STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155777	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREASY SPRINGS HEALTH CAMPUS	1750 S CREASY LN LAFAYETTE, IN 47905

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00374336 and IN00374363. Complaint IN00374336 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725. Complaint IN00374363 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725. Survey dates: September 29, 30 and October 3, 4, 5 and 6, 2022. Facility number: 012285 Provider number: 155777 AIM number: 201006770 Census Bed Type: SNF/NF: 27 SNF: 34 Residential: 42 Total: 103 Census Payor Type: Medicare: 26 Medicaid: 19 Other: 16 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 17,	F 0000	The submission of this plan of correction does not indicate an admission by Creasy Springs health campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Creasy springs health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenny McCurdy	RN, Clinical support nurse	11/02/2022

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	2022.			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure the PASARR (preadmission screening and resident review) was completed when an antipsychotic medication and mental health diagnosis was added for 1 of 1 resident reviewed for PASARR. (Resident 1) Finding includes: The record for Resident 1 was reviewed on 10/3/22 at 11:48 a.m. Diagnoses included, but were not limited to, delirium due to a known physiological condition, dementia without behavioral disturbance, chronic pain and depression. A PASARR, dated 5/4/22, indicated the resident	F 0644	Resident 1 missing required updated PASARR with diagnosis of delirium due to a known physiological condition, dementia without behavioral disturbance, chronic pain and depression. PASARR reviewed on 10/06/22 missing medication Risperdal which was prescribed on 09/16/2022. PASARR documentation updated with appropriate diagnosis and medication for resident 1. Residents in the health care center that are admitted to the	10/30/2022

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	did not have a mental health diagnosis. The only medication listed was Zoloft (an antidepressant). A physician's order, dated 9/15/22, indicated Risperdal (an antipsychotic) 0.5 mg (milligram) once a day at 1:00 p.m. A physician's order, dated 9/16/22, indicated to monitor for the target behaviors of sundowning, repetitive anxious concerns, anger and repetitive calls to son. During an interview, on 10/6/22, the Clinical Support Nurse indicated a new PASARR was not completed when the resident was prescribed Risperdal and received the diagnosis of delirium due to a known physiological condition and a new PASARR was indicated. A current policy, titled "Indiana PASRR," not dated and received from the DHS (Director of Health Services) on 10/6/22 at 4:56 p.m., indicated "...Preadmission Screening and Resident Review {PASRR] is a federal requirement to help ensure that individuals are appropriately placed in nursing facilities for long-term care...Trilogy Best practices...To comply with the pre-admission procedures within your state requires team approach...While it takes a team, here is a crosswalk to help you understand who best positioned to ensure each step of the process based upon their primary role and function...Change in status and Level II follow up...Social Services ensures paperwork is submitted...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		facility have the potential to be affected by alleged deficient practice. Social services or designee will complete review on all residents who have medications or diagnosis's appropriate to PASARR questionnaire. The Executive director (ED)/or Designee will conduct an in-service with Social services, admission coordinator, DHS (Director of health services), ADHS (assistant director of health services) related to ensuring PASARR documentation is completed correctly to reflect any current or new diagnosis's and/ or medications. As a measure of ongoing compliance, the ED or designee will audit 3 resident PASARRs for appropriate diagnosis and medications for 4 weeks, then twice monthly for 2 months, then monthly for 3 months to ensure PASARR documentation is completed appropriately. For quality assurance, The ED (executive director) and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will	

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			decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to update care plans for advanced directives, respiratory care and antipsychotics for	F 0657	1. Residents 1, 11, 17, 19 and 20 were missing documentation in comprehensive care plan to	10/30/2022

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	5 of 17 residents reviewed for care plans. (Resident 1, 19, 11, 20 and 17) Findings include: 1. The record for Resident 1 was reviewed on 10/3/22 at 11:48 a.m. Diagnoses included, but were not limited to, dementia, depression, age related physical debility and acute kidney failure. A physician's order, dated 9/19/22, indicated the resident was a DNR (do not resuscitate). A care plan, dated 9/16/22, indicated the resident's advanced directives were located in the resident documents. The long term goal was to honor the resident's and the resident's representative decision regarding advanced directives. The approaches included, but were not limited to, the advanced directives would be reviewed quarterly and as needed. 2. The record for Resident 19 was reviewed on 10/4/22 at 4:24 p.m. Diagnoses included, but were not limited to, atrial fibrillation, pneumonia, recurrent depressive disorder and generalized muscle weakness. A physician's order, dated 10/19/2018, indicated the resident was a full code. A care plan, dated 1/10/2020, indicated the advanced directives were located in the resident documents. The long term goal was to honor the resident's and the resident's representative decision regarding advanced directives. The approaches included, but were not limited to, the advanced directives would be reviewed quarterly and as needed.		support the following: appropriateness of services and communication that meets the resident's needs, severity/stability of conditions, impairment, disability or disease. Resident's 1, 11, 17, 19 and 20 care plans have been revised to meet requirements to best communicate resident needs to the interdisciplinary team. 2. All residents have the potential to be affected. All resident care plans were reviewed and revised for appropriateness reflecting the specific needs of each resident. The interdisciplinary team has been educated on the care planning process, additional need for documentation inside each individualized careplan and appropriateness of care plans per each resident. will complete audit 5 residents weekly x4 weeks, then 5 residents every other week for 2 months, and then 5 residents monthly x3 months to ensure comprehensive care plans are appropriateness to resident needs and appropriate services are documented in the care plans as well as appropriate communication to the interdisciplinary team. 4. As a quality measure, the DHS or designee will review any findings and corrective action at	

