STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 00 B. WING	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOMESTEAD HEALTHCARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

(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 the Investigation of Complaint IN00439096. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00433061 and IN00433647 completed on June 17, 2024, which resulted in unrelated deficiencies. This visit was in conjunction with the PSR to the Investigation of Complaints IN00437007 and IN00438015 completed on July 5, 2024, which resulted in unrelated deficiencies. Complaint IN00439096 - Federal/State deficiencies related to the allegations are cited at F625. Complaint IN00433061 - Federal/State deficiencies related to the allegations are cited at F760. Complaint IN00433647 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00437007 - Corrected. Complaint IN00438015 - Corrected. Unrelated deficiency cited. Survey dates: July 31 and August 1 and 2, 2024 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 59 Total: 59	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Gunter	RN	08/21/2024

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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	Census Payor Type: Medicare: 2 Medicaid: 50 Other: 7 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 8, 2024.			
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.			

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	The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on record review and interview, the facility failed to ensure resident rights were maintained related to being able to go outside in the facility courtyard unsupervised during non-smoking times for 5 of 5 residents reviewed for resident rights. (Residents F, Resident G, Resident H, Resident J, Resident K) Findings Include: 1. During an interview with Resident K on 8/1/24 at 1:00 p.m., he indicated could only go outside in the courtyard during smoking times. He indicated this changed after there was a "fight" in the gazebo and the Executive Director would not let anyone go out without supervision. Those residents who got in the fight aren't here anymore so residents should be able to go outside. He stated "I don't want to be inside all the time with TV." He wanted to go outside and enjoy the beautiful weather. He indicated if you signed out you could go off the property to smoke. 2. During an interview with Resident F on 8/1/24 at 1:14 p.m., he indicated he had been informed by	F 0550	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Due to the confidentiality of the complaint survey residents F, G, H, J and K can't be identified. 2. All residents interviewed to ensure there was no negative psychosocial impact. 3. RDCO educated DON and ED on facility's policy Residents Rights 4. ED will interview 5 resident a week for 4 weeks to ensure they	08/27/2024

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	facility staff he was not allowed to go outside to the courtyard to get fresh air at any time unless he was supervised. He stated "the heat helps my arthritis pain." The record for Resident F was reviewed on 8/1/24 at 1:43 p.m. A Quarterly Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated the resident was cognitively intact and felt it was very important to go outside and get fresh air when the weather was good. A care plan, dated 7/23/24, indicated the resident had a concern of psychosocial well-being with a goal that the resident would report decreased feelings of social isolation by next review. Interventions included, but not limited to, observe resident for signs and symptoms of new onset of psychosocial issues and initiate resident specific interventions. 3. During an interview on 8/1/24 at 1:08 p.m., Resident G indicated she could not go outside except during smoking times without supervision. Facility staff had informed her of this a few weeks ago. She stated "it's just not right." The record for Resident G was reviewed on 8/1/24 at 1:49 p.m. A Quarterly MDS assessment, dated 5/10/24, indicated the resident was cognitively intact. An MDS assessment, dated 4/10/24, indicated the resident felt it was very important to go outside to get fresh air when the weather was good. A care plan, dated 7/30/24, indicated the resident had a problem of at risk for impaired psychosocial well-being related to negative interactions with peers with a goal the resident will report maintained/improved psychosocial well-being.		are able to freely go outside then 3 residents a week for 4 weeks and then 1 resident a week times 4 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	4. During an interview with Resident H on 8/1/24 at 1:15 p.m., he indicated he was not allowed to go outside unless it was smoking time or his wife was with him. He was newly admitted and was informed this on admission. The record for Resident H was reviewed on 8/1/24 at 1:52 p.m. An Admission MDS assessment, dated 7/24/24, indicated the resident was cognitively intact and it was very important to go outside to get fresh air when the weather was good. A care plan, dated 7/22/24, indicated at risk for psychosocial well being with a goal the resident would report decreased feelings of social isolation. 5. During an interview with Resident J on 8/1/24 at 1:33 p.m., he indicated he cannot go outside in the courtyard unless it is supervised smoking times. The rules had changed so often it was hard to keep up. The record for Resident J was reviewed on 8/1/24 at 1:58 p.m. An MDS assessment, dated 7/24/24, indicated the resident was cognitively intact and felt it was very important to go outside to get fresh air when the weather was nice. During an interview with CNA 6 on 8/1/24 at 1:33 p.m., she indicated residents cannot go outside in the courtyard at any time unless they are supervised. During an interview with the Executive Director on 8/1/24 at 2:25 p.m., he indicated the residents had designated smoking times and could be outside during those times. Residents were not allowed in			

