ANGELA

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

04/11/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/23/2023			ETED	
	ROVIDER OR SUPPLIER	t.	990	EET ADDRESS, CITY, STATE, ZIP C D PROGRESS PARKWAY ELBYVILLE, IN 46176	OD	
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE A	IOULD BE	(X5) COMPLETION DATE
Bldg. 00	IN00391445. Complaint IN0039 to the allegations and Survey date: March Facility number: 0 Residential Census These State Resider accordance with 41	14548 44 Atial Findings are cited in 0 IAC 16.2-5. Appleted on March 27, 2023	R 0000	R 0000 Submission of this Plar Correction does not co admission or agreemed provider of the alleged of deficient practice(s). of Correction is prepare submitted as a required state and federal law. The attachments heret support and provide even compliance with the surplan of Correction and the facility meets the resunder state and federal The facility respectfully paper compliance for the allegations. Respectfully, Angela M Mann, HFA/RCA/CNA Timber Creek Village A Living Facility Administrator Timber Creek Village A Living	nstitute nt by the allegations This Plan ed and ment under o serve to ridence of bmitted to ensure equirements I law. requests ne alleged	
Bldg. 00	Health Services - (e) The administration of residence as ordered by the shall be supervised the premises or of the Medication shall be supervised the premises or of the medication shall be supervised the premises or of the medication shall be supervised to the medication of the medication shall be supervised to the medication shall be supervised to the medication of the medication shall be supervised to the medication of the medication shall be supervised to the medication of the medication shall be supervised to the med	Offense ation of medications and the ential nursing care shall be resident 's physician and d by a licensed nurse on				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE	TITLE		(X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMP			COMPL	LETED
			B. WING 03/23/2023				/2023
		<u>I</u>	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			OGRESS PARKWAY		
TIMBED	CREEK VILLAGE				YVILLE, IN 46176		
IIIVIDEK	UNEEK VILLAGE			SHELB	1 VILLE, IIN 401/0		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medication aides.						
		and record review, the facility	R 0	241	R 241		04/21/2023
		vsician orders were followed			410 IAC 16.2-5-4(e)(1) Health		
		or 1 of 4 residents reviewed for			Services Offense		
	injectable medication	ons. (Resident D)					
					We respectfully request paper	•	
	Findings include:				compliance for this alleged		
					deficiency.		
		nt D's clinical record on 3-23-23					
		ted her diagnoses included, but			The Rule: Based on an interv	iew	
		type 2 diabetes mellitus. A			and record review, the facility		
		Examination (MMSE), dated			failed to ensure physician orde		
		she is cognitively intact. In an			were followed, for insulin orde	rs for	
		23 at 3:47 p.m., with Resident D,			1 of 4 residents reviewed for		
		oes not take any medications			injectable medications.		
		at it is controlled through her			(Resident D)		
	diet alone.						
		1 . 1			What corrective action(s) wil	I	
		dated 10-24-22, indicated she			be accomplished for those		
		us 20 units subcutaneously			residents found to have been	n	
		ly in the evening. This order			affected by the deficient		
	_	-12-22 to Lantus 24 units			practices		
		ly in the evening. Both orders			DONINA to to a second second	- 4 - f f	
		s administered from 12-1-22 to			DONW to in-service the QMA	starr	
		ers were identified as being			on QMA Scope of Practices	4	
	ordered by differen	i physicians.			regarding residents with diabe	etes;	
	An additional and	for Humalog insuling stiding			which included administering,		
		for Humalog insulin sliding neal, dated 10-24-22, with no			monitoring and documenting	_	
					glucose readings; including th		
	1	r blood sugars of 1-150, 2 units 151 to 200, 3 units for blood			parameters regarding physicia	411	
	I -	0, 4 units for blood sugars of			prescribed insulin injectable	hor	
	1 -	for blood sugars of 301 to 351.			medication (Exhibit I) and Tim	nei	
		pecify what was to be done for			Creek Village Policy and Procedure for Medication		
		r than 351. However, on the			Administration and the Adden-	dum	
		ive 5 units for blood sugars					
		AR did not specify what was to			Residents with Diabetes (Exhi	IDIL	
		ugars greater than 400. An			II).		
