STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155478	A. BUILDING 00 B. WING	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERS OF JASPER THE	2909 HOWARD DR JASPER, IN 47546

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00445169 and Complaint IN00445700. Complaint IN00445169 - No deficiencies related to the allegations are cited. Complaint IN00445700 - Federal/state deficiencies related to the allegations are cited at F761. Survey dates: October 15, 16, 17, 18, 21, 2024 Facility number: 000314 Provider number: 155478 AIM number: 100274210 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 1 Medicaid: 48 Other: 21 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 28, 2024.	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 20th, 2024 to the annual survey completed on October 21st, 2024. We respectfully request that a desk review be considered. The facility will provide additional information as needed to identify compliance.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record	F 0761	**F761 Label/Store Drugs and**	11/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Beau Kellams | Executive Director | 11/06/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	review, the facility failed to ensure medications were stored safely or under proper temperature controls for 2 of 15 residents sampled for medications on the floor, and 2 of 2 medication storage rooms. (Resident D, Resident M, 100 Hall Medication Storage Room, 300/400 Hall Medication Storage Room) Findings include: 1. On 10/15/24 at 9:19 A.M., the 100 Hall Medication Storage Room medication refrigerator log was observed to be missing temperatures. The 100 Hall medication refrigerator log lacked a temperature on days from 10/1/24 through 10/15/24. The 100 Hall medication refrigerator log was missing a temperature for night shift on 10/1/24, 10/2/24, 10/4/24, 10/5/24, 10/6/24, 10/7/24, 10/9/24, 10/10/24, 10/12/24, 10/13/24, and 10/14/24. At that time, QMA (Qualified Medication Aide) 11 indicated that temperatures were taken twice a day and logged for medication refrigerators. The 300-400 Hall medication refrigerator log was observed to be missing temperatures for day shift from 10/2/24 through 10/15/24. The log was observed to be missing a temperature for night shift on 10/10/24. A note on the temperature log indicated "Medications must be kept 36-46 degrees F [Fahrenheit] in Refrigerator." The temperatures on night shift were recorded as the following: 10/1/24 30 10/2/24 32 10/3/24 28 10/4/24 20 10/5/24 30 10/6/24 33 10/7/24 32 10/8/24 32		**Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident D and Resident M were assessed with no ill effects noted related to alleged deficient practice. Resident M care plan has been updated to include interventions related to spitting out medications Resident D care plan has been updated to include interventions related to medication administration • Medications are being stored safely and under proper temperature controls. The 100 hall and 300-400 hall medication refrigerator log is being completed and monitored per protocol. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • All residents have the potential to be affected by the alleged deficient practice. • Medication carts/medication storage refrigerator were audited by DNS/designee to ensure all medications are stored per policy and with temperature monitoring logs being completed with any temperatures outside of	

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	10/9/24 30 10/11/24 32 10/12/24 34 10/13/24 34 During an interview on 10/17/24 at 2:35 P.M., the Administrator indicated the temperature in medication refrigerator should be in the range that was in the policy. Policy for Medication Storage indicated temperature range should be 36-46 degrees Fahrenheit. The Administrator indicated he would ask maintenance if there had been any work orders for the refrigerator. During an interview on 10/17/24 at 3:14 P.M., the Administrator indicated maintenance had not worked on the refrigerator, but he checked the temperatures and it was working correctly. 2. On 10/21/24 at 8:56 A.M., an oval peach colored pill was observed lying on the floor next to bottom of bed of Resident M. At that time LPN 15 indicated the pill was Namenda 5 mg which Resident M took twice a day. She verified the identity of the pill with the pill card in the medication cart. LPN 15 indicated she didn't know why the pill was on the floor or how long it had been there. She indicated she stayed with resident while he took his medication. On 10/21/24 at 10:06 A.M., Resident M's clinical records were reviewed. Diagnosis included, but was not limited to dysphagia, oropharyngeal phase, and dementia, unspecified severity. The most recent Significant Change in Condition MDS (Minimum Data Set) assessment, dated 10/3/24, indicated Resident M had moderate cognitive impairment and required extensive assistance of two for bed mobility, transfers and		appropriate range are reported to maintenance. • Nurses and QMAs will be in-serviced by CEN/designee on medication storage and refrigerator temperature log completion. All residents were reviewed and care plans updated for residents who do not take medications per protocol by DNS/Designee **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • DNS/designee will complete Daily audit of medication carts, medication rooms and resident rooms to ensure appropriate storage of medications and to ensure that temperature monitoring logs are being completed per policy. DNS/Designee will round daily to ensure medications are administered per policy/action plan **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • The DNS/designee will complete medication storage QA tool weekly x4 weeks, monthly x6 months and then quarterly until	

