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	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK OF FRANKLIN	1435 CHRISTIAN BLVD FRANKLIN, IN 46131

(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: October 11 and 12, 2023 Facility number: 004017 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 19, 2023.	R 0000	*Submission of this plan of correction shall not constitute or be construed as an admission by Cedar Creek of Franklin, that the allegations contained in this survey report are accurate or reflect accurately the provision of service to residents of Cedar Creek of Franklin.*	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carmen Bowling	Executive Director	11/01/2023

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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	in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure monthly fire drills were conducted for 2 of 10 calendar months reviewed. Findings include: On 10/11/23 at 1:45 p.m., the Administrator provided documentation of the 2023 facility fire drills that were conducted. A review of the record indicated the during the months of February and March 2023 fire drills were not completed. During an interview on 10/11/23 at 1:40 p.m., the Administrator indicated the facility lacked supporting documentation that fire drills were conducted in February or March of 2023. Fire drills are required to be conducted on a monthly basis. On 10/12/23 at 8:20 a.m., the Administrator provided an undated copy of the Cedarhurst Senior Living Staff in-Service and Fire Safety Training Policy and Procedures document and indicated it was the current policy in use by the facility. A review of the policy indicated, "...a fire drill or in-service staff training session is required on each shift, every month...fire drill: must be conducted once per quarter on each shift..."	R 0092	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Executive Director (ED) has observed that fire drills have been conducted since April 2023 and each month thereafter with no concerns identified. No residents have been affected by this deficient practice. This facility will continue to adhere to the requirements of completing one fire drill per month ensuring each shift is completed on a quarterly basis to mitigate the potential for additional residents to be affected. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of 2023 fire drill logs was completed on 10/13/2023 by Executive Director with no additional fire drills omitted since March 2023. No residents have been affected by this deficient practice. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient**	10/13/2023

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			practice does not reoccur: The Maintenance Director was provided re-education by Executive Director on 10/16/2023 regarding fire drill regulation requirement. **4. 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 Executive Director is responsible for sustained compliance. The Executive Director/designee will audit the fire drill log monthly for 3 months. Monitoring will be ongoing. **5. By what date will the systemic changes be completed?** **Monitoring will be ongoing.**	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting			

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	work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to provide documentation for an employee's TB (tuberculosis) skin test 1 of 5 employees reviewed TB tests. (QMA 2) Finding includes: On 10/12/23 at 9:00 a.m., the employee record was reviewed for Qualified Medication Aide (QMA) 2. The record indicated a hire date of 12/30/22. The record for QMA 2 lacked documentation of any TB skin tests (a test required for healthcare workers to assess for the presence of tuberculosis; a contagious and potentially serious bacterial disease that mainly affects the lungs).	R 0121	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Employee received a first step tuberculin skin test (TST) on **10/19/2023** administered by the Director of Nursing (DON). The second step TST will be administered by the Director Of Nursing or designee on or after **10/30/2023**. **2. How the facility will identify other residents having the**	11/10/2023

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	During an interview on 10/12/23 at 10:55 a.m., the Executive Director (ED) indicated that QMA 2 lacked records for a TB skin test. On 10/12/22 at 9:15 a.m., the ED provided a copy of the Tuberculosis Policy and Procedures, dated March 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "The community will conduct TB Screening for all its employees and residents according to State regulations ...all new hires (employees and volunteers who have 10 or more hours/week of direct resident contact) need to have symptom screen and step one given and read of the two-step T.B. skin test before resident contact. Employee annual one-step tests are required ..."		**potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of employee TST's was completed on **10/17/2023** by the Executive Director to ensure all current employees have received a TST at hire and annual health screen thereafter. All residents were identified as potentially being affected during this audit. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Director of Nursing was re-educated on **10/17/2023** by the Executive Director on the need to ensure employees receive a TST at hire and if negative, a second step TST within 1-3 weeks after. **4. 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:** Effective **10/17/2023**, the Executive Director/designee will audit 5 employee tuberculin skin test records weekly x 4 weeks, then monthly for 2 months to ensure employees receive a TST at hire and an annual health screen thereafter.	

