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	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT PLACE WEST	55 N MISSION DR INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 28, 29, and 30, 2024 Facility number: 011840 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 12, 2024.	R 0000		
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure all food was labeled and dated and thermometers were used to measure the internal temperature of refrigerators and freezers in the facility kitchen for 1 of 1 kitchen observation. Findings include: On 5/28/24 at 9:50 a.m., the kitchen was toured with the Dietary Manager (DM). During an observation of the dairy refrigerator an opened and undated box of cream cheese was observed.	R 0273	1. All food items in the kitchen were assessed, discarded, or appropriately labeled and dated. Appropriate thermometers were placed in the refrigerator and freezer, and dietary staff educated as to the facility policy addressing hand hygiene. 2. All residents have the potential to be affected. 3. In an effort to ensure the deficient practice will not recur, all staff received education addressing food storage, date marking and discarding foods when expired or should be	06/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Harris		06/21/2024

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	During an observation of the walk-in freezer an opened, then closed, plastic bag of cheese omelets and an opened, then closed plastic bag of sausage links were observed with no date. On 5/28/24 at 10:03 a.m., the DM indicated the facility had stickers to place on foods that had been opened, but the stickers fell off. No loose stickers were observed. During an interview, on 5/30/24 at 11:02 a.m., the Admin indicated the kitchen staff should have been following the facility policy on dating of foods in the kitchen. A current policy titled, "Food & Equipment Thermometers," dated 5/2018, was provided by the Administrator, on 5/28/24 at 12:20 p.m. A review of the document indicated, " ...Bi-metallic coil thermometers should be used to determine the internal temperature of food ...Equipment ...Thermometers should be easy to locate and placed at eye level ...." A current policy titled, "Storage of Foods under Sanitary Conditions," dated 5/2018, was provided by the Administrator, on 5/30/24 at 10:30 a.m. A review of the document indicated, " ...All food items stored in the refrigerator must be labeled and dated ...."		discarded per facility policy, and hand hygiene. 4. In an effort to ensure continued monitoring to ensure corrective actions are sustained, the Administrator/Designee shall conduct observations in the kitchen and other food storage areas of the facility, presence of thermometers and monitoring of refrigerator/freezer temps, and observation of hand hygiene during meal service twice weekly times eight weeks, weekly times eight weeks and monthly for a minimum of a cumulative six months. Should concerns or non-compliance be identified, additional education shall be provided. Continued monitoring may be increased or decreased on the basis of findings.	
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview, and record review, the facility failed to ensure medications were secure for 2 of 3 residents observed for	R 0295	1. Residents 27 and 7 have been re-educated as to the ability to self-medicate as long as they	06/21/2024

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	self-administration of medications (Resident 27 and 7). Findings include: 1. On 5/28/24 at 1:20 p.m., Resident 27 indicated she self-administered her own medications. She indicated she went to the dining room for all meals and did not lock her door when she left her apartment. She kept her medications in weekly pill containers on her kitchen table. Her door was observed to be wide open and her medications were visible from the door. Her Medication Administration Record (MAR) was reviewed. She had orders for: a. norco 5-325 milligrams (mg) (opioid pain reliever) b. aspirin 325 mg (mild pain relief) c. atorvastatin 10 mg (for high cholesterol) d. cinacalcet 60 mg (reduces parathyroid hormone) e. docusate sodium 100 mg (stool softener) f. fenofibrate 54 mg (for high triglycerides) g. ferrex 150 mg (iron supplement) h. Flonase nasal spray (congestion) i. hydrochlorothiazide (diuretic) j. losartan 100 mg (high blood pressure) k. magnesium oxide (supplement) l. senna-time (constipation) m. vitamin D3 (supplement) n. hydralazine 100 mg (for high blood pressure) o. gabapentin 600 mg (neuropathy) p. amlodipine besylate 10 mg (relaxes blood vessels) Resident 27's, "Controlled Drug Record," indicated the nursing staff received a 90 day supply of hydrocodone-apap 5-325 mg on 2/27/24. The instructions indicated to take 1 tablet by mouth three times a day.		keep their medications secured from other residents. 2. All residents who self-medicate have the potential to have been affected. 3. In an effort to ensure the deficient practice will not recur, Residents were addressed during a Town Hall meeting to explain the necessity of keeping medications secured when not in use to prevent other residents from accessing their medications. Those residents who currently self-medicate will be identified for routine monitoring for compliance. 4. In an effort to ensure continued monitoring to ensure corrective actions are sustained, for those Residents who self-medicate, random observations shall be made by the Director of Nursing/Designee to confirm security of medications twice weekly times eight weeks, weekly times eight weeks and monthly for a minimum of a cumulative six months. Should concerns or non-compliance be identified, additional education shall be provided. Continued monitoring may be increased or decreased on the basis of findings.	