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	During an interview, on 10/5/22 at 2:49 p.m., the Social Services Director indicated she did not put anything on the advance directive care plan other than to look at the resident's documents and all the resident care plans for advanced directives were the same. 3. The record for Resident 11 was reviewed on 10/03/22 at 11:34 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypercapnia (excessive carbon dioxide in the blood stream) and personal history of other malignant neoplasm (cancer) of the bronchus (wind pipe) and lung. A physician's order, dated 1/16/22, indicated an order for BIPAP (bilevel positive airway pressure machine) at night and as needed during the day. The order did not include IPAP (inspiratory positive airway pressure) and EPAP (expiratory positive airway pressure) settings. A care plan, dated 7/14/22, indicated the resident was short of breath while lying flat related to chronic obstructive pulmonary disease. Interventions included, but were not limited to, administer oxygen per physicians order and elevate head of bed. A care plan for the BIPAP machine was not located. 4. The record for Resident 20 was reviewed on 09/30/22 at 03:07 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, delusional disorder and dementia without behavioral disturbance.		least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	A physician's order, dated 08/13/22, indicated Seroquel (an antipsychotic) 25 milligrams twice daily. A physician's order, dated 03/19/22, indicated valproic acid solution (an anticonvulsant) 250 milligrams/5 milliliters, 5 milliliters twice daily. A physician's progress note, dated 09/02/22 at 5:22 p.m., indicated the Alzheimer's disease plan of treatment was to continue Seroquel 25 milligrams twice daily. The plan of treatment for dementia without behavioral disturbance was to continue Depakote (valproic acid) to help with mood stability and behaviors. A care plan, dated 08/11/22, indicated the resident was at risk for adverse consequences related to receiving antipsychotic medication for behaviors including delusions. During an interview, on 10/5/22 at 2:59, the Clinical Support Nurse indicated a resident on antipsychotic medications should have had 2 care plans, one for the side effects of the medication and one for the behaviors the resident exhibited and one or both should have an appropriate diagnosis for the use of the medication and/or treatment documented. 5. The record for Resident 17 was reviewed on 10/04/22 at 11:05 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, mood disturbance and anxiety. A physician's order, dated 07/25/22, indicated the resident received Risperdal (an antipsychotic medication used to treat mental illness) for dementia with behavioral disturbances. The resident's care plan for the use of a			

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	psychotropic medication, dated 08/02/2022, was not revised to indicate the targeted behavioral disturbances the resident was exhibiting to indicate the use of the psychotropic medication. During an interview, on 10/05/22 at 2:59 p.m., the Corporate MDS (Minimum Data Set) Consultant indicated a resident on an antipsychotic medication should have a care plan with specific targeted behaviors related to the use of that specific medication. A current policy, titled "Comprehensive Care Plan Guidelines" dated 05/18/22, received on 10/5/22 at 04:00 p.m., from the Director of Health Services indicated "...to ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines...comprehensive care plans need to remain accurate and current".... 3.1-35(b)(1)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to access and document a skin condition after a resident received a laceration to her left calf while being transferred from her wheelchair to her	F 0684	1. Resident 17 was affected. This resident no longer resides at the facility.	10/30/2022

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	bed resulting in a trip to the Emergency Room where she received 31 stitches and subsequently developed a complicated skin infection 25 days later for 1 of 1 resident reviewed for non-pressure skin conditions. (Resident 17) Finding includes: The record for Resident 17 was reviewed on 10/04/22 at 11:05 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, anxiety and unspecified fall. An Incident Report, dated 09/01/2022 at 8:51 p.m., indicated Resident 17 was being assisted to bed from her wheelchair and received a laceration to her left lower extremity. On 09/02/22, the facility Nurse Practitioner gave an order to send the resident to the Emergency Room for evaluation and treatment. A Nurse Practitioner note, dated 09/02/22 at 9:19 a.m., indicated Resident 17 was being seen for a laceration to her left leg and evaluation of the wound. The area measured approximately 6 to 7 inches long and was draining heavy amounts of watery bloody fluid. The staff reported the laceration was deep and fat tissue could be seen at the inner most layer of skin in the body. Her left lower extremity was swollen and purple from bruising. It was very tender to touch. Due to the nature of the injury, the resident was sent out to the hospital for sutures. The initial assessment documentation from the hospital, dated 09/02/22 at 11:30 a.m., indicated the resident had a laceration to her left leg measuring approximately 10 cm (centimeters) in the shape of a C.		2. All residents with sutures have the potential to be affected. All nurses educated hospital discharge documentation, order implementation from discharge orders and event documentation in EMAR (electronic medication administration record). All residents currently in the facility with sutures are being monitored weekly and as needed for signs and symptoms of infection. All residents currently in the facility with sutures have current orders to discontinue sutures times appropriate for use. 3. As a measure of ongoing compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 resident to ensure that discharged orders are transcribed to EMAR system accurately 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance	

