STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

(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
F 0000 Bldg. 00	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.	F 0000	**This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.**We respectfully request a desk review and ask that your office accept the plan as our facility's compliance. (Please review the attachments provided with this plan of correction, which include audit and re-education tools which will be provided to you by 1/1/25.) Please feel free to contact Jay Myers, Executive Director, should you need any additional information to support the desk review at 812-522-2416. Thank you for your consideration.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record	F 0554	**F554**	01/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Castetter	DNS	12/27/2024

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	review, the facility failed to ensure a resident was clinical appropriate prior to medication being left unattended at bedside for a resident to self-administer for 1 of 3 residents reviewed for self-medication administration. (Resident C) Findings include: During an observation and interview on 12/10/2024 at 8:48 A.M., Resident C was in her wheelchair with her bedside table in front of her. A medicine cup filled with various colored pills sat on the table to her left and two separate medicine bottles with liquid drop medications laid on the bed in front of her. The resident indicated that she was in the restroom when the nurse brought her 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 self-administered medications, and she never left medications unattended at a resident's bedside. 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.		**The facility does ensure a resident was clinically appropriate prior to medications being left unattended at bedside for a resident to self-administer.** **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident C received all medications according to physician orders, resident is not assessed to self-administer medications.. LPN 3 educated on medication administration, with skill validation completed. **2)** **How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents receiving medications have the potential to be affected by the alleged deficient practice. A walk thru observation audit was completed on 12/10/24 & 12/11/24 to ensure no medications were left at bedside for self-administration. The DNS or designee re-educated the facility nurses on the General Dose Preparation and Medication Administration policy Completed by 01/01/2025 **3)** **What measures will be put**	

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	The clinical record for Resident C was reviewed on 12/10/24 at 11:11 A.M.. A Quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, seizure disorder, anxiety, and depression. The clinical record for Resident C lacked an assessment or an order to self-administer medications until after the observation on 12/10/24. The current facility policy titled, "General Dose Preparation and Medication Administration" with a review date of 04/30/24 and was provided by the DON on 12/10/24 at 1:50 P.M. The policy indicated, "...Facility staff should not leave medications or chemicals unattended ...Observe the resident's consumption of the medication(s) ..." 3.1-11(a)		**into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS/designee conducted medication pass skills validation with all licensed staff. Medication administration observations will be completed daily by DNS/designee per physician orders. The DNS or designee in-serviced facility nurses on General Dose Preparation and Medication Administration policy. The DNS or designee will check rooms daily during morning GEMBA check for medications left at bedside. **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?** 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.	

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			5) **Completion Date: 01/01/2025**	