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	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWOOD MANOR	5200 S BURLINGTON DR MUNCIE, IN 47302

(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 the Investigation of Complaint IN00344084. Complaint IN0000344084 - Substantiated. State Residential Findings related to the allegations are cited at R0241.. Survey date: March 31, 2021 Facility number: 000312 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 8, 2021.	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. With respect, we would prefer granting of desk compliance, considering immediate corrective actions taken and annual survey just completed on 4/21	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure a resident did not take another residents (Resident D) prescribed medication for 1 of 3 residents reviewed. (Resident B) This deficient practice resulted in Resident B taking his roommates prescribed medication and then having to go to the hospital for medication overdose. Findings include:	R 0241	·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No other residents were affected by this deficient practice. All other residents had the potential to be affected. The resident affected was	04/23/2021

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

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.

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	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWOOD MANOR	5200 S BURLINGTON DR MUNCIE, IN 47302

(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
	A. Resident B's clinical record was reviewed on 3/31/21 at 10:25 a.m. The resident's diagnoses included, but were not limited to, a history of traumatic brain injury, depression, and epileptic seizures. The resident had a 12/15/20, "Nurse's Note" which indicated the resident took his roommate's pills from the table, took them and was sent to the emergency room. The resident had a 12/15/21, "Change of Condition Form" which indicated the resident had taken the following medications in error: Benztropine 1 mg (an anti-tremor medication), Clozapine 500 mg (an antipsychotic medication), Singular 10 mg (a medication to treat asthma and/or allergies), and Zocar 20 mg (a medication to treat high cholesterol). The resident had a 12/21/20, hospital "Impatient Discharge Summary" which indicated he received treatment in the hospital due to an accidental overdose, COVID-19 virus pneumonia, and sepsis due to pneumonia. B. The clinical record for Resident D was reviewed on 3/31/21 at 11:10 a.m. The clinical record lacked an order for self administration. During a 3/31/21, 1:15 p.m., interview, the Director of Nursing (DON) indicated during the 12/15/20, accidental overdose event Resident B had grabbed his roommate's medications from the roommate's table and had taken the medications. She indicated, she and the roommate had been right there and could not stop him. She additionally indicated, both the DON and roommate had called out for him not to consume		immediately transferred and treated. - 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; No other residents were affected, however all residents had the potential to be affected. All nursing staff were in-serviced to reinforce our policy on medication administration protocol. - What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; No resident has a physician's order to self-administer medications, other than injections such as BS checks and insulin. Nursing has been in-serviced as to our and regulatory policy on appropriate supervision/administration. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; Monitoring by the DON or designee shall occur weekly for 4 weeks, then monthly until 100%	

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	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWOOD MANOR	5200 S BURLINGTON DR MUNCIE, IN 47302

(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
	the medication and the resident didn't listen and took the pills. Resident B had just returned from the hospital that day after being treated for COVID-19 and he was not acting like his normal self. Resident B's roommate did not have an order for his medication to be left at bedside and/or an order for self-administration. Review of a current 1/11, facility policy titled "Policy and Procedure Administration & Self Administration of Medication", which was provided by the administrator in 3/31/21 at 12:43 p.m., indicated the following: "Facility staff will obtain Physician's orders for all residents for 'self administration of meds' ... All staff will be trained in observation and monitoring of self-administration of medication and administrating medication daily. ... Staff will observe and monitor proper usage..." This residential tag relates to complaint IN00344084.		compliance has been achieved for 3 months. In addition, Nursing in-services shall contain appropriate medication administration protocols at least twice yearly. - By what date the systemic changes will be completed 4/23/21	