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	Discharge instructions from the hospital, dated 09/02/22 at 12:32 p.m., indicated most skin wounds heal within ten days. To keep the wound clean, remove the dressing, wash the area with soap and water, and apply a thin layer of antibiotic ointment. However, even with proper treatment, a wound infection may sometime occur. Therefore, the wound should be assessed daily for signs of infection and the stitches should be removed within 7 to 14 days. There was not a physician's order in the resident's chart to assess the wound or clean and apply a thin layer of an antibiotic cream daily as documented in the hospital discharge instructions. There was also not a physician's order for when to remove the sutures. There was not a care plan with interventions related to the laceration she received on 09/01/22. From 09/02/22 through 09/26/22, the below progress notes were the only documentation related to the assessment of the resident's laceration to her left lower extremity. On 09/02/22 at 2:21 p.m., the resident returned from the Emergency Room with sutures and a bandage to her left lower extremity. On 09/02/22 at 9:30 p.m., the area was assessed to her left lower extremity and 31 sutures were observed. On 09/05/22, the sutures were intact with no signs or symptoms of infection. On 09/06/22, the dressing to her left lower extremity was clean, dry, and intact. The dressing was changed.		met.	

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	On 09/20/22, the dressing to her left lower extremity was changed and the wound had watery bloody drainage and the sutures were intact. On 09/26/22 at 1:11 p.m., the Nurse Practitioner documented the reason the resident was being seen was for her leg wound. She indicated the wound was examined and found to be swollen with marked redness. There was a foul smelling pus drainage noted. Her sutures were still in place and the edges of the entire wound was covered with this drainage. The wound was starting to come apart where sutured and the majority of the laceration was open. The thirty-one sutures were removed from the resident's left lower extremity. The area was swollen, red and warm, there was a foul odor coming from the wound and the area was painful to touch. Almost the entire laceration had signs and symptoms of infection. She indicated the wound infection was intense and complex. On 09/26/22 at 3:22 p.m., the IDT (interdisciplinary team) indicated the resident's sutures were removed that day by the nurse practitioner. A current care plan, dated 09/26/22, indicated the resident had an infection to a skin tear to her left lower extremity. A current physician's order, dated 09/26/22 through 10/06/22, indicated the resident was started on linezolid (an antibiotic) for a complicated skin infection. A current physician's order, dated 09/26/22, indicated to cleanse the resident's wound to her left lower extremity and apply medication once a day.			

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	During an interview, on 10/5/22 at 3:19 p.m., the Director of Nursing indicated the resident's discharge instructions from the hospital was considered an order and should have been documented as an order in the resident's chart. The skin tear should have been cleaned and assessed daily and documented with a description and measurements weekly. The sutures should have also been removed within 7 to 14 days prior to 09/26/22. A current policy, titled "Pressure/Stasis/Arterial/Diabetic Wound Guidelines," dated as revised 12/01/2021 and provided by the Director Of Nursing on 10/05/22 at 5:00 p.m., indicated "...Purpose: To provide weekly documentation of wound measurements and condition...Re-assessment/measurement weekly or with significant change in wound noting the current treatment, medical interventions provided, and comments as needed...." 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the			

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	resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to recognize and notify the physician of a significant weight gain and obtain weights for a resident with congestive heart failure (CHF) for 1 of 4 residents reviewed for nutrition. (Resident 15) Finding includes: The record for Resident 15 was reviewed on 9/30/22 at 2:42 p.m. Diagnoses included, but were not limited to, fracture of left patella (kneecap), congestive heart failure (CHF), atrial fibrillation (irregular, often rapid heartbeat) and long-term anticoagulants (blood thinner). During an interview, on 9/30/22 at 11:06 a.m., Resident 15 indicated she was having swelling in her left lower leg. The nurses were aware of the swelling and she had a diagnoses of CHF. A physician's order, dated 7/18/22, indicated furosemide (a diuretic) 40 mg (milligram) tablet to give 1 tablet by mouth daily. A physician's order, dated 8/27/22, indicated furosemide 20 mg tablet to give 1 tablet by mouth daily. A physician's order, dated 9/23/22, indicated the resident was a daily weight.	F 0692	1. Resident 15 had 8.23% weight gain in 17 days without documentation of physician notification. Physician has since been notified of weight changes. Resident 15 also is free of adverse reactions to weight change. 2. All residents have the potential to be affected. All nurses have been educated on ensuring the attending physician is notified of any significant weight changes. Nurses have been educated to document notification in electronic record of respective resident. 3. As a measure of ongoing compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 resident to ensure that 4 residents attending physician was notified of any significant weight changes per ordered 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months.	10/30/2022