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	a. On 3/5/24 at 8:00 a.m., 10 pills were dispensed to the resident by the nursing staff. b. On 3/12/24 at 11:00 p.m., 21 pills were dispensed to the resident by the nursing staff. c. On 3/19/24 at 8:00 a.m., 21 pills were dispensed to the resident by the nursing staff. d. On 3/26/24 at 8:00 a.m., 21 pills were dispensed to the resident by the nursing staff. e. On 4/2/24 at 1:00 p.m., 17 pills were dispensed to the resident by the nursing staff. 2. On 5/30/24 at 12:21 p.m., Resident 7 indicated he self-administered his own medications. He indicated he went to the dining room for all meals and did not lock his door when he left his apartment. He kept his medications in weekly pill containers on at table. His door was observed to be wide open and his medications were visible from the door. His MAR was reviewed. He had orders for: a. allopurinol 100 mg (for gout) b. atorvastatin 80 mg c. isosorbide mononitrate ER 120 mg (prevents chest pain) d. lisinopril 20 mg (for high blood pressure) e. vitamin D3 f. torsemide 20 mg (diuretic) g. carvedilol 12.5 mg (heart medication) h. clonidine hydrochloride (for high blood pressure) i. docusate sodium 100 mg j. Eliquis sodium 5 mg (blood thinner) k. metformin hydrochloride (for diabetes) l. baclofen 5 mg (for muscle spasms) He was observed to have Mucinex Fast-Max in his room. No physician order was noted for it. During an interview, on 5/30/24 at 10:56 a.m., the			

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	Administrator (Admin) indicated the residents had a drawer in the kitchen that locked and it was a resident right not to lock up their medications. A current policy titled, "Medication Self-Administration," dated 2024, was provided by the Admin, on 5/30/24 at 11:56 a.m. A review of the policy indicated, " ...The weekly dispenser will be located/stored within the resident's room/apartment and secured as deemed necessary to prevent potential misappropriation ...."			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record reviews and interview, the facility failed to respond to pharmacy recommendations in a timely manner for 2 of 8 residents reviewed for pharmacy recommendations (Resident 20 and 40). Findings include: 1. On 5/30/24 at 12:15 p.m., A record review was completed for Resident 20. He had the following diagnoses which included but were not limited to	R 0298	1. The pharmacy recommendations for Resident 20 and Resident 40 have been communicated to their physicians with response acknowledged/documented. 2. In an effort to identify all residents who have the potential to have been affected, an audit was conducted of all pharmacy	06/21/2024

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	depression, hypothyroidism, insomnia, and dementia. The pharmacist conducted a medication regimen review on 4/10/24. The pharmacist recommended, "this dementia resident's orders include the following antipsychotic medication to treat a chronic enduring condition: Seroquel and resident has a diagnosis of dementia." Seroquel has a black box warning when used in patients with a diagnosis of dementia of risk of death. The pharmacist included the criteria that must be met in order to continue the use of Seroquel. The criteria included: behavior presents a danger to the resident or others and: the symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations, delusions, paranoia or grandiosity) or behavioral interventions have been attempted and included in the plan of care, except in an emergency or uncooperativeness (e.g. refusal or difficulty receiving care). The pharmacy recommendation was to reduce this medication with an endpoint of discontinuation or include documentation of symptoms and therapeutic goals as described above. Resident 20 continued on Seroquel 25 milligrams (mg) with a start date of 2/1/24 by mouth (PO) two times daily for dementia. The facility did not provide documentation that the pharmacy recommendation was addressed. 2. On 5/30/24 at 12:30 p.m., a record review was completed for Resident 40. He had the following		recommendations for the last three medication regimen reviews conducted by the licensed pharmacist. All recommendations were confirmed as being communicated to the physician with response acknowledged/documented. 3. In an effort to ensure the deficient practice will not recur, licensed staff responsible for review, communication and tracking of pharmacy recommendations has been re-educated as to facility policy. 4. In an effort to ensure continued monitoring to ensure corrective actions are sustained, the Director of Nursing shall be responsible to provide to the Administrator the pharmacy recommendations conducted every 60 days for those Residents for whom medications are administered by facility qualified staff with documented evidence of physician notification and subsequent physician response documented. The Administrator shall sign acknowledgment of the review conducted and compliance confirmed with physician notification/acknowledgment. This process shall continue every 60 days ongoing.	

