STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: June 26, 27, 28, 29, 30, and July 3, 2023 Facility number: 004075 Provider number: 155734 AIM number: 200491220 Census Bed Type: SNF/NF: 15 SNF: 29 Residential: 14 Total: 58 Census Payor Type: Medicare: 6 Medicaid: 26 Other: 12 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 11, 2023.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

Stephanie Miller | Executive Director | 07/23/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the physician was notified of residents change in condition for 2 of 16 residents reviewed for physician notification. (Residents 32 and 35) Findings include: 1. The record for Resident 32 was reviewed on 6/27/23 at 9:26 a.m. The diagnoses included, but were not limited to, essential hypertension and hyperlipidemia. The Quarterly MDS (Minimum Data Set) assessment, dated 5/28/23, indicated the resident was cognitively intact. The care plan, initiated on 2/23/23 and last revised on 6/5/23, indicated the resident had a potential for cardiovascular distress related to a diagnosis of hypertension. The interventions included, but were not limited to, provide medications as ordered, observe for and report side effects as needed, observe for signs/ symptoms of cardiovascular distress and report as needed, and obtain vital signs as ordered and needed. The nurse's note, dated 5/2/23 at 5:00 p.m., indicated the resident was sitting up in the dining room and stated, "Can you check my blood pressure, I feel dizzy." His blood pressure at the time was 77/47 mmHg (millimeters of mercury) and his pulse was 80 bpm (beats per minute). At 5:12 p.m., he continued sitting up in the dining room, his blood pressure was 99/59 mmHg and his pulse was 76 mmHg. At 5:14 p.m., the resident was assisted back to his room by a nursing assistant,	F 0580	**The submission of this plan of correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Thornton Terrace Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.** Corrections to be completed by 7/21/23 **Tag: MD notification for out of range vitals F580** 1. Residents 35 and 32 were affected by this alleged deficient practice. MD was notified on 35 and resident 32 for out of range	07/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	and he was sitting in his recliner. The clinical record lacked documentation of any notification to the physician of the resident having an episode of low blood pressure with dizziness on 5/2/23. The nurse's note, dated 5/4/23 at 11:21 a.m., indicated new orders for the resident's blood pressure parameters were received from the NP (Nurse Practitioner). The physician's orders, dated 5/4/23, indicated parameters were added to the resident's atenolol 50 mg (milligrams) once daily and his lisinopril 5 mg once daily to hold the medications for a systolic blood pressure (the top number of a blood pressure/heart at work) of less than 100, or a pulse of less than 60. The parameters did not indicate any diastolic (bottom number/heart at rest) parameters. The nurse's note, dated 5/11/23 at 8:06 p.m., indicated the resident complained of blurry vision after his evening meal. Staff checked his blood pressure at 5:20 p.m. and it was 83/44 mmHg. They offered him a full glass of water and he drank it. They advised him to stay seated until they rechecked his blood pressure. His blood pressure was rechecked at 5:45 p.m. and was 95/58 mmHg. The resident was assisted to his room and sat in his recliner. He was offered another large glass of water, and was up walking in his room at the time. The clinical record lacked documentation of any notification to the physician of the resident having an episode of low blood pressure with blurry vision on 5/11/23. The nurse's note, dated 6/17/23 at 7:17 p.m.,		vitals 2. All resident have the potential to be effected by this alleged deficiency. Residents audited for MD notification with out of range vitals with no further findings. Nurses educated on MD notification policy 3. As a measure of ongoing compliance, DHS or designee with review to ensure MD notification for out of range vital signs as warranted during clinical care meeting. Audits will be as follows; 5xs weekly x4 weeks, 3xs weekly x4 weeks and then once weekly x4 months. 4. Findings and corrective action will be reviewed and updated as warranted by the QAPI committee. The results of these audits will be reviewed by QA committee overseen by the Executive Director if a threshold of 100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	indicated the resident reported feeling queasy after his evening meal. His blood pressure was checked an was 69/41 mmHg at 5:05 p.m. One glass of water was offered, which the resident drank. Staff monitored the resident. At 5:30 p.m., the resident was assisted back to his room. His blood pressure was rechecked and was 89/53 mmHg. The resident stated he felt a little bit better and was offered another large glass of water, which he consumed. His recheck at 7:15 p.m. was 101/61mmHg. The resident indicated he felt fine, and was just sleepy. Staff would continue to monitor. The clinical