		s effective on 11-28-22 to inject			DONIW contacted the prescrib	ina	
		_			DONW contacted the prescrib	ung	
	5 units of Humalog	insulin at each meal, plus the	1		physicians of Resident (D), to		l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED	
			B. WING 03/23/2023				
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
TIMPED					OGRESS PARKWAY		
TIMBER CREEK VILLAGE				SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	sliding scale insulin	ı.			clarify the current diabetic		
					medication orders and the		
	An order for Novol	in insulin 12 units, dated			physician approved order for		
	12-13-22, indicated	it was to be provided			self-administration of any		
	subcutaneously at b	edtime, with further			prescribed diabetic injectable		
	instructions for it to	be increased by 2 units every			medication.		
	day until the fasting	g blood sugar was					
	-	en 80 and 130. In review of					
	•	ry and March, 2023, MAR's,			How the facility will identify		
	_	d unchanged with blood			other residents having the		
	sugars not remainin	g within the targeted range			potential to be affected by the	ie	
	and the dosage uncl	hanged.			same alleged deficient pract	ice	
					and what corrective action w	<i>i</i> ill	
		n the Administrator on 3-23-23			be taken:		
	-	ndicated the facility currently					
		t are insulin-certified, but was			The residents of the communi		
	unsure if those two				have the potential to be affect	ed	
	_	in to any residents. The names			by the alleged deficient praction	ce.	
	of those staff were	not provided.			The DONW or designee, will		
					complete an audit review of ch	narts	
		3-23-23 at 5:30 p.m., with QMA			and orders, ensuring insulin		
		has only been at facility for a			diabetic residents have active		
		en't really been trained as to			physician orders and orders to)	
		AL [assisted living facility],"			self-administer any physician		
	as a QMA. She inc				prescribed injectable diabetic		
		'm not really clear on what I			medication.		
	•	ping a resident with their				_	
	<u>-</u>	s really explained it to me."			What measures will be put in	ito	
		s unclear on the MAR if			place or what systematic		
		nsulin order means the QMA			changes will the facility mak	e	
	-	sident give the ordered insulin			to ensure that the deficient		
	· ·	MA or nurse actually			practice does not recur:		
		edication. She indicated it is			Commont Staff and annual		
	•	ad the MAR to identify whose			Current Staff and any new sta	.11	
	-	let alone determine if that			hired to be in-serviced on the	4	
		at is insulin certified. She			policy and procedure for Residuals		
		naware of a listing of staff			with Diabetes. The DONW or		
		titles, except possibly in the			designee to be sure any new		
	narcotic book.				current resident, or any currer		
					resident who is newly diagnos	ed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WING 03/2			03/23/	2023
				CTREET A	ADDRESS SITV STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
TIMPED					OGRESS PARKWAY		
HINDER	CREEK VILLAGE			SHELD	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	In an interview on 3	3-23-23 at 6:05 p.m., with the			as a diabetic has current		
	Administrator, she	indicated the facility's policies			physician medication orders a	nd if	
	"come from the cor	porate offices in Illinois. We			required a physician order on t	file	
	are the only buildin	g they have in Indiana. So, the			authorizing self-administer of a	any	
	policies are mostly	focused on the Illinois			prescribed injectable diabetic		
	-	end to more lax than this state.			medication.		
		in Illinois, you don't even have					
		an administrator [in an			How will the corrective action	n	
	•	ity]. I am not a nurse, but I am			be monitored to ensure the		
		tting my QMA certification			deficient practice will not		
	-	als at an area nursing home			recur; what quality assurance	е	
	-	te this will give me a better			program will be put into plac	e:	
		hat my staff are required to do.					