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	the courtyard unless they were supervised, even if they were cognitively intact. There had been a resident to resident altercation out there so their could not be large groups outside without supervision. 3.1-3(u)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate			

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	corrective action must be taken. Based on observation, interview, and record review, the facility failed to notify the state health department of an injury of unknown origin for 1 of 3 residents reviewed for abuse. Staff observed a scrape with swelling and bruising to the nose and left eye but did not know how the injury occurred. (Resident M) Finding included: The clinical record for Resident M was reviewed on 8/1/24 at 1:30 p.m. The diagnoses included, but were not limited to, autistic disorder, intellectual disability, and epilepsy. A Quarterly MDS (Minimum Data Set) assessment, dated 7/13/24, indicated Resident M was severely cognitively impaired. A physician's telephone order, dated 7/24/24, indicated x-ray of nose. The order was discontinued. A physician's verbal order, dated 7/25/24 at approximately 3:00 a.m., indicated x-ray of nose due to swelling, mass, lump. An x-ray result, dated 7/25/24 at 9:45 a.m., indicated exam of nasal bones for nasal pain. There was no fracture, dislocation, nor bony destructive lesion noted. Paranasal air cells demonstrate no specific abnormality. No acute traumatic osseous abnormality. A progress note, dated 7/25/24 at 1:17 p.m., indicated the DON observed Resident M "bump" into a wall while ambulating. The Nurse Practitioner was notified and gave a new physician's order for an x-ray. The progress note	F 0609	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1) Resident M was assessed and an investigation was initiated and incident report was submitted to IDOH 2) All residents have the potential to be affected by the deficient practice. All residents will be interviewed for any allegation of abuse, neglect, or misappropriation. Any findings will be investigated and reported per the facility policy. 3) The RDCO/Designee has educated the Executive Director and DON on Indiana Reporting Guidelines with emphasis on reporting. DON/Designee has educated all staff on the policy Abuse & Neglect & Misappropriation of Property 4) DON/Designee will ask	08/27/2024

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	was entered into the electronic medical record on 8/1/24 at 1:18 p.m. (7 days after the x-ray was ordered) A weekly skin assessment, dated 7/29/24 at 11:27 a.m., indicated Resident M did not refuse a skin assessment. Resident M did not have any skin alterations noted. The weekly skin assessment was completed by the DON. During an interview on 8/1/24 at 1:43 p.m., the Activity Director indicated Resident M looked like he had a broken nose because his nose was swollen, cut, and bruised. The Activity Director couldn't remember the exact date she first saw the injury but was sure it was before Resident M moved to the 600 hall on 7/24/24. During an interview on 8/1/24 at 2:17 p.m., the Administrator indicated, during the morning clinical meeting, on 7/25/24, he was made aware of a scratch and some discoloration on Resident M's nose. The nurse got a physician's order for an x-ray of Resident M's nose to make sure there was no further injury. The Administrator needed to speak with the DON to find out if the DON found anyone that knew what happened. This would have been considered an injury of unknown origin. During an interview on 8/1/24 at 2:34 p.m., the DON indicated on the morning of 7/25/24, she was going outside to take a break when she watched Resident M "bump" into a wall. It was possible that Resident M's nose had swelling, a cut, and bruising before the DON saw Resident M "bump" into the wall. The DON may not have been notified of any injury prior to that. The DON should have documented the injury and entered a progress note the morning she watched Resident		a series of questions to 5 residents a week for any experienced/witnessed suspected abuse, neglect or misappropriation for x 4 weeks, then 3 residents a week x 4 weeks, then 1x resident a week x 4 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance	