record lacked documentation of any notification to the physician of the resident having an episode of low blood pressure with complaints of feeling queasy on 6/17/23. The nurse's note, dated 6/19/23 at 1:43 p.m., indicated the physician was notified of the resident's hypotensive event. There were no new orders at the time. During an interview on 6/30/23 at 11:14 a.m., LPN (Licensed Practical Nurse) 9 indicated she would notify the physician of any blood pressures below 100 for systolic or 60 for diastolic. If the resident had symptoms like dizziness or feeling lightheaded she would notify the physician. She would notify the physician as soon as the resident presented with symptoms after she assessed the resident. During an interview on 6/30/23 at 1:40 p.m., LPN 8 indicated in the evening time, usually around supper was when the resident would say he was not feeling very good, and staff would check his blood pressure and it would be low. The physician should be notified anytime it was that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	low. She would notify any time the resident's blood pressure was below the parameters to where staff needed to hold the medication. He did not have parameters to notify for diastolic pressure, but she would notify the physician of a diastolic pressure of less than 50. She would notify any time the resident had a change in the symptoms, such as feeling queasy or dizzy with low blood pressures. The physician should have been contacted on the resident's blood pressure on 5/2/23 and 5/11/23, but she could not locate any documentation of notification to the physician on either of the incidents. They had not done any laboratory testing. The notes sounded like they were giving fluids because they thought he could be dehydrated. Low blood pressure could occur if a resident was dehydrated. There was an order to check his blood pressure in the evenings. Staff were supposed to notify the physician of any out of range results. During an interview on 7/3/23 at 9:56 a.m., the DON (Director of Nursing) indicated she would have expected the physician to be notified on 6/17/23 when the resident had the low blood pressure and queasiness. She would expect the doctor to be notified of anything below 90 and symptomatic, depending on their parameters. The review of all documentation from clinical record provided by the facility, on 7/3/23 at 10:50 a.m., lacked documentation of any parameters for diastolic pressure, any parameters for physician notification, any notification to the physician of the resident's blood pressures and change of conditions on 5/2/23 (until the following day), on 5/11/23, and on 6/17/23 (until two days later by LPN 8 on 6/19/23). During an interview on 7/3/23 at 11:24 a.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	Resident 32's physician indicated he expected to be notified of any clinical change or any blood pressure associated with symptoms or a change. If the concern was somewhat pressing staff were free to text and they texted him all the time. He would expect to be notified pretty promptly. He could not locate any documentation of being notified. During an interview on 7/3/23 at 11:35 a.m., the Executive Director (ED) indicated nurses were to make the documentation of physician notification. 2. The clinical record for Resident 8 was reviewed on 6/27/23 at 12:45 p.m. The diagnoses included, but were not limited to, type 2 Diabetes Mellitus with hypoglycemia without coma, hypocalcemia and hypokalemia. The care plan, initiated on 9/2/20 and last revised on 6/1/23, indicated the resident was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The interventions included, but were not limited to, laboratory testing per physician's order and observe the resident for symptoms of hypoglycemia such as sweating, cold, clammy skin, numbness of the fingers, toes, mouth, rapid heartbeat, tremors, and dizziness. The nurse's note, dated 4/18/23 at 2:54 p.m., indicated the CNA (Certified Nurse Aide) called the nurse to the resident's room. The resident was convulsing. Her skin was red, cool, and clammy. The resident was alert and attempting to communicate with staff. Her blood sugar was 60 mg/dl (milligrams per deciliter). The resident stopped convulsing and was able to drink orange juice. After a few moments the resident able to communicate with this nurse and told her she felt awful. Her blood sugar was obtained again and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	was 66 mm/dl. The resident was taken to the common area and given snack and fluids. Her blood sugar was obtained again at 99 mg/dl. The physician was notified and gave new orders to discontinue the resident basaglar insulin and to check her hgb (hemoglobin) A1C. The nurse's note, dated 5/9/23 at 3:16 p.m., indicated the resident was presenting with seizure like activity. Her face was flushed, and she was very diaphoretic. Her blood sugar was 76 mg/dl. The incident lasted about 2 to 3 minutes. The record lacked documentation of the physician being notified at the time of the occurrence on 5/9/23. During an interview on 6/30/23 at 