		en much thought to how our			A CQI monitoring tool see (Exl		
	-	or documenting the insulin and			III), will be implemented, on or		
		policies we have. Our MAR		before 04/21/2023, to ensure			
		ou if the staff member was just			compliance is maintained and	that	
		the resident to give their			only licensed nursing staff		
		ff member actually gave the			personnel or residents who ha	ve a	
	-	I believe we have only 2			physician's order to		
		ilin-certified. We need to look			Self-Administered injectables		
		sure we are doing everything			administering insulin medication	ons.	
	within the state guid	delines."			The DONW or designee will		
					monitor daily for 2 weeks, ther		
		p.m., the Administrator			weekly for 4 weeks, then mont	-	
		a policy entitled, "Assistance			until compliance is maintained		
		vith a review date of January,			consecutively for a period of 3		
		ndicated, "Residents may			months or until the Quality		
	-	nedications unless the			Assurance Committee finds		
		order for the facility to			compliance has been met.		
	provide oversight of						
		of medicationThe facility			By what date will the systemic		
		tration policies must be			changes be completed:		
		ician, pharmacist, or licensed onal and needs to address4.			Cyatamia abazza will be		
	_	Administration of medication.			Systemic changes will be		
	-	dication assistance provided to			completed by 04/21/2023		
	_	enance of medication records.					
	Supervising the Sel						
		Only RN's or a LPN can					
	wieuleme-Flucess.	Omy Kins of a Li in Call					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/23/2023	
	ROVIDER OR SUPPLIER CREEK VILLAGE		990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	medications to reside Medication [proceded out of the locked medication contained physically unable to remove medication. Confirming that residuality the dosage properties of the medication professional will created assistance QMA's or authorized appropriate box for supervision was addrived the medication of the medi	for a QMA to administer entsAdministration of ure] Getting the medication ed cabinet. Opening the er for a resident who is edo so. (Resident must from the container.) idents have obtained and are rescribed. Document in elent has taken (or refused to aThe licensed health care eate a MAR (Medication ord) for each resident that has e with Medication assistance. It is with Medication assistance. It is the time of day the medication ministered (examples AM, N)A QMA or licensed resident with injections"			
R 0296 Bldg. 00	(b) The facility sha policies and proce assistance. The fa	b) ervices - Noncompliance Ill maintain clear written dures on medication cility shall provide for ensure competence of			
	Based on interview failed to provide cle procedures pertainin assistance staff Qua (QMA's) may provi residents for 2 of 4 n	and record review, the facility arly written policies and ag to the administration and/or lified Medication Aides de to insulin-dependent residents reviewed for ons. (Residents D and E)	R 0296	R 296 410 IAC 16.2-5-6(b) Pharmaceutical Services-Noncompliance We respectfully request paper compliance for this alleged deficiency.	04/21/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. W	ING		03/23/2	2023	
		<u> </u>		CTDEET 4	ADDRESS CITY STATE ZIR COR			
NAME OF P	ROVIDER OR SUPPLIER	3		1	ADDRESS, CITY, STATE, ZIP COD			
					OGRESS PARKWAY			
HIMBER	CREEK VILLAGE			PHETR	YVILLE, IN 46176			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					The Rule: Based on an interv	iew		
	1. A review of Res	ident E's clinical record on			and record review, the facility			
	3-23-23 at 2:47 p.m	., indicated her diagnoses			failed to provide clearly writter	,		
	_	not limited to, type 2 diabetes			policies and procedures pertai			
		an order, dated 6-2-22, and			to the administration and/or	9		
		ndicated she was to receive			assistance staff Qualified			
	-	cutaneously (under the skin)			Medication Aides (QMA's) ma	, l		
		esident E's most recent Service			provide to insulin-dependent	,		
	•	, indicated the facility provides			residents for 2 of 4 residents			
	· ·	medication administration"			reviewed for injectable			
	and "injections."				medications. (Residents D and	4 E)		
	una injections.				medicatione. (Nosidente B'and	'		
	In an interview with	n the Director of Nursing			What corrective action(s) wil			
		at 3:10 p.m., she indicated she			be accomplished for those	•		
	would have to verif	-			residents found to have been	,		
		er insulin, but was of the			affected by the deficient	'		
		t did self-administer her			practices and what corrective	,		
	physician-ordered r				action will be taken:			
	physician-oracica i	nedication.			action will be taken.			