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	diagnoses which included but were not limited to chronic kidney failure, hypertension, hyperlipidemia, and chronic pain. The pharmacist made a recommendation on 4/10/24 to add a corresponding diagnosis/indication for the use of the following medications. a. Venlafaxine ER 225 mg every day (QD). This medication may be used for depression. The order lacked a diagnosis for use. b. Gabapentin 300 mg at bedtime (QHS). This medication may be used for pain. The order lacked a diagnosis for use. c. Trazodone 75 mg QHS. This medication may be used for depression and/or sleep. The order lacked a diagnosis for use. The facility did not provide documentation that the pharmacy recommendation was addressed. On 5/30/24 at 12:45 p.m., the Administrator indicated she phoned the pharmacy to receive the recommendations. The Director of Nursing (DON) was on vacation. The pharmacy recommendations were reviewed with the Administrator. A 2023 policy titled, "Pharmacy Recommendations/Medication Regimen Review," was provided by the Administrator on 5/30/24 at 12:57 p.m. It indicated, "For recommendations of non-emergent nature ... should response not be received five business days of the notification, the Director of Clinical Services, or designee, shall be responsible to ensure the attending physician is again contacted and response received and documented ...."			

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R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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. Based on observation and interview, the facility failed to date eye drops and remove expired medications from the first-floor medication cart for 2 of 15 residents reviewed for medication storage (Residents 9 and 2). Findings include: On 5/28/24 at 11:21 a.m., the first-floor medication cart was observed for medication storage. Qualified Medication Aide (QMA) 4 was present during the observation. The following medications were found on the medication cart to be expired or lacked a date to indicate when opened. 1. Resident 9 had insulin lispro (used for diabetes mellitus) on the cart with a date opened of 4/1/24. This medication was expired. She had discontinued eye drops in the medication cart that lacked an open date. The eye drops were prednisone 1% and pred forte (both used for inflammation of the eye). 2. Resident 2 had a bottle of latanoprost 0.05% (used for glaucoma), combigan 0.2%/0.5% (used for glaucoma), and fluticasone propionate (used for allergies) on the medication cart. They lacked a date to indicate when opened. 3. A vial of aplisol 5TU/0.1ml (used in tuberculin	R 0300	1. Undated and/or expired medications were discarded upon discovery. 2. All residents have the potential to have been affected 3. In an effort to ensure the deficient practice will not recur, qualified nursing staff received training addressing correct dating of opened medications, vials, etc., and listing of expiration date. Visual reminders were placed to alert staff of continued compliance. 4. In an effort to ensure continued monitoring to ensure corrective actions are sustained, random observations of medication carts, medication room and refrigerator shall be made by the Director of Nursing/Designee to confirm dating upon opening of medications and discarding of expired medications twice weekly times eight weeks, weekly times eight weeks and monthly for a minimum of a cumulative six months. Should concerns or non-compliance be identified, additional education shall be provided. Continued monitoring may be increased or decreased on	06/21/2024

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	testing) was in the medication room refrigerator and lacked a date when it was opened. During an interview with Licensed Practical Nurse (LPN) 3, she verified the findings and indicated the aplisol had been just opened. A policy titled, "Storing Drugs," dated 4/2021, was provided by the Administrator on 5/28/24 at 2:22 p.m. It indicated, " ...Any outdated, contaminated or deteriorated drugs, or those drugs that have containers that are cracked ... and destroyed according to policy ...."		the basis of findings.	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to complete a drug disposal log for residents that discharged from the facility for 2 of 2 residents reviewed (Resident 4 and 5).	R 0306	1. Residents 4 and 5 have discharged and no further corrective action can be taken. 2. In an effort to identify any other residents who have the potential to	06/21/2024

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	Findings include: 1. On 5/28/24 at 10:20 a.m., a record review was conducted for Resident 4. She had the following diagnoses, which included but were not limited to, hypertension, anemia, and hypothyroidism. She was discharged from the facility on 3/28/24. A progress note indicated her medications were sent with her family upon discharge, but it did not specify what medications were sent and the quantity of each medication except for lacosamide (a medication used to treat seizures) 200 milligrams (mg). Her record lacked the reconciliation of the following medications: a.) Metoprolol succinate 50 mg (milligrams) daily b.) Levothyroxine 200 mcg (micrograms) daily c.) Losartan 25 mg two times daily d.) Alendronate sodium 70 mg give daily on Mondays e.) Amlodipine 10 mg daily f.) Atorvastatin 40 mg at bedtime g.) Vitamin D 50 mcg daily h.) Famotidine 20 mg daily i.) Ferrous gluconate 225 mg daily j.) Leflunomide 20 mg give daily k.) Levetiracetam ER 24 hour/750mg 2 tablets at bedtime l.) Sertraline 50 mg daily m.) Tylenol 500 mg 2 tablets every 8 hours n.) Zofran 4 mg every 4 hours as needed 2. On 5/28/24 at 2:10 p.m., a record review was conducted for Resident 5. He had the following diagnoses which included, but were not limited to, anxiety disorder, osteoarthritis, hypertension,		have been affected, an audit was conducted to review the records of any residents discharged within the last 60 days to identify any further deficient practice and address applicable staff, if indicated. 3. In an effort to ensure the deficient practice will not recur, all qualified nursing staff were provided inservice training on discharge planning of Residents, including correct disposal of medications and/or correct reconciliation and documentation of disposition of medications should a Resident be discharged with medications. 4. In an effort to ensure continued monitoring to ensure corrective actions are sustained, the Director of Nursing/Designee shall be responsible to ensure review of the medication disposition of any Resident who has expired, transferred or discharged to ensure correct disposal, reconciliation or transfer of custody with the same documented. The Director of Nursing/Designee shall be responsible to provide documented drug disposition to the Administrator following each Resident discharge. Should non-compliance be identified, additional corrective action shall be taken. This process to ensure compliance will be ongoing.	