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	155777	A. BUILDING 00 B. WING	10/06/2022

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CREASY SPRINGS HEALTH CAMPUS	1750 S CREASY LN LAFAYETTE, IN 47905

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	A care plan, dated 7/29/22, indicated the resident had a potential for complications related to CHF (congestive heart failure). The interventions included, but were not limited to, weight as ordered, observe for and report complications as needed and diet per MD order. A care plan, dated 7/29/22, indicated the resident was at risk for potential cardiovascular distress related to diagnosis labs per MD order. Report results to MD as needed, observe for signs and symptoms of cardiovascular distress and report if needed and observe for and report any side effects as needed. A care plan, dated 7/29/22, indicated the resident received diuretic medication related to CHF. The interventions included, but were not limited to, administer medication per MD orders, observe and report effectiveness as needed and labs per physician's orders, observe cardiovascular system and fluid status to determine effectiveness of diuretic therapy (e.g., edema, jugular vein distention, mental confusion). The resident had the following weights: 1. On 9/16/22, weight was 228.4 lbs. 2. On 10/3/22, weight was 247.2 lbs. The resident had an 8.23% weight gain in 17 days. The physician was not notified the significant weight gain occurred. There was no documentation of the physician being notified of the significant weight gain. A Vitals Report indicated the resident was missing 6 daily weights for 9/23, 9/24, 9/28, 9/29, 10/1 and		4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	10/2/22. During an interview, on 10/4/22 at 3:56 p.m., the Director of Health Services (DHS) indicated it was their expectation if the physician ordered a daily weight they were to get the weight within 24 hours. A current policy, titled "Guidelines for Weight Tracking," dated as revised on 1/16/22 and received from the DHS on 10/5/22 at 9:30 a.m., indicated "...To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration...Residents will have their weight taken and recorded upon admission to establish a baseline...The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days (unless on a planned weight loss or gain program). The facility may open and complete a [name of facility-Weight/Nutrition Event for a significant weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. (Unless on a planned weight loss or gain program)...Residents with a significant weight changes can be added to Clinically At Risk...." A current policy, titled "Clinical Services-Weight Monitoring," dated as revised on 12/21/20 and received from the DHS on 10/4/22 at 4:41 p.m., indicated "...Weight monitoring is essential to the well-being of the residents we serve and requires a multidisciplinary approach...Review of missing weights...Daily Weights as ordered...May be delegated to DHS, ADHS or MDS...Weekly review of 5% weight changes in KeyStats...Open weight event for true 5% or greater weight changes...." 3.1-46(a)(1)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on record review, interview and observation, the facility failed to obtain complete physician's orders for the use of a BIPAP (a non-invasive ventilation machine generating two adjustable pressure levels) for 2 of 2 residents reviewed for respiratory care. (Residents 49 and 11) Findings include: 1. During an observation, on 10/03/22 at 11:41 a.m., Resident 49 was sitting in a wheelchair in her room. She indicated she was having a rough day and appeared anxious. She had multiple questions about the BIPAP and the oxygen. She was asking for information to read to help her understand how it worked. The record for Resident 49 was reviewed on 09/30/22 at 3:07 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute respiratory failure with hypercapnia (excessive carbon dioxide in the blood stream), acute and chronic respiratory failure with hypoxia (not enough oxygen in the tissue to sustain bodily functions), pleural effusion and obstructive sleep apnea (intermittent airway blockage during	F 0695	1. Resident 49 was affected. Resident with order for BIPAP in medical record. Order for BIPAP did not include appropriate settings as indicated per policy. 2. All like residents that have order for BIPAP have the potential to be affected. All nurses have been educated on ensuring BIPAP settings are located inside of order listed in medical record. A house wide audit has been completed in the health center to ensure that all residents that require BIPAP have appropriate orders with settings are up to date and present in the medical record appropriately. 3. As a measure of ongoing compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 resident to ensure BIPAP settings are present and correct in the residents respective clinical record 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3	10/30/2022