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			5. By what date will the systemic changes be completed? Monitoring will be ongoing.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure an electric dryer was in safe working condition for 1 of 5 dryers observed in the facility laundry room. Findings include: During initial tour on 10/11/23 at 9:30 a.m., observed an unlocked laundry room located in the front of the facility next to the 100 hall. The laundry room was observed to have 5 dryers. The third dryer from the door had an, undated, hand written sign loosely taped to the top with a small piece of scotch tape. The dryer was observed to be plugged in. The sign taped to the top of the	R 0148	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Every resident could have been affected by this deficient practice. A work order was placed for dryer on 9/20/2023 for Maintenance Director and was placed back in working order on 9/27/2023. **2. How the facility will identify other residents having the potential to be affected by the**	10/13/2023

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	dryer indicated "We do not want it to catch fire. We will have to remove residents. Dryer is burning items please do not use Thanks." During in interview at that time, the Maintenance Director indicated the sign was placed a few weeks ago. The dryer should have been taped shut. During an interview on 10/11/23 at 10:00 a.m., the Administrator indicated a work order had been put in for the dryer because of the napkins burning. During an interview on 10/11/23 at 12:30 p.m., the Maintenance Director indicated the dryer was checked and he had tried to replicate what had happened to the melted napkins and was unable to do so. He indicated he left the sign in place so that he could recheck the dryer for safety. He had not had the opportunity to re-evaluate, so the sign was left in place. During an interview on 10/12/23 at 9:00 a.m., the Executive Director indicated the facility lacked a policy for maintaining the facility equipment.		**same deficient practice and what corrective action will be taken:** Dryer was tested by Maintenance Director during the time frame the work order was placed to ensure the initial issue was not recurring and that the dryer was in safe, operating order. Dryer was noted to be in safe, operating order on 9/27 by Maintenance Director, work order was closed. Every resident could have been affected by this deficient practice. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** One dryer in the front laundry room has been designated for kitchen linens only. Knob on dryer has been removed to ensure the setting does not change from the delicate setting for the kitchen linens. **4. 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 Maintenance Director is responsible for sustained compliance. The Maintenance Director/designee will continue to monitor the dryer to ensure the setting remains at delicates and is	

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			being used for kitchen linens. Maintenance Director will monitor work orders to ensure no further concerns related to this dryer arise. **5. By what date will the systemic changes be completed?** Monitoring will be ongoing.	
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on observation, interview, and record review, the facility failed to ensure pets who resided in the facility had received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 3 residents who housed pets in the facility. (Resident 5, Resident 20) Findings include: On 10/11/23 at 12:30 p.m., the Administrator provided a list of Residents who housed pets in the facility. A review of the animal vaccinations indicated the following: 1. On 10/11/23 at 12:45 p.m., Resident 20's canine vaccination record was reviewed. The document titled "Rabies Vaccination Certificate" indicated the canine's rabies vaccination was expired on 10/12/22. The record lacked a current rabies vaccination certification and an annual veterinary examination of the canine.	R 0151	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Those residents that have pets residing in the facility who were identified as not having current vaccinations were informed and will receive vaccinations. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. An audit took place on 10/12/2023 of pet records to identify all pets residing in the facility that do not have up-to-date vaccinations. Those residents who have pets residing in the facility	11/10/2023

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	During an observation on 10/12/23 at 12:33 p.m., Resident 20's canine was observed asleep in his crate. During an interview at that time, Resident 20 indicated the canine was "past due" for the annual veterinarian exam and rabies shot. 2. On 10/11/23 at 12:50 p.m., Resident 5's feline vaccination record was reviewed. The document titled "Rabies Vaccination Certificate" indicated the feline's rabies vaccination had expired on 12/14/20. The record lacked a current rabies vaccination certification and an annual veterinary examination of the feline. During an observation on 10/12/23 at 12:40 p.m., Resident 5's door had a sign posted that indicated a feline was housed inside the apartment. The feline was observed walking around in the apartment. During an interview at that time, Resident 5 indicated it has been "several years" since the feline had been seen by a veterinarian and had received any rabies shots. During an interview on 10/11/23 at 1:15 p.m., the Administrator indicated the resident's pet records lacked current rabies vaccinations and the annual physical examinations as required by the facility's policy. On 10/11/23 at 1:10 p.m., the Administrator provided a copy of the Pet and Pet Therapy Visits policy, dated 7/20/18, and indicated it was the current policy in use by the facility. A review of the document indicated, "...completion of the Pet Agreement is required...specific requirements regarding pets must be followed...an annual physical examination...vaccinations from common		were informed and will receive vaccinations. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Executive Director will review pet records monthly to make sure that all new and current pets have their up-to-date vaccinations. **4. 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 Executive Director is responsible for sustained compliance. The Executive Director/designee will complete audits by reviewing the pet records list to verify vaccinations are up-to-date, weekly for 4 weeks then monthly for 1 month to ensure pets residing in the facility have current vaccinations. **5. By what date will the systemic changes be completed?** Monitoring will be ongoing.	