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	M "bump" into the wall, so the medical record was accurate. During an interview on 8/1/24 at 2:54 p.m., CNA 10 indicated on 7/24/24 at approximately 3:00 p.m., Resident M's left eye was black, his nose was swollen, cut, and bruised. Resident M's nose looked "crooked like it was broken". CNA 10 reported this to RN 9 but didn't feel like the injury was taken seriously. During an observation on 8/2/24 at 7:30 a.m., Resident M was sitting in his room. Observed a small scratch and discoloration along the bridge and to the left side of Resident M's nose. On 8/2/24 at 11:15 a.m., the Corporate Nurse provided a copy of an undated facility policy, titled Indiana Abuse and Neglect and Misappropriation of Property, and indicated this was the current policy used by the facility. A review of the policy indicated all allegations involving injuries of unknown injury will be reported to the state. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to investigate an injury of unknown origin when a resident was observed to have a scrape on his nose with swelling and bruising on his nose and left eye for 1 of 3 residents reviewed for abuse. (Resident M) Finding includes: The clinical record for Resident M was reviewed, on 8/1/24 1:30 p.m. The diagnoses included, but were not limited to, autistic disorder, intellectual disability, and epilepsy. A quarterly MDS (Minimum Data Set) assessment, dated 7/13/24, indicated Resident M was rarely/never understood. A physician's phone order, dated 7/24/24, indicated x-ray of the nose. A physician's verbal order, dated 7/25/24, indicated x-ray of nose due to swelling, mass, lump. An x-ray result, dated 7/25/24 at 9:45 a.m., indicated exam of nasal bones for nasal pain. There was no fracture, dislocation, nor bony destructive lesion noted. Paranasal air cells demonstrate no specific abnormality. No acute traumatic osseous abnormality.	F 0610	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1 Resident M was assessed and Investigation was initiated and incident was submitted to IDOH 2 All residents have the potential to be affected by the deficient practice. DON/Designee will complete an audit of all injuries in the last 14 days to ensure an investigation has been completed. 3 RDCO will educate DON and ED on the facility's abuse policy with emphasis on completing a thorough investigation with all injuries. 4 ED/Designee will audit 5 injuries a week to ensure a	08/27/2024

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	A progress note, dated 7/25/24 at 1:17 p.m., indicated the DON (Director of Nursing) observed Resident M "bump" into a wall while ambulating. The Nurse Practitioner was notified and gave a new physician's order for an x-ray. This progress note was entered into the electronic medical record on 8/1/24 at 1:18 p.m. (7 days after the x-ray was ordered) During an interview on 8/1/24 at 2:17 p.m., the Administrator indicated, during the morning clinical meeting, on 7/25/24, he was made aware of a scratch and some discoloration on Resident M's nose. The nurse got a physician's order for an x-ray of Resident M's nose to make sure there was no further injury. The Administrator needed to speak with the DON (Director of Nursing) to find out if the DON found anyone that knew how the scrape, swelling, and bruising to Resident M's nose happened. This would have been considered an injury of unknown origin. During an interview on 8/1/24 at 2:34 p.m., the DON indicated, on the morning of 7/25/24, she was going outside to take a break when she watched Resident M "bump" into a wall. The DON may not have been made aware of the scrape with swelling and bruising to Resident M's nose and eye prior to Resident M bumping the wall. The DON should have documented the injury and entered a progress note the morning she watched Resident M "bump" into the wall, so the medical record was accurate. During an interview on 8/1/24 at 2:54 p.m. CNA 10 (Certified Nursing Aide) indicated, on 7/24/24 at approximately 3:00 p.m. Resident M's left eye was black, his nose was swollen, cut, and bruised. Resident M's nose looked "crooked like it was broken". CNA 10 reported this to RN 9 but didn't		thorough investigation has been completed times 4 weeks then 3 injuries a week times 4 weeks then 1 injury a week times 4 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance	

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	feel like the injury was taken seriously. During an observation on 8/2/24 at 7:30 a.m., Resident M was sitting in his room. Observed a small scratch and discoloration along the bridge and to the left side of Resident M's nose. On 8/2/24 at 11:15 a.m., the Corporate Nurse provided a copy of an undated facility policy, titled Indiana Abuse and Neglect and Misappropriation of Property, and indicated this was the current policy used by the facility. A review of the policy indicated all allegations involving injuries of unknown origin will be investigated. On 8/2/24 at 11:35 a.m., the facility had not identified the source of the cut, swelling, and bruising to Resident M's nose and left eye by survey exit. 3.1-28(d)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to provide the written bed hold policy prior to leaving the facility or at any time after for 2 of 3 residents reviewed for transfers and discharges. (Resident D, Resident E) Finding included: 1. The clinical record for Resident D was reviewed on 7/31/24 at 11:40 a.m. The diagnoses included, but were not limited to, end stage renal disease, fistula of intestine, and dysphagia. A quarterly MDS (Minimum Data Set) assessment, dated 4/24/24, indicated Resident D was moderately cognitively impaired. A progress note, dated 7/27/24 at 9:40 p.m., indicated Resident D called 911 and asked to be sent to the hospital. Resident D complained of nausea and vomiting and pain at his port site. The clinical record lacked documentation that the written bed hold policy was provided to the resident at the time of transfer or anytime after.	F 0625	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Due to confidentiality of the complaint survey Resident D and E can't be identified. 2. Executive Director/Designee completed an audit of discharges in the last 14 days to ensure residents had received the written bed hold policy. 3. Executive Director/Designee completed education to Business Office Manager and all licensed	08/27/2024