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	sleep). A physician's order, dated 9/29/22, indicated an order for BIPAP at night and as needed during the day. The order did not include the IPAP (inspiratory positive airway pressure-high pressure when breathing in) and the EPAP (expiratory positive airway pressure-low pressure when breathing out) settings. A template in the facilities orders for BIPAP included an area to fill in settings for the IPAP, EPAP and oxygen settings. A treatment administration record, dated 9/1/22 to 9/30/22, indicated the BIPAP was administered to the resident by the nurse on 9/30/22. A treatment administration record, dated 10/1/22 to 10/6/22, indicated the BIPAP was administered to the resident by the nurse on 10/1/22, 10/2/22 and 10/3/22. A care plan, dated 9/30/22, indicated the resident was short of breath while lying flat and required continuous oxygen and the BIPAP at night. The interventions included, but were not limited to, oxygen per physician orders, elevate head of bed as needed and therapy to evaluate and treat as needed. 2. The record for Resident 11 was reviewed on 10/03/22 at 10:34 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypercapnia (excessive carbon dioxide in the blood stream) and personal history of other malignant neoplasm (cancer) of the bronchus (wind pipe) and lung.		months 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	A physician's order, dated 1/16/22, indicated an order for BIPAP at night and as needed during the day. The order did not include the IPAP (inspiratory positive airway pressure) and the EPAP (expiratory positive airway pressure) settings. A care plan for the BIPAP was not located. During an interview, on 10/5/22 at 10:41 a.m., the Director of Health Services indicated she was aware the BIPAP orders were incomplete without the IPAP, EPAP and oxygen settings. A facility policy was not obtained before the date of exit. 3.1-47(a)(6)			
F 0725 SS=D Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents			

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	in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview and record review, the facility failed to ensure there was adequate staff to administer medications to residents within the administration time frame for 2 of 3 residents reviewed for medication administration. (Residents C and D) Findings include: 1. During a review of the resident council meeting minutes, on 10/3/22 at 11:29 a.m., the following were noted: a. January 2022, the residents reported feeling guilty asking staff for anything after seeing how hard they work. b. April 29, 2022, reported difficulty talking to one staff although they did not identify the staff by name. c. May 30, 2022, reported needing more qualified help. d. June 7, 2022, reported nursing still seems overwhelmed. e. August 2022, reported help on the 200 hall disappears around meal times, the staff were chit chatting and call lights times were lengthy on the 200 hall at nights. During a resident council meeting, on 10/3/22 at 1:00 p.m., the residents indicated there was only one or two staff who passed out pills for the	F 0725	1. Residents were not affected by the alleged deficit practice. Medication administration times have been reviewed and medications have been given in accordance to written orders. 2. All residents have the potential to be affected. All nurses and QMA's (Qualified medication assistants) have been educated on ensuring medications are signed out in medical record in accordance to the written order. A 3. As a measure of ongoing compliance, the ED or designee, will complete audits of 5 residents medication administration to ensure medications are given per written order 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring	10/30/2022

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	whole unit and it was a lot for the staff to do. The whole health care system was in a turmoil and they needed to be patient getting their problems straightened out. The 200 hall had been short staffed and the facility needed to hire more nurses. There may be only one staff to work on a hall with 17-18 residents. They need more staff coming to work because some of the staff would get "burned out" and not stay. During an interview, on 10/4/22 at 12:04 p.m., the Executive Director indicated during the April resident council meeting a resident was worried about a staff member being stressed. There was no further concern. During an interview, on 10/5/22 at 11:50 a.m., the DHS (Director of Health Services) indicated the nurses were allotted about 1.03 minutes for each pill that needed administered. The residents and staff had given feedback about the staff being rushed. Staff had brought up concerns about the medication pass and some of the scheduled morning medications had been moved from the 8:00 a.m., time slot. 2. During an interview, on 10/4/22 at 10:11 a.m., Resident C's family indicated the facility did not administer the resident's medications on time. The record for Resident C was reviewed on 10/3/22 at 11:07 a.m. Diagnoses included, but were not limited to, pneumonia, acute respiratory failure, chronic kidney disease, cerebral infarction and depression. A physician's order, dated 1/28/22, indicated ropinirole (a medication for restless leg syndrome) 0.25 mg (milligram) twice a day.		will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	A medication administration record (MAR), dated 1/31/22 through 2/28/22, indicated the ropinirole was to be administered at 11:30 a.m. and 5:00 p.m. The medication was administered late for the 5:00 p.m., dose on the following date: a. On 2/2/22 was administered at 6:34 p.m. b. On 2/9/22 was administered at 6:34 p.m. c. On 2/15/22 was administered at 6:11 p.m. d. On 2/20/22 was administered at 6:12 p.m. e. On 2/22/22 was administered at 6:27 p.m. f. On 2/23/22 was administered at 6:41 p.m. During an interview, on 10/5/22 at 10:51 a.m., the DHS indicated a medication scheduled for 5:00 p.m., would be considered late if it was administered after 6:00 p.m. She did not know what the facility staffing was like in January and February. During Covid the building was short staffed. 3. During an interview, on 9/29/22 at 3:36 p.m., Resident D indicated there were concerns about his medications. The medication was administered late and they work short staffed. The record for Resident B was reviewed on 9/30/22 at 2:57 p.m. Diagnoses included, but were not limited too, metabolic encephalopathy, atrial fibrillation, gout, hypertension and malignant neoplasm of the kidney. The Medication Administration Record (MAR) indicated, in September, Resident D had 25 medications administered late. During an interview, on 10/3/22 at 10:15 a.m., an anonymous staff indicated the staffing was horrible. They normally work with 1 nurse and 1 CNA. The staff was told by the Executive Director to "just deal with it." During an interview, on 10/4/22 at 9:09 a.m., an			