11:05 a.m., LPN 9 indicated on 5/9/23 the resident had jerking movements, she wasn't responding, she was twitching and jerking. Her whole body was twitching and jerking. It lasted 2 to 3 minutes from the time she was notified. She checked her sugar and they laid her down because she was in her wheelchair at the time. By the time they got her laid down the jerking had subsided. They always make the doctor aware of anything that was different. She would have typed it up in the system and she would have called the office or made him aware when he came in to the facility, but this was an incident and she would have made a call to the physician. If he gave orders she would have charted it. She could not recall any conversation with the physician. The physician notification should be located in the progress notes. The notification on the event was for the initial event on 4/18/23. During an interview on 6/30/23 at 1:33 p.m., LPN 8 indicated on 4/18/23 the resident had been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	convulsing, like with a seizure, but she was still alert. They were able to get her to come back around and get some juice and snack into her, and then when they notified the doctor they did change her insulin. If she had another incident of convulsions, she would notify the doctor. She reviewed the record and indicated she did not see any notification to the physician of the incident on 5/9/23. It would be in the progress notes. It was something the physician should have been notified of. During an interview on 7/3/23 at 9:50 a.m., the DON indicated the resident had some low blood sugars with seizure like activity. They were working on getting staff to put the documentation of physician notification in the nurse's notes. The physician should have been notified at the time of the occurrence. If the resident was having seizure like activity, she would expect the physician to be notified as soon as the resident was stabilized. The review of all documentation from the clinical record provided by the facility, on 7/3/23 at 10:47 a.m., lacked documentation of any notification to the physician of the resident having seizure-like activity with low blood sugar levels on 5/9/23. The Provider Notification Guidelines policy and procedure, last reviewed 12/31/22, provided on 6/29/23 at 2:10 p.m. by the Clinical Nurse, included but was not limited to, " ... Procedures 1. Resident assessments for change in condition ... should be completed in a timely manner ... 2. The provider should be notified of critical lab results or an immediate need by phone as soon as the results are known with a response received before the call is completed when possible. If the provider must be paged a call back is expected within 15 minutes to one hour depending on severity of the concern.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	If unable to reach the primary provider, the campus Medical Director will be notified ... 6. During non-office hour times the nurse should notify the physician/provider by phone or abnormal lab results or the need for physician/provider intervention ... 11. Attempts to notify the physician/provider and their response should be documented in the resident electronic health record ..." 3.1-5(a)(2) 3.1-5(a)(3)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure residents received the appropriate perineal care related to infection control guide lines to prevent urinary tract infections for 3 of 6 residents reviewed for bowel and bladder. (Residents 3, 18, and 29) Findings include: 1. During an observation of incontinence and catheter care for Resident 3 on 6/29/23 at 9:45 a.m., CNAs (Certified Nurse Aides) 5 and 6 had the washcloths and towels set up on the bedside table. They performed hand hygiene and applied gloves. The labial area and catheter tubing were cleaned by CNA 5 and the resident was rolled onto her left side. The catheter bag was lifted above the level of the bladder and held there as CNA 5 was able to take it and place it on the left side of the bed. CNA 6 performed hand hygiene and applied gloves. CNA 6 used a folded washcloth, using a four-corner method with no rinse soap applied to each corner. CNA 6 cleaned the left buttock with 13 swipes of the same area of the washcloth corner. She folded the corner over and with 31 swipes of the same area of the washcloth, she cleaned the right buttock. She folded down the corner of the washcloth and cleaned the rectal area. The last corner was used to clean the rectal area, using a front to back	F 0690	**Tag: Incontinence care/Cath Care F690** 1. Residents 18, 19 and 3 were affected by this alleged deficient practice. Immediate interventions of proper peri care procedure in place for resident's 18, 29 and 3 and skilled staff members identified immediately educated. 2. All like residents have the potential to be affected by this alleged deficiency. Incontinent residents audited with no further findings. CNA/QMA/Nurses educated on incontinence care and catheter care. 3. As a measure of ongoing compliance staff will be observed providing incontinence care and/or catheter care by DHS/designee on 3 residents 2xs weekly for 2 months, then 2 residents 2xs monthly for 4 months. 