	In an interview with	n Resident E on 3-23-23 at 3:48			DONW contacted the physicia	ın(e)		
		she does not self-administer			of residents D and E and obta	, ,		
	-	nursing staff administers her			a copy of the physician	ilicu		
		age to her. A Mini-Mental			authorization to self-administe	r		
		(MMSE), dated 1-20-23,			physician prescribed diabetic	'		
	indicated she is cog				injectable medication. DONW	, to		
	indicated sile is cog	muvory muot.			in-service the QMA staff on Q			
	In an interview with	1 QMA 4 on 3-23-23 at 12:20			Scope of Practices regarding	IVI/		
		she is not certified to do			residents with diabetes; which			
	-	She indicated she recalled she			includes administering,			
	-	ious DONwhen I was on the			monitoring, and documenting			
	•	it mean when I was signing the			glucose readings; and with the	_		
		that had a blood sugar and			parameters regarding physicia			
		at it meant when I signed the				AII		
		for someone that might have a			prescribed insulin injectable	and		
		order or just an insulin order.			medication(s), see (Exhibit I),			
	-	-			Timber Creek Village Policy a	iiu		
	_	meant that I had done the blood			Procedure for Residents with			
		n not sure that we as QMA's			Diabetes, see (Exhibit II).			
		esident with their insulin when						
		ves. I wasn't sure if it is okay			114 6			
for us to sign on the date and time block to sign it					How the facility will identify			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> C			COMPL	ETED
			B. WING 03/23/2023				
				_	_		
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					OGRESS PARKWAY		
TIMBER CREEK VILLAGE			SHELB	YVILLE, IN 46176			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	if the resident does	their own insulin. Nobody			other residents having the		
		d that to me. I don't want to be			potential to be affected by th	e	
		at I shouldn't be doing." In a			same alleged deficient practi		
		w with QMA 4 on 3-23-23 at			and what corrective action w		
	_	cated she has provided cueing			be taken:		
		sident E for the resident to					
	self-administer her				The residents of the communi	tv	
					have the potential to be affect	-	
	A review of Reside	ent E's medication			by the alleged deficient practic		
		ord (MAR) for 12-22, 1-23, 2-23			The DONW to in-service the	•	
		pecify if the staff person's			Qualified Medication Aide's,		
	initials indicated or				(QMA's) and nursing staff on t	he	
		antus or supervised the			Timber Creek Village Assisted		
		istering the medication.			Living Policy and Procedure for		
		5			Residents with Diabetes, (Exh		
	2. A review of Res	ident D's clinical record on			l II).		
		n., indicated her diagnoses			,		
	_	not limited to, type 2 diabetes					
		Mental Status Examination			What measures will be put ir	nto	
	(MMSE), dated 7-2	25-22, indicated she is			place or what systematic		
		In an interview on 3-23-23 at			changes will the facility mak	e	
		sident D, she indicated she does			to ensure that the alleged		
	not take any medica	ations for her diabetes, that it is			deficient practice does not		
	controlled through	her diet alone.			recur:		
		1 4 110 24 22 2 2 2			DONNA I I I I I I		
		dated 10-24-22, indicated she			DONW or designee to in-servi	ce	
		tus 20 units subcutaneously			any new Qualified Medication		
		ily in the evening. This order			Aides, (QMA's) on the Timber		
	_	-12-22 to Lantus 24 units			Creek Village Assisted Living		
		ly in the evening. Both orders			Policy and Procedure for		
		as administered from 12-1-22 to			Residents with Diabetes.		