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	anonymous staff indicated it was just a nurse and a CNA. The nurses would state it was hard to get their work done because of answering lights and passing medication. There are times when medication were signed out late. A current policy, titled "Preparation and General Guidelines," dated as revised on 11/18 and received from the DHS on 10/5/22 at 9:30 a.m., indicated "...Medications are administered as prescribed in accordance with good nursing principles and practices and only be persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration)...Administration...Medications are administered in accordance with written orders of the prescribe...Medication are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility..." This Federal tag relates to Complaints IN00374336 and IN00374363. 3.1-17(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in			

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	the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or			

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	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure residents had an appropriate diagnosis for the use of psychotropic medications for 3 of 4 residents reviewed for psychotropic medication use. (Resident 1, 20 and 17) Findings include: 1. The record for Resident 1 was reviewed on 10/3/22 at 11:48 a.m. Diagnoses included, but were not limited to, cerebral infarction, dementia without behavioral disturbance, delirium due to a known physiological condition, chronic pain and hearing loss. A physician's order, dated 4/27/22, indicated risperidone (an antipsychotic) 0.5 mg (milligram) once a day. The physician's order did not include a diagnosis with the medication. A care plan, dated 5/3/22, indicated the resident received an antipsychotic medication and was at a risk for adverse consequences. The medication was for the diagnosis of depression. The approaches included, but were not limited to, administer medications per the physician order, attempt to give the lowest dose possible, a pharmacy consultant review as needed and to observe and report signs of sedation. A PASARR (preadmission screening and resident review), dated 5/4/22, indicated the resident had no known or suspected mental health diagnosis and no known mental health behaviors which affected interpersonal interactions. The mental health medication listed was Zoloft (an	F 0758	1. Resident 1, 17 and 20 lacked documentation of appropriate diagnosis for the use of psychotropic medication use. Documentation of appropriate documentation has been obtained for these residents. AIMs assessments (abnormal involuntary movement scale) assessment could not be located. AIMs assessments have since been completed on resident receiving psychotropic medications. 2. All residents with orders for psychotropic medications have the potential to be affected. The DHS (Director of health services), ADHS (assistant director of health services), SSD social services director and MDS (minimum data set) nurse have been educated to ensure that an appropriate diagnosis is correlated with psychotropic medications as well as correct diagnosis for perspective medications. A house wide audit has occurred to ensure appropriate diagnosis are correlated with psychotropic medications. 3. As a measure of ongoing compliance, the DHS or designee, will complete audits of 5 residents to ensure appropriate diagnosis is in place for psychotropic medication use all AIMs assessments as per policy.	10/30/2022

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	antidepressant) for depression. There were no other mental health medications listed on the PASARR. A pharmacy recommendation, dated 5/6/22, indicated the resident had orders for risperidone which could put the resident at higher risk for falls. There was not an appropriate diagnosis for the resident to receive treatment with the medication. Please consider evaluating for continued use and taper down to risperidone 0.25 mg daily for 2 weeks then discontinue if not a candidate for continued treatment. The NP's (Nurse Practitioner) response, dated 5/11/22, indicated the resident was started on risperidone at [name of facility] mid April for dementia with behaviors. The son was aware and agreed with this choice. The resident was currently stable on this dose with no behavioral concerns. The dose was to be continued. An order set for target behaviors, dated 9/16/22, indicated to monitor each shift for sundowning (confusion and restlessness in people with dementia), repetitive anxious concerns, anger and repetitive calls to son. A care plan, dated 9/16/22, indicated the resident demonstrated behaviors including anger, repetitive anxious complaints, repetitively calling son at night and sundowning. The approaches included, but were not limited to assess for unmet needs, rest, food and companionship. During an interview, on 10/6/22 at 2:07 p.m., the Clinical Support Staff indicated the resident came from a different facility and was on risperidone when she came to the facility.		Audits to be completed 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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The Nursing Drug Handbook indicated risperidone had a black box warning for elderly patients with dementia related psychosis with an increased risk for death. The medication was not approved to treat elderly patients with dementia related psychosis.2. The record for Resident 20 was reviewed on 09/30/22 at 3:07 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, delusional disorder and dementia with behavioral disturbance.

A physician's order, dated 3/19/22, indicated valproic acid solution 250 milligrams/5 milliliters, 5 milliliters twice daily.

A physician's order, dated 8/13/22, indicated Seroquel 25 milligrams twice daily.