4. Findings and corrective action will be reviewed and updated as warranted by the QAPI committee. The results of these audits will be reviewed by QA committee overseen by the	07/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	swipe. A clean washcloth was obtained and with 14 swipes of the same area of the washcloth, she cleaned the left buttock. She folded the corner down and with 14 swipes of the same area of the washcloth, she cleaned the right buttock. She folded the washcloth and with 10 swipes of the same area of the washcloth, she cleaned the anal area. She folded the washcloth and with 8 swipes of the same area of the washcloth she cleaned the anal area again. The resident was dried and rolled onto her back. The catheter bag was lifted above the bladder and was held above the resident until CNA 6 could place it back onto the right side of the bed. Urine was observed backflowing toward the urethra. During an interview on 6/29/23 at 10:55 a.m., CNA 6 indicated she used the four-corner method to perform incontinence care. She would clean from front to back and would not use the same area of the washcloth to clean an area. The record for Resident 3 was reviewed on 6/29/23 at 1:50 p.m. The diagnoses included, but were not limited to, acute kidney failure, type 2 Diabetes Mellitus with diabetic chronic kidney disease, and neurogenic bladder. The Annual MDS (Minimum Data Set) assessment, dated 4/6/23, indicated the resident was cognitively intact. She required extensive assistance of 2 staff for toileting. The care plan, dated 8/23/19 and last revised on 4/7/23, indicated the resident used a Foley catheter for the diagnoses of urinary retention, neurogenic bladder, and obstruction. The interventions, dated 8/23/19, included, but were not limited to, observe for any signs of complication such as UTI (urinary tract infection),		Executive Director if a threshold of 100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	urethral trauma, strictures, bladder calculi or silent hydronephrosis and to notify the doctor, observe the tubing and avoid any obstructions, provide assist with catheter care, and change the Foley catheter per physician orders. The nurse's note, dated 1/18/23 at 8:53 a.m., indicated new orders for Doxycycline 100 mg for 7 days for a UTI. 2. During an observation on 6/29/23 at 12:47 p.m., CNAs 1 and 2 performed incontinence care for Resident 18. They performed hand hygiene and applied gloves and used wipes to clean the resident. The labial area was cleaned per policy. The resident was rolled onto her right side and CNA 2 obtained a wipe and using a circular motion she cleaned the right buttock toward the vaginal area with two passes with the same area of the wipe. She obtained another wipe and using a circular motion she cleaned toward the vaginal area with two more passes of the same area of the wipe. She dried the resident with a dry washcloth in the same manner. During an interview on 6/29/23 at 1:03 p.m., CNA 2 indicated when performing incontinence care she would clean the resident with wipes, folding between swipes or use it once, front to back. The record for Resident 18 was reviewed on 6/29/23 at 2:15 p.m. The diagnoses included, but were not limited to, dementia, immobility syndrome (paraplegic), muscle weakness (generalized), and unsteadiness on feet. The Quarterly MDS assessment, dated 4/2/23, indicated the resident was moderately cognitively impaired. She required extensive assistance of two staff for toileting.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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 physician's order, dated 8/25/22, indicated may dip urine with signs or symptoms of a UTI, then may send for culture and sensitivity if positive for leukocytes.

The care plan, dated 9/13/22, indicated the resident experiences episodes of incontinence related to impaired cognition, impaired mobility, medications, and IBS (irritable bowel syndrome). The interventions, dated 9/13/22, included, but were not limited to, observe for signs and symptoms of a UTI and notify the physician as needed, provide incontinence care as needed

3. During an observation on 6/30/23 at 9:56 a.m., Resident 29 received incontinence care by CNAs 3 and 4. They performed hand hygiene and applied gloves. CNA 3 lowered the bed with her gloved hands, then performed incontinence care of the labial area, front to back. CNA 4 swiped 3 times the left and right creases in a back to front direction. No drying was observed. The resident was rolled onto her left side. CNA 3 obtained a wipe and swiped 2 times from back to front to the vaginal area from the left buttock. She obtained a new wipe and again swiped back to front from the left buttock. She obtained another wipe and swiped the anal area 5 times with the same area of the wipe from back to front. She obtained a wipe and swiped the coccyx area two times with the same area of the wipe. No drying was observed. Cream was applied to the coccyx and the brief was fastened.

