg. The nurse indicated the staff could use medications from their EDK when needed. Antibiotics should be started as soon as they were ordered, in less than 24 hours. During an observation on 08/21/24 at 11:00 A.M., Resident C was sitting in a wheelchair in the common area in front of the television. Large yellowing bruises were noted on both cheeks, and she had a golf ball size knot protruding from her forehead. The current "Change of Condition" policy, with a revised date of 06/20/24, indicated, "...change of condition to be addressed with...assessment...development of Interim Service Plan...include...falls...Medication changes...Broken			

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	bones..." This citation relates to complaint IN00440216.			