		ers were identified as being					
	ordered by differen	ı pnysicians.			Hammall Abordon C.	_	
	A = 44121 1 1	. f H			How will the corrective actio	n	
		for Humalog insulin sliding			be monitored to ensure the		
		neal, dated 10-24-22, with no			deficient practice will not		
	_	r blood sugars of 1-150, 2 units			recur; what quality assuranc		
	_	151 to 200, 3 units for blood			program will be put into place	e:	
	_	0, 4 units for blood sugars of					
	251 to 300, 5 units	for blood sugars of 301 to 351.			A CQI monitoring tool will be		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/23/2023	
	PROVIDER OR SUPPLIE	R	990 PF	ADDRESS, CITY, STATE, ZIP COD ROGRESS PARKWAY BYVILLE, IN 46176	•
	CREEK VILLAGE SUMMARY (EACH DEFICIE REGULATORY OF The order did not solve to blood sugars great MAR, it added to go 351 to 400. The Mode additional order was 3 units of Humalog sliding scale insuling	r STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION specify what was to be done for er than 351. However, on the give 5 units for blood sugars IAR did not specify what was to sugars greater than 400. An as effective on 11-28-22 to inject g insulin at each meal, plus the n. Itin insulin 12 units, dated d it was to be provided bedtime, with further to be increased by 2 units every g blood sugar was een 80 and 130. In review of ary and March, 2023, MAR's, ed unchanged with blood ing within the targeted range changed. Ith the Administrator on 3-23-23 indicated the facility currently at are insulin-certified, but was to staff are actually lin to any residents. The names	990 PF	ROGRESS PARKWAY	aff to DATE DATE DATE DATE
	5, she indicated she short time and "ha what I can do in ar as a QMA. She ir insulin-certified." can do as far as he insulin. Nobody he indicated she signing off on the just observed the ror if it means the C	e has only been at facility for a ven't really been trained as to a AL [assisted living facility],"			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER TIMBER CREEK VILLAGE				990 PR	DDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	regulations, which as a matter of fact, to be licensed to be assisted living facilin the process of ge and am doing clinic right now. I feel lil understanding of w I guess I hadn't give MAR's are set up for that fits in with the doesn't really tell yo observing or cueing insulin. Right now QMA's that are insu at all this and make within the state gui	ad the MAR to identify whose let alone determine if that lat is insulin certified. She naware of a listing of staff titles, except possibly in the 3-23-23 at 6:05 p.m., with the indicated the facility's policies porate offices in Illinois. We g they have in Indiana. So, the focused on the Illinois tend to more lax than this state. in Illinois, you don't even have an administrator [in an ity]. I am not a nurse, but I am tting my QMA certification last at an area nursing home te this will give me a better that my staff are required to do. In much thought to how our or documenting the insulin and policies we have. Our MAR ou if the staff member was just to the tresident to give their ff member actually gave the policies. It is the tresident to give their ff member actually gave the policies. We need to look sure we are doing everything			CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	
	2023. This policy is manage their own rephysician writes an provide oversight of self-administration	ndicated, "Residents may nedications unless the order for the facility to					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. WING			03/23	/2023	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	₹			OGRESS PARKWAY			
TIMBER	CREEK VILLAGE				YVILLE, IN 46176			
					,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
	* * * *	ician, pharmacist, or licensed						
	*	onal and needs to address4.						
	-	-Administration of medication.						
		dication assistance provided to						
		enance of medication records.						
	Supervising the Sel							
		Only RN's or a LPN can						
	oversee the training	g for a QMA to administer						
	medications to resid	dentsAdministration of						
	Medication [proced	lure] Getting the medication						
	out of the locked m	ed cabinet. Opening the						
	medication containe	er for a resident who is						
	physically unable to	o do so. (Resident must						
	remove medication	from the container.)						
	Confirming that res	idents have obtained and are						
	taking the dosage pr	rescribed. Document in						
		dent has taken (or refused to						
	take) the medication	nThe licensed health care						
		eate a MAR (Medication						
	-	cord) for each resident that has						
		e with Medication assistance.						
	-	ed staff will initial the						
		the time of day the medication						
		ministered (examples AM,						
	-	N)A QMA or licensed						
		t resident with injections"						
	•	•						
	This State tag relate	es to Complaint IN00391445.						
	2.5-6(b)							
	- ()							

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