During an interview on 6/30/23 at 10:05 a.m., CNA 3 indicated she should wipe the creases and between, using different wipes or a different side to the wipe. She was unsure if the area should be dried, but indicated they would be given time to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	air dry. They would pat dry the area if they used a washcloth during care. She would swipe from front to back during care. The record for Resident 29 was reviewed on 6/30/23. The diagnoses included, but were not limited to, dementia with behavioral disturbance, falls, contractures of the left hand and forearm, contractures of the right hand and forearm, difficulty in walking, and hospice care. The physician's order, dated 4/15/21, indicated may dip urine for signs or symptoms of a UTI, then may send the urine for a culture and sensitivity if positive for leukocytes. The Admission MDS assessment, dated 4/22/21, indicated the resident was severely cognitively impaired. The resident required extensive assistance of 2 staff with toileting. The care plan, dated 4/29/21 and last revised on 4/25/23, indicated the resident experienced episodes of incontinence related to dementia, medication, and weakness. The interventions, dated 4/29/21, included, but were not limited to, observe for signs and symptoms of a UTI, and provide incontinence care as needed. The physician's order, dated 2/6/23, indicated to administer Macrobid 100 mg twice daily for 7 days for a UTI. The urinalysis, dated 2/15/23, indicated the urine was dark yellow and turbid. There was a trace of leukocytes and two plus bacteria. The nurse's note, dated 2/16/23 at 11:14 a.m., indicated the urine culture was pending. The physician was aware of the final UA results. A			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	new order for Bactrim DS 800/160 mg twice a day for 5 days unless the culture results indicated this ABT would not be effective. The nurse's note, dated 2/17/23 at 8:43 a.m., indicated the ABT was administered per order with no ASE. The final urine culture was received and indicated <10,000 CFU/ML mixed flora isolated. The physician was notified with orders to continue the current ABT treatment. The nurse's note, dated 2/22/23 at 9:49 a.m., indicated the ABT was complete. Urine was to be obtained and sent to lab for follow up on 2/24/23. During an interview on 6/30/23 at 12:37 p.m., the DON (Director of Nursing) indicated her expectations were for staff to provide incontinence care using a front to back method. They could use either a wipe or a washcloth with the four-corner method. They could obtain a wipe for each swipe, instead of folding. During an interview on 7/3/23 at 9:48 a.m., the DON indicated staff shouldn't hold the catheter bag above the bladder. Instead they should set it on the bed to prevent urine backflow. The Perineal Care for Incontinence policy, last revised on 11/9/17, was provided by the Clinical Nurse on 6/30/23 at 12:43 p.m. The policy included, but was not limited to, " ... 7. Pay particular attention to infection prevention and control techniques when performing pericare, to prevent introduction of contamination that may lead to a urinary tract infection ..." The Urinary Catheter Care policy, last revised on 5/11/16, was provided by the Clinical Nurse on 6/30/23 at 12:43 p.m. The policy included, but was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	not limited to, " ... 4. The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder ... 20 ... g. Remove gloves and discard into the designated container. Wash and dry your hands thoroughly ... l ... Use one area of the wipe or washcloth for each downward, cleansing stroke. Change the position of the wipe or washcloth with each downward stroke. Next, change the wipe or washcloth to drag on the resident's skin or bed linen ..." 3.1-41(a)(2)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were appropriately labeled and discarded within appropriate time frames in 3 of 3 medication carts observed for medication storage. (200 Front Hall cart, 200 Back Hall cart, and the Memory Care unit cart) Findings include: 1. During an observation on 6/30/23 at 8:49 a.m. ,of the 200 Hall Medication Cart with LPN (Licensed Practical Nurse) 9, the following concerns were observed: a. Resident 197's albuterol pro-air HFA (hydrofluoroalkane inhaler) was stored lying down in its side in the box. The side label of the medication indicated to store with the mouthpiece down. The clinical record for Resident 197 was reviewed on 6/30/23 at 1:00 p.m. The diagnoses included, but were not limited to COPD (chronic obstructive pulmonary disease) with acute exacerbation, acute respiratory failure with hypercapnia, and acute bronchitis. The physician's order, dated 6/9/23, indicated the resident received albuterol sulfate HFA aerosol inhaler 90 mcg/act (micrograms per actuation) 2 inhalations every 6 hours as needed. b. Resident 198's albuterol HFA inhaler was lying in its side in the top drawer of the medication cart.	F 0761	**Tag: Med Storage F761** 1. No residents were effected by this alleged deficient practice. Identified items were immediately discarded and inhalers stored upright. 2. All residents have the potential to be affected by this alleged deficiency. Medication carts audited by DHS/ADHS with no further findings. Nurse/QMA educated on labeling, discarding expired medications, proper storage of inhalers and medication storage policy. 