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	major depressive disorder, and muscle weakness. Resident was discharged from the facility. His record lacked reconciliation of the following medications. a.) Cetirizine HCL 10 mg daily b.) Fluticasone Prop 50 mcg 1 spray each nostril daily c.) Melatonin 10 mg at bedtime d.) Ocuvite preservation tablet daily e.) Pantoprazole 40 mg daily f.) Prenatal vitamin plus low iron daily g.) Trazodone 50 mg at bedtime h.) Vitamin B-1 100 mg daily i.) Vitamin B-12 1000 mcg daily j.) Buspirone 5 mg two times daily k.) Calcium 600 +D 400 two times daily l.) Eliquis 5 mg two times daily m.) Metoprolol tartrate 25 mg two times daily n.) Naproxen 250 mg two times daily o.) Risperdal 0.5 mg two times daily p.) Topamax 50 mg two times daily q.) Benzonatate 100 mg three times daily r.) Simethicone 80 mg every 6 hours as needed s.) Tramadol 50 mg four times daily as needed t.) Tylenol 325 mg 2 tablets four times daily as needed u.) Albuterol hfa 90 mcg 2 puffs every 4-6 hours as needed On 5/28/24 at 2:30 p.m., during an interview with Licensed Practical Nurse 3, she indicated they reconciled the medications in a progress note with the quantity of controlled substances. She indicated the family member signed the note to agree they had the medications. On 5/30/24 at 11:00 a.m., the Administrator			

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	provided a copy of the "Drug Disposal Log." There was no policy along with it.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation and interview, the facility failed to disinfect the blood glucometer after use for 1 of 1 resident observed (Resident 6). Findings include: On 5/28/24 at 11:21 a.m., Qualified Medication Aide (QMA) 4 obtained Resident 6's blood sugar via a blood glucometer. The result was 188. The QMA 4 sat the machine with a Kleenex underneath it back inside a basket with unused lancets. Licensed Practical Nurse (LPN) 3 entered the medication room and was interviewed about the disinfecting of the glucometer. She indicated they cleaned the glucometer between residents with an alcohol prep and when they finish, they will clean with a disinfectant wipe (Dispatch Hospital Cleaner Disinfectant Towels with Bleach). She indicated the kill time for the wipes was 3 minutes.	R 0407	1. The staff member was immediately re-educated as to appropriate manner in which to disinfect the glucometer if used for multiple Residents. 2. All Residents have the potential to have been affected 3. In an effort to ensure the deficient practice will not recur, all qualified nursing staff received education as to the appropriate disinfection of the glucometer. 4. In an effort to ensure continued monitoring to ensure corrective actions are sustained, the Director of Nursing/designee shall conduct three random interviews or observations of qualified staff as to knowledge of disinfection of the glucometer twice weekly times eight weeks, weekly times eight weeks and monthly for a minimum	06/21/2024

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	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT PLACE WEST	55 N MISSION DR INDIANAPOLIS, IN 46214

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	A policy titled, "Blood Glucose Measurement, Evencare G2," dated 10/2014, was provided by the Administrator on 5/28/24 at 1:00 p.m. It indicated, " ...If a facility meter was used, follow instructions for sanitization listed on the facility designated wipe in an effort to prepare for next use ...." A label was provided from the designated wipe used to clean the glucometers. The wipe package indicated, "Wipe surface with towel until completely wet. Let stand for 3 minutes. Wipe dry or allow to air dry. Gross soil must be removed prior to disinfecting. Gloves must be worn ...."		of a cumulative six months. Should concerns or non-compliance be identified, additional education shall be provided. Continued monitoring may be increased or decreased on the basis of findings.	