PRINTED: 01/03/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/10/2024	
	PROVIDER OR SUPPLIE JR CROSSING	R	707 S .	ADDRESS, CITY, STATE, ZIP COD JACKSON PARK DR OUR, IN 47274	
(X4) ID PREFIX TAG F 0000	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0554 SS=D Bldg. 00	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for the Investigation of Complaints IN00446263 and IN00448885. Complaint IN00446263- No deficiencies related to the allegations are cited. Complaint IN00448885- No deficiencies related to the allegations are cited. Unrelated deficiency cited. Survey date: December 10, 2024 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 3 Medicaid: 58 Other: 12 Total: 73 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 13, 2024. 483.10(c)(7) Resident Self-Admin Meds-Clinically Approp		F 0000	This Plan of Correction constitutes the facility's writ allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admissi of or agreement with the deficiencies or conclusions contained in the Department inspection report. We respectfully request a desk reand ask that your office accepplan as our facility's compliant (Please review the attachmen provided with this plan of correction, which include audi re-education tools which will be provided to you by 1/1/25.) Plefeel free to contact Jay Myers Executive Director, should you need any additional information support the desk review at 812-522-2416. Thank you for consideration.	on "s view of the ce. ts t and ee ease , u on to
		ion, interview, and record	F 0554	F554	01/01/2025
LABORATOI	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATURE	TITLE	(X6) DATE

Heather Castetter DNS 12/27/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
155377		B. W	B. WING		12/10/2024		
en en r			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIE	K		707 S J	JACKSON PARK DR		
SEYMOUR CROSSING				SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	_	failed to ensure a resident was			The facility does ensure a		
		e prior to medication being left			resident was clinically		
	unattended at bedside for a resident to self-administer for 1 of 3 residents reviewed for				appropriate prior to		
					medications being left		
	self-medication add	ministration. (Resident C)			unattended at bedside for a		
	Findings include: During an observation and interview on				resident to self-administer.		
				1) What corrective a		ill	
					be accomplished for those		
					residents found to have bee	en	
	12/10/2024 at 8:48	A.M., Resident C was in her			affected by the deficient pra	ectic	
	wheelchair with her bedside table in front of her. A medicine cup filled with various colored pills sat				e?		
					Resident C received all		
	on the table to her left and two separate medicine				medications according to		
	bottles with liquid drop medications laid on the				physician orders, resident is	not	
	bed in front of her. The resident indicated that she				assessed to self-administer		
	was in the restroom when the nurse brought her				medications		
	medications, so they were left on the table for her to take. She doesn't typically administer them herself, but sometimes she does. No staff were in the resident's room or within sight of the resident. During an interview on 12/10/2024 at 10:34 A.M., Qualified Medication Aide (QMA) 2 indicated on Resident C's unit there was a confused resident that wandered the hallway on a regular basis. During an interview on 12/10/24 at 12:04 P.M., Licensed Practical Nurse (LPN) 3 indicated that she was unaware of any residents that				LPN 3 educated on medication	on	
					administration, with skill valid	ation	
					completed.		
					2)		
					How other residents having		
					the potential to be affected	by t	
					he	_	
					same deficient practice will	be	
					identified and what correcti		
					action(s) will be taken.		
					All residents receiving medica	ations	
					have the potential to be affect		
					by the alleged deficient pract		
	self-administered medications, and she never left				A walk thru observation audit was		
	medications unattended at a resident's bedside.				completed on 12/10/24 & 12/		
	Staff were to stay in the resident's room until the medication was taken. During an interview on 12/10/24 at 1:50 P.M., the Director of Nursing (DON) indicated Resident C lacked a care plan and an order for self-administration prior to the medication being left at bedside on 12/10/24.				to ensure no medications we		
					at bedside for self-administra		
					The DNS or designee re-edu		
					the facility nurses on the Ger		
					Dose Preparation and Medica		
					Administration policy Complete		
					by 01/01/2025		
					3)		
					What measures will be put		
	I		ı		I TTHE INCOSULES WILL DE PUL		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/10/2024 155377 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 707 S JACKSON PARK DR SEYMOUR CROSSING SEYMOUR. IN 47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The clinical record for Resident C was reviewed into place or what systemic on 12/10/24 at 11:11 A.M.. A Quarterly Minimum changes will be made to ensur Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively intact. The that the deficient practice does resident's diagnoses included, but were not not recur? limited to, anemia, seizure disorder, anxiety, and The DNS/designee conducted depression. medication pass skills validation with all licensed staff. The clinical record for Resident C lacked an Medication administration assessment or an order to self-administer observations will be completed medications until after the observation on daily by DNS/designee per 12/10/24. physician orders. The DNS or designee in-serviced The current facility policy titled, "General Dose facility nurses on General Dose Preparation and Medication Administration" with Preparation and Medication a review date of 04/30/24 and was provided by the Administration policy. The DNS or DON on 12/10/24 at 1:50 P.M. The policy designee will check rooms daily indicated, "...Facility staff should not leave during morning GEMBA check for medications or chemicals unattended ... Observe medications left at bedside. the resident's consumption of the medication(s) ..." How the corrective action(s) will be monitored to ensure the 3.1-11(a) deficient practice will not recur , i.e. what quality assurance program will be put into place? To ensure compliance the DNS/Designee will complete the Medication Administration CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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					5) Completion Date:01/0 2025	01/	

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