3. As a measure of ongoing compliance, medication carts will be audited to ensure proper labeling and storage of medications by DHS/designee, 2xs weekly for 2 months, then 2xs monthly for 4 months. 4. Findings and corrective action will be reviewed and updated as warranted by the QAPI committee. The results of these audits will be reviewed by QA committee overseen by the Executive Director if a threshold of 100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining substantial compliance.	07/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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 clinical record for Resident 198 was reviewed on 6/30/23 at 1:05 p.m. The diagnoses included, but were not limited to, obstructive sleep apnea, dependence on supplemental oxygen, and congestive heart failure. The physician's order, dated 6/21/23, indicated the resident received albuterol sulfate HFA aerosol inhaler 90 mcg/act (micrograms per actuation) 2 inhalations every 6 hours as needed. During an interview on 6/30/23 at 8:51 a.m., LPN 9 indicated she was not aware of the inhaler needing to be stored mouthpiece down. 2. During an observation on 6/30/23 at 9:08 a.m., of the 200 Hall Front Medication Cart with QMA (Qualified Medication Aide) 10, the following concerns were observed: There was a opened foil package of Xiidra eye drop vials, containing 2 vials of the medication in the top drawer of the medication cart. There was no pharmacy labeling or resident information on the packet and it was not with the original container. QMA 10 indicated the eye drops belonged to Resident 31. It had a label she thought, but she could not locate it. There was an opened vial of lidocaine injection 1% solution in the top drawer of the cart belonging to Resident 31. The rubber stopper of the medication had several puncture marks in it. The vial indicated to discard the medication after being opened for 28 days. QMA 10 indicated the medication was supposed to be taken out when the order was completed, and it was completed on 6/26/23. The physician's order, dated 3/28/23, indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	resident received Xiidra 5% 1 drop to each eye twice daily for glaucoma. The physician's order, dated 6/16/23 and ending on 6/26/23, indicated the resident received ertapenem 1 gram solution to be reconstituted with 1% lidocaine and injected intramuscularly once daily. 3. During an observation on 6/30/23 at 9:33 a.m., of the Memory Care Unit medication cart with LPN 8, Resident 8's Levemir flex pen was located in the top drawer of the medication cart. The medication cap indicated it was opened on 5/21/23 and was to be discarded on 6/18/23. During an interview on 6/30/23 at 9:35 a.m., LPN 8 indicated she did not have another insulin pen in the cart. The resident's last dose was on 6/29/23. The clinical record for Resident 8 was reviewed on 6/30/23 at 1:15 p.m. The diagnosis included, but was not limited to, diabetes mellitus type 2. The physician's order, dated 5/11/23, indicated the resident received Levemir flex pen 100 unit/mL (units per milliliter) 5 units once daily. During an interview on 7/3/23 at 10:09 a.m., the DON (Director of Nursing) indicated staff were usually pretty good about putting the inhalers upright. The nurse had them in plastic cups to keep them sitting upright and she didn't know what happened. She thought the nurse opened the new insulin pen, got sidetracked or distracted, and put the cap from the old insulin on the new insulin. They usually would mark the eye drops with the date opened, and normally they still had them with their bag with the labeling. Normally the foil package would be marked with the date			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	opened and they would be kept in the box with the labeling on them. The Medication Ordering and Receiving from Pharmacy policy, last revised 11/18, provided on 6/30/23 at 11:13 a.m. by the Clinical Nurse, included, but was not limited to, " ... Procedures A. Labels are permanently affixed to the outside of the prescription container ... If a label does not fit directly onto the product, e.g., eye drops, the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container ... B. Each prescription medication label includes: 1) Resident's name. 2. Specific directions for use, including route of administration. 3) Medication Name ... 4. Strength of medication ... 5) Prescriber's name. 6.) Date dispensed. 7) Quantity of medication. 8) Beyond use (or expiration) date of medication. 9) Name, address, and telephone number of dispensing pharmacy ... 11) Prescription number. 12. Accessory labels indicating storage requirements and special procedures ..." The Medication Storage in the Facility policy, last revised 11/18, provided on 6/30/23 at 11:13 a.m. by the Clinical Nurse, included, but was not limited to, " ... Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier ... Procedures ... C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label ... H. Outdated, contaminated, or deteriorated medications ... are immediately removed from inventory, disposed of according to procedures for medication disposal ..." 3.1-25(k)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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
	3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7) 3.1-25(o)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: June 26, 27, 28, 29, 30, and July 3, 2023 Facility number: 004075 Residential Census: 14 Thornton Terrace Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review competed on July 11, 2023.	R 0000		