A physician's progress note, dated 09/02/22 at 5:22 p.m., indicated the staff had communicated the resident was more alert after the gradual dose reduction of Seroquel. The Alzheimer's disease plan of treatment was to continue Seroquel 25 milligrams twice daily. The plan of treatment for dementia without behavioral disturbance was to continue Depakote (valproic acid) to help with mood stability and behaviors.

A care plan, dated 8/11/22, indicated the resident was at risk for adverse consequences due to antipsychotics for behaviors including delusions.

A recent publication of "PDR.net" indicated "...Seroquel (quetiapine) was indicated for the treatment of bipolar disorder, including mania, bipolar depression and major depressive disorder...the black box warning indicated antipsychotics are not approved for the treatment

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	of dementia-related psychosis in geriatric patients and the use of Seroquel in this population should be avoided if possible due to an increase in morbidity and mortality..." A recent publication of "PDR.net" indicated "...Depakote (divalproex) was indicated for the treatment of bipolar disorder including mania...the black box warning indicated antipsychotics are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Depakote in this population should be avoided if possible due to an increase in morbidity and mortality..."3. The record for Resident 17 was reviewed on 10/04/22 at 11:05 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, anxiety and unspecified fall. A physician's order, dated 07/25/22, indicated the resident received Risperdal (an antipsychotic medication used to treat mental illness) for dementia with behavioral disturbances. A pharmacy recommendation, dated 08/03/22, indicated the resident was receiving Risperdal and it lacked an allowable diagnoses to support its use. A current care plan, dated 08/02/22, indicated the resident was at risk for side effects from receiving an antipsychotic medication. Interventions included, but were not limited to, performing an AIMS assessment (abnormal involuntary movement scale) assessment (used to measure abnormal involuntary movements after taking anti-psychotic medications for a prolonged period of time) per guidelines. An AIMS assessment could not be located in the			

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	resident's medical record. During an interview, on 10/05/22 at 2:34 p.m., the Director of Health Services (DHS) indicated the diagnosis of dementia with behavioral disturbances was not an appropriate diagnosis for an antipsychotic medication. During an interview, on 10/05/22 at 5:00 p.m., the DHS indicated if a resident was taking an antipsychotic medication an AIMS assessment should be completed and she could not provide one for Resident 17. A current policy, titled "Psychotropic Usage and Gradual Dose Reductions," dated 10/9/17 and received from the DHS on 10/6/22 at 4:56 p.m., indicated "...resident shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the...resident's medical record and in the care planning process...." A current policy, titled "Guideline for: Abnormal Involuntary Movement Scale (AIMS)," dated as revised 12/01/2021 and provided by the DHS on 10/06/22 at 2:00 p.m., indicated "...1. A licensed nurse will complete an AIMS scale assessment on all residents on antipsychotic medications...2. The AIMS assessment will be completed...prior to the resident beginning this type of medication, or at the earliest possible time...." A current policy, titled "MEDICATION MONITORING AND MANAGEMENT," dated as revised on 11/18 and provided by the DHS on 10/06/22 at 3:45 p.m., indicated "...4) The resident's medication regimen is evaluated when...there is an			

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	irregularity identified in the pharmacist's monthly medication review...When a resident receives a new medication, the medication order is evaluated for the following...A written diagnosis...support each medication..." 3.1-48(a)(3) 3.1-48(a)(4)			
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 interview and record review, the facility failed to label eye drops with an opened date,	F 0761	1. No residents were affected. No adverse effects noted. Nurses	10/30/2022

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	dispose of a loose pill in the drawer and dispose of a compromised controlled substance in 1 of 3 medication carts and 1 of 2 medication refrigerators observed for medication storage. (a 200 hall medication cart and medication refrigerator) Finding includes: During an observation, on 10/04/22 at 10:23 a.m., the cart for the back of the 200 hall had a card of Hydrocodone-acetaminophen (a controlled pain medication) 10/325 milligrams for Resident 35. The 29th slot in the card had the covering torn with tape covering the slot and pill. A bottle of artificial tears for Resident 32 had been opened and did not have a date open. A small green pill was found loose in the in the bottom of the drawer in the medication cart. The refrigerator in the medication room for medication storage contained ensure supplements. During an interview, on 10/04/22 at 10:23 a.m., Nurse 5 indicated the medication should not have tape over the medication. She indicated the medication should be destroyed in the disposal fluid in the medication room with a witness. The hydrocodone-acetaminophen and the green pill were destroyed by the nurse and the Director of Health Services (DHS). The nurse re-ordered the eye drops. The nurse indicated she thought the ensure would be considered a medication. A current policy, titled "Medication Storage In the Facility," dated 9/1/13 and received from the DHS on 10/4/22 at 4:45 p.m., indicated "...medications and biologicals are stored safely, securely and properly, following manufacture's recommendations or those of the supplier...refrigerated medications are kept		were immediately educated on policy regarding dating and labeling all medications, discarding lose medications in the cart and keeping supplemental oral drinks in separate location. Nurses have also been educated on the proper disposal of medications removed from the original packaging. 2. All residents have the potential to be affected. All nurses to be educated by DHS (Director of Health Services) on medication storage policy. DHS will complete visual observations while rounding daily in campus. 3. As a measure of ongoing compliance, the DHS or designee, will complete audits of 3 medication carts to ensure that medications that are opened are correctly dated, cart will be free of lose medications and that all dietary supplement drinks are stored in a separate refrigerator 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring	