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	155780	A. BUILDING 00 B. WING	08/02/2024

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	During an interview on 7/31/24 at 3:24 p.m., the DON (Director of Nursing) indicated when Resident D called 911 so he could go to the hospital, the staff should have provided a bed hold policy to Resident D before he left the facility. If the nurse sent the bed hold policy, the nurse should have documented a progress note that indicated the document was sent.2. The record for Resident E was reviewed on 7/31/24 at 2:02 p.m. The diagnosis included, but was not limited to, wounds on bilateral thumbs. A progress note, dated 7/27/24 at 7:20 p.m., indicated Resident E was to sent to the hospital per his request. He complained of bilateral hand pain, inflammation, and redness at the site. The record lacked documentation the resident was given the written bed-hold policy information at time of transfer or at any time after. The resident was his own responsible party. On 7/31/24 at 2:20 p.m., the Administrator provided a copy of an undated facility policy, titled Transfer and Discharge Policy, and indicated this was the current policy used by the facility. A review of the policy indicated when an acute transfer occurs, present the acute transfer letter to the resident prior to the transfer. Discuss the transfer and transfer letter with the resident or responsible party if the resident is incapable of understanding or the transfer is an emergency. The resident's bed will be held while the facility representative contacts the resident or responsible party to discuss bed hold. This Federal tag relates to Complaint IN00439096. 3.1-12(a)(25)		nurses using policy titled Transfer and Discharge Policy. 4. Executive Director/DON/Designee will audit 3 transfers a week times 4 weeks to validate written bed hold policy has been given to resident, then 2 transfers a week times 4 weeks than 1 transfer a week times 4 weeks. Executive Director /Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	3.1-12(a)(26)			
F 0761 SS=D 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 ensure medications were secured and labeled for 1 of 1 medication rooms and 1 of 1 random observations. Controlled substances were not double locked and TPN was not labeled and dated. (Resident P, Resident D) Finding included:	F 0761	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is	08/27/2024

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	1. During an observation on 8/1/24 at 1:38 p.m., an unlocked medication refrigerator was inside the South Medication Room. Inside the refrigerator, observed a clear plastic bag sitting in a pink bin with other medications. The label on the bag, dated 7/30/24, indicated Resident P with a prescription number, Ativan (a controlled anti-anxiety/anti-seizure medication) 2 mg/ml (milligrams/milliliter), inject 0.5 ml (1 mg) intramuscularly (into the muscle) as needed for seizures. The bag contained 5 capped 1 ml vials of liquid. At that time, QMA 1 indicated the Ativan injections should be locked in the lock box in the refrigerator not laying in the pink bin with the other medications. On 8/1/24 at 9:11 a.m., the Administrator provided a copy of a policy, dated 9/2018, titled Storage of Medications, and indicated this was the current policy used by the facility. A review of the policy indicated controlled substances that require refrigeration are stored within a locked box attached to the inside of the refrigerator. 2. During an observation on 7/31/24 at 9:09 a.m., a clear plastic bag that contained 1400 ml of yellowish liquid was hanging on a pole in Resident D's room. The bag was labeled Resident D with a prescription number, TPN (total parental nutrition) 2:1, total bag volume 1660 ml, volume to be infused 1560 ml, and instructions to infuse 1560 ml over 24 hours. The bag of TPN was not labeled with any initials nor the date it was hung. During an interview on 7/31/24 at 9:25 a.m., the DON (Director of Nursing) indicated Resident D's TPN should have been labeled with the nurses initials and dated for the date it was administered. The TPN should have been taken down when		required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Due to confidentiality of the complaint survey Resident P and D can't be identified. 2. All residents on TPN were audited to ensure TPN was labeled and dated. The med room was audited to ensure all controlled substances that needed to be refrigerated were stored in a locked box attached to the inside of the refrigerator. 3. DON/Designee educated all licensed nurses on dating and initialing TPN bag when it is hung using policy titled "Parenteral Nutrition". DON/Designee educated all licensed nurses and medication techs on controlled substances that needed to be refrigerated were stored in a locked box attached to the inside to the refrigerator using policy titled "Medication Storage" 4. DON/Designee will complete an audit 3 times a week times 4 weeks to ensure all TPN is dated and initialed then 2 times a week times 4 weeks and then 1 time a week times 4 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3	

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	Resident D went out to the hospital, on 7/27/24. (4 days before the observation and interview) On 8/2/24 at 11:35 a.m., the facility was unable to provide a policy regarding labeling medications. 3.1-25(j) 3.1-25(m) 3.1-25(n)		months with 100% compliance.	