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	infectious agents, including rabies..." On 10/11/23 at 1:10 p.m., the Administrator provided an undated copy of the Pet Agreement Addendum policy, and indicated it was the current policy in use by the facility. A review of the document indicated, "...the Resident shall maintain, and provide evidence to the Community of current and proper immunizations and licenses of the pet, in accordance with the laws, regulations, and health customs of the city/county in which the Community is located...Resident shall provide Community with evidence that the pet has received a recent, satisfactory examination by a veterinarian..."			
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit for 1 of 5 resident apartments reviewed. (Resident 9) Finding includes: During a facility tour with the Maintenance Director on 10/12/23 from 9:55 a.m. to 10:15 a.m., Resident 9's apartment water temperatures were observed. The hot water temperature at the kitchen sink was 122 degrees Fahrenheit (F). The	R 0187	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director will check and log water temperatures and ensure temperatures are within the regulated range of 100-120 degrees in resident apartments. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and**	10/20/2023

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	hot water temperature at the bathroom sink was 122 degrees F. On 10/12/23 at 11:15 a.m., Resident 9's clinical record was reviewed. The Mini Mental State Examination (MMSE, a cognitive mental status exam), dated 8/11/23, indicated Resident 9 was mildly cognitively impaired. During an interview on 10/12/23 at 10:20 a.m., the Maintenance Director indicated the hot water temperatures were to be monitored and maintained between 100 degrees F and 120 degrees F. The hot water temperatures were to be held at a safe and comfortable temperature for the residents. During an interview on 10/12/23 at 11:15 a.m., the Administrator indicated the hot water temperatures were to be monitored and maintained between 100 degrees F and 120 degrees F. The Administrator indicated the facility lacked a specific hot water temperature policy; however, the facility was to follow the State regulations regarding the appropriate temperature parameters.		**what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. The Maintenance Director will check and log water temperatures in different hallways of facility. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** Maintenance Director was provided re-education on **10/20/2023** regarding the regulation pertaining to water temperatures. The Maintenance Director will provide the Executive Director with water temperature logs. They will review these records weekly and maintain. **4. 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 Executive Director is responsible for sustained compliance. The Executive Director/designee will complete audits by reviewing the Maintenance Director water temperature log weekly for 4 weeks, then monthly for 1 month to ensure water temperatures remain within regulated	

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			temperature of 100-120 degrees in resident apartments. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** Monitoring will be on-going.	
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 the Activity Department's refrigerator/freezer unit's temperatures were recorded and monitored as indicated by facility policy. Finding includes: During a facility tour with the Activity Director on 10/11/23 from 10:55 a.m. to 11:00 a.m., the following was observed: - The refrigerator/freezer unit, located in the activity room, was observed. Inside the freezer portion of the unit, multiple ice cream sandwiches and ice cream cups were observed. No thermometer was observed in the freezer portion of the unit. During an interview at that time, the Activity Director indicated no thermometer was kept in the freezer and no freezer temperatures were recorded. - Hanging on the outside of the refrigerator/freezer unit was a document titled "Gathering Place	R 0273	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An audit took place on 10/12/2023 of refrigerator and freezer temperature in the Activity area. Executive Director (ED) will monitor the temperature log to ensure both refrigerator and freezer temperatures are logged in the Activity area. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. Executive Director will monitor the temperature log to ensure both refrigerator and freezer temperatures are logged in	10/13/2023

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		A. BUILDING 00 B. WING	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK OF FRANKLIN	1435 CHRISTIAN BLVD FRANKLIN, IN 46131