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	toilet use and supervision with set up for eating. Physician orders included, but was not limited to the following: memantine tablet (Namenda) (medication used to treat dementia) 5 mg; oral Twice A Day 07:00 AM - 11:00 AM, 07:00 PM - 11:00 PM, dated 9/20/2024. Review of the MAR (Medication Administration Report) for 10/20/24 and 10/21/24 indicated memantine had been given on 10/20/24 at 7:00 P.M. - 11:00 P.M. and on 10/21/24 from 7:00 A.M. - 11:00 A.M. Care Plan: Resident frequently spits his medication, pockets his medications in his mouth and spit his food out, Interdisciplinary Team (IDT) discussed crushing medications and resident declined Start date: 9/25/24 Approach Start Date: 9/25/24 Staff to encourage resident not to spit food/medications out or hold food in mouth. On 10/21/24 at 9:46 A.M., the Director of Nursing (DON) indicated Resident M would pocket medications and food sometimes, and an action plan had been started to make sure all residents were taking their medications when administered. At that time, she indicated no other residents had that concern. She indicated she had met with all staff administering medications on all shifts individually to go over the action plan. 3. On 10/21/24 at 9:11 A.M., Resident D's room was observed. A small pink round pill was observed on the floor under the bedside table with marking "1" on one side, and "30" on the other. At that time, Licensed Practical Nurse (LPN) 17 indicated it was a 10mg (milligram)		continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 11.20.24	

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	rosuvastatin, which Resident D took once a day at around 4:00 P.M. On 10/21/24 at 10:02 A.M., Resident D's clinical record was reviewed. Diagnosis included, but were not limited to, diabetes mellitus, anxiety, and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 8/18/24, indicated no cognitive impairment. Resident D required setup assistance with eating, and substantial to maximum assistance with showering, toileting, and transfers. Current physician orders included, but were not limited to: Crestor (rosuvastatin) 10mg once a day, at 5:00 P.M., dated 10/17/23. Resident D's Medication Administration Record (MAR) for October 2024 indicated the last time rosuvastatin was administered was at 5:00 P.M. the previous evening, 10/20/24. On 10/21/24 at 9:23 A.M., LPN 15 indicated when passing medications, staff should stay with the resident to make sure the pills were taken, and if one dropped, it should be put into the drug buster and a new pill administered. On 10/21/24 at 10:14 A.M., an action plan for medications on the floor was provided that was initiated 10/15/24. Actions to be taken from staff included, but were not limited to, asking resident to open mouth after taking medications to make sure they were swallowed, staff to offer additional water when taking medications to ensure they were swallowed, and guiding the resident's hand to mouth when taking medications.			

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	On 10/21/24 at 10:27 A.M., the DON provided a current General Dose Preparation and Medication Administration policy, dated 4/30/24, that indicated "If a medication which is not in a protective container is dropped, facility staff should discard it according to facility policy ... Observe the resident's consumption of the medication(s)" On 10/17/24 at 1:30 P.M., a Medication Storage policy, dated August, 2022 was provided by the Administrator which indicated " Temperature is maintained between 36-46 degrees Fahrenheit. Daily temperature logs must be maintained and visible. This citation relates to Complaint IN00445700. 3.1-25(m)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on interview, observation, and record review, the facility failed to ensure food was stored and prepared safely in accordance with professional standards for food service for 1 of 2 kitchen observations. Foods were not labeled correctly, food was stored uncovered, and the facility failed to dispose of outdated food. Findings include: On 10/15/24 at 9:13 A.M., the following was observed in the kitchen: Freezer in the kitchen: -- 5 undated, uncovered, and unlabeled bowls of pink ice cream -- 5 covered bowls undated and unlabeled.	F 0812	**F 812 Food Procurement, store/prepare/serve-sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • No residents were identified • Food is being stored and prepared safely in accordance with professional food standards for food service. Foods are being labeled correctly and covered for storage when applicable. Expired foods are being disposed of per policy.	11/20/2024

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	Refrigerator in the kitchen: -- clear container with cheese that had a label printed on 10/2/24 with a discard date of 10/8/24 -- applesauce with an opened date of 10/8/24 and a discard date of 10/14/24 -- clear container of lettuce undated and unlabeled -- 3 trays of fruit with several bowls uncovered on all 3 trays -- silver container with hotdogs and hamburgers undated and unlabeled -- silver container with an unknown substance that was undated and unlabeled Walk in freezer -- apple roasted pork prepared on 9/29/24 with a discard date of 10/1/24 During an interview on 10/17/24 at 11:30 A.M., the Dietary Manager indicated if there are multiple items of the same food, staff only placed a label on one time. All items should be covered and all staff is required to dispose of expired items, and she does a morning walk through to discard of expired items. On 10/17/24 at 1:34 P.M., the Administrator provided a current Food Storage policy, reviewed 5/24, that indicated, "...Leftover prepared foods...are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared, and marked to indicate the date by which the food shall be consumed or discarded...Frozen Foods...should be covered or wrapped tightly, labeled, and dated with the date the item is being placed in the freezer..." 3.1-21(i)(2) 3.1-21(i)(3)		The identified pink ice cream, cheese, applesauce, lettuce, fruit bowls, hot dogs, hamburgers and apple roasted pork were discarded. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • All residents have the potential to be affected by the alleged deficient practice. • Culinary Staff will be educated by culinary manager/designee on food storage, preparing food safely in accordance with professional food standards for food service, labeling/dating correctly, covering food for storage as well as disposing of expired foods per policy. Dietary Manager/designee observed food in the freezer, refrigerator, and walk in freezer to ensure all food items were appropriately labeled and were discarded if outdated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Culinary Manager/designee will complete AM checklist to ensure	

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			appropriate storage, labeling/dating and expired items are being disposed of timely. • Executive Director will make weekly rounds to ensure appropriate storage, labeling/dating and expired items are being disposed of timely. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • The RD/designee will be responsible for the completion of the safety/sanitation review QAPI Tools weekly x4 weeks, monthly x6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If company threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 11.20.24	