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	separate from fruit juice, applesauce and other foods...." 3.1-25(j)		will continue past 6 months if warranted until 100% compliance met.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00374336 and IN00374363. Complaint IN00374336 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725. Complaint IN00374363 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725. Survey dates: September 29, 30 and October 3, 4, 5 and 6, 2022. Facility number: 012285 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 17, 2022.	R 0000	The submission of this plan of correction does not indicate an admission by Creasy Springs health campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Creasy springs health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.			

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	Based on observation, interview and record review, the facility failed to ensure an appropriate transfer took place for a resident who was transferred from her wheelchair to a recliner chair without a gait belt for 1 of 1 resident randomly observed for transfers. (Resident 8) Finding includes: During a random observation, on 10/03/22 at 1:25 p.m., CRCA (Certified Resident Care Aide) 3 and CRCA 9 was observed transferring Resident 8 from her wheelchair to a recliner chair in the common area. Both CRCAs reached under the resident's arms, by her arm pits, with one hand, grabbed the back of her pants with the other and lifted her into the chair. During an interview, at that time, CRCA 3 indicated she should have used a gait belt to transfer the resident. The record for Resident 8 was reviewed on 10/04/22 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, osteoporosis and muscle weakness. Resident 8's "Admission AL/Legacy Evaluation and Service Plan," dated 12/04/21, indicated the resident needed assistance with transfers. During an interview, on 10/04/22 at 5:00 p.m., the Director of Health Services (DHS) indicated the CRCAs should have used a gait belt with transfers. During an interview, on 10/6/22 at 12:04 p.m., Physical Therapy Assistant 1 indicated gait belts should always be used to safely transfer residents who require assistance with transfers. A current policy, titled "Guidelines for Gait Belt	R 0240	1. No residents were affected. No adverse effects noted. CRCA (certified resident care aide) 3 and CRCA 9 was observed transferring resident 8 from her wheelchair to the recliner. Both CRCAs lifted resident without the use of a gait belt. 2. All like residents have the potential to be affected. All nursing staff educated by DHS (Director of Health Services) on gait belt use policy. DHS will complete visual observations while rounding daily in campus. 3. As a measure of ongoing compliance, the DHS or designee, will complete audits of 3 gait belt transfers to ensure proper transfer technique and gait belt use, 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	10/30/2022

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	Use," dated as reviewed on 12/01/21 and provided by the DHS on 10/05/22 at 5:10 p.m., indicated " ...Purpose: To ensure safety for the resident and staff during transfers and mobility activities. Procedures: 1. Gait belts should be used according to the plan of care for the individual resident...."			
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 assure medications were safely secured inside a resident's room for 1 of 1 residents reviewed for self administration of medications. (Resident 1) Finding includes: During an observation, on 10/3/22 at 3:40 p.m., Resident 1's medications were observed in a plastic bag inside her middle drawer of her bed side table. At that time, she indicated it was where she had always kept her medications. The record for Resident 1 was reviewed on 10/04/22 at 10:28 a.m. Diagnoses included, but were not limited to, kidney failure, heart disease and anxiety. A Self Administration of Medications Assessment document, dated 06/21/22, indicated Resident 1 was appropriate to self-administer her own medications and her medications could be stored in her room. During an interview, on 10/4/22 at 5:00 p.m., the	R 0295	1. No residents were affected. No adverse effects noted. Resident 1 observed to have medications in room, bedside table without drawer being locked. All residents that self-administer medications have been supplied with locked drawer with key per policy 2. All like residents have the potential to be affected. All nursing staff educated by DHS (Director of Health Services) on medication storage policy for residents whom self-administer medications. DHS will complete visual observations while rounding daily in campus. 3. As a measure of ongoing compliance, the DHS or designee, will complete audits of 2 residents, with resident consent, who self-administer their medications to ensure medications are locked properly in designated area 3x	10/30/2022

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	Director of Health Services (DHS) indicated medications for residents who administer their own medications should be kept locked in their room and the facility followed their policy and procedure related to guidelines for self administration of medications. A current policy, titled "Guidelines for Self Administration of Medications," dated as revised on 08/05/22 and provided by the DHS on 10/04/22 at 5:05 p.m., indicated "...Procedures...The medications will be kept in a locked drawer in the residents' room..."		weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	