(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
	Fridge Temperature Log Sheet...October - 2023...Refrigerator temperatures need to be between 32-40 degrees" was observed. A review of the document indicated staff were to record and initial the daily temperatures for the refrigerator portion of the unit. The document lacked recorded temperatures and staff initials for 5 of 11 days. During an interview at that time, the Activity Director indicated there were 5 days during the month of October when no temperatures had been recorded. The Activity Director indicated she was not aware that both the refrigerator and the freezer temperatures were to be recorded and monitored. On 10/11/23 at 1:45 p.m., the Administrator provided an undated copy of the Cedarhurst Senior Living Refrigerator/freezer temperatures policy and procedures document and indicated it was the current policy in use by the facility. A review of the document indicated, "...In order to ensure all perishable food stuff stays fresh and palatable, temperatures will be recorded on all refrigerators and freezers in use...each refrigeration or freezer unit located outside the main kitchen is checked daily and logged on food temperature record..." On 10/12/23 at 3:30 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...temperature measuring devices...shall have a numerical scale, printed record..."		the Activity area. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Executive Director updated the log to reflect both refrigerator temperatures and freezer temperatures as well as the acceptable range they must maintain. Executive Director re-educated all members of leadership on maintaining this log and designated members to be responsible for doing so each day. **4. 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 Executive Director is responsible for sustained compliance. The Executive Director/designee will complete audits by reviewing the refrigerator and freezer temperature log in the Activity area for 4 weeks, biweekly for 2 weeks, then monthly for 1 month to ensure temperatures are being logged for both the refrigerator and freezer in the Activity area. Monitoring will be ongoing. **5. By what date will the systemic changes be completed?** Monitoring will be ongoing.	

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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 ensure the disposition of discharged resident's medications were documented in the clinical record for 2 of 2 residents reviewed for discharge. (Resident 30 and Resident 31) Findings include: 1. On 10/12/23 at 10:00 a.m., the clinical record of Resident 30 was reviewed. Resident 30 was discharged to hospital on 8/11/23. Physicians orders, dated 4/7/23 through 8/15/23, included but were not limited to: - Aspirin (non-steroidal anti-inflammatory medication) 325 mg (milligrams) - Duloxetine DR (anti-depressant medication) 30 mg	R 0306	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Unable to correct the clinical record for residents found to have been affected by the deficient practice. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Audit of all drug disposal logs was completed on **10/18/2023**. All residents had the potential to be affected by this deficient practice.	10/18/2023

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	- Ferrous sulfate (iron supplement) 325 mg - Gabapentin (a medication that treats nerve pain) 300 mg - Memantine (a medication used to treat Alzheimer's disease) 10 mg - Acetaminophen (a medication used to treat minor aches and pains) 500 mg The clinical record lacked documentation that indicated the disposition for Resident 30's medication. 2. On 10/12/23 at 10:30 a.m., the clinical record of Resident 31 was reviewed. Resident 31 was discharged from the facility on 8/18/23. Physician orders, dated 4/7/23, included but were not limited to: - Atenolol (a medication used to treat high blood pressure) 50 mg - Citalopram (an anti-depressant medication)20 mg - Culturelle (a probiotic medication) 1 capsule - Dicyclomine (a medication used to treat intestinal spasms) 20 mg - Humira (a medication used to treat arthritis) 40mg/0.4 ml (milliliters) - Levothyroxine (a medication used to treat hypothyroidism) 137 mcg (micrograms) - Lisinopril (a medication used to treat high blood pressure) 20 mg - Magnesium oxide (a mineral supplement) 400 mg - Myrbetriq (a medication used to treat overactive bladder) 50 mg - Potassium chloride (a mineral supplement) 20 meq (milliequivalent) - Vitamin D (a vitamin supplement) 1000 u (units) - Famotidine (an antacid medication) 10 mg - Hydrocodone/acetaminophen (a opioid pain		**3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** Director Of Nursing and Executive Director implemented updated drug disposal log titled "Medication Destruction Form". Executive Director/designee will complete monthly medication disposition audits for three months in order to ensure disposal of medications are being documented according to policy. **4. 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 Executive Director is responsible for sustained compliance. The Executive Director/designee will complete audits by reviewing 7 logs weekly for 4 weeks, biweekly for 2 weeks, then monthly for 1 month to ensure drug disposal documentation is occurring consistently. **5. By what date will the systemic changes be completed?** Monitoring will be ongoing.	

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	medication) 3/325 mg - Lidocaine patch (a topical pain medication) 4 % - Loperamide (a medication used to treat diarrhea) 2 mg The clinical record lacked documentation that indicated the disposition for Resident 31's medications. During an interview on 10/12/23 at 10:30 a.m., the Administrator indicated there were no drug disposition records for Resident 30 and Resident 31. On 10/12/23 at 10:30 a.m., the Administrator provided a policy titled, Medication Disposal Policy and Procedures, dated 9/22/22, and indicated it was the current policy being used by the facility. A review of the policy indicated, "Drug Disposal, 1. Put all unused, expired over the counter and prescription medications in a plastic container with a lid or plastic sealable bag mixed with used coffee grounds obtained from the dietary department or cheap cat litter. Drug Buster or such product can also be ordered to dispose of medications." The policy lacked documentation regarding a procedure for documenting and recording the medication dispositions.			