PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			ETED
			B. W	B. WING			2022
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			OUBLEDAY DRIVE		
MICKSH	IRE FORT HARRIS	SON			APOLIS, IN 46216		
_		-			, a deld, ii 402 id	,	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
			R 0	000	04/23/2022		
		a State Residential Licensure			ISDH		
	_	included the Investigation of			ATT: Brenda Buroker		
	Complaints IN003	64234 and IN00374615.			Director of Division Long Term	1	
	G 11 - B1000	4224 6 1 4 4 4 5 5			Care		
	_	4234 - Substantiated. State			2 North Meridian Street		
	Kesidential Finding	gs are cited at R117.			Indianapolis, Indiana 46204		
	C 1 : 4 D 10027	24615 0 1 4 4 4 1 04 4			Day Ammural Cumray		
	_	4615 - Substantiated. State			Re: Annual Survey Wickshire Fort Harrison		
	Residential Finding	gs are cited at R117 and R240.			8025 Doubleday drive		
	Survey dates: Apri	1.7 and 9. 2022			Indianapolis, IN 46216		
	Survey dates. Apri	1 7, and 8, 2022			Dear Ms. Buroker,		
	Facility number: 0	1/100			On April 8, 2022, a State		
	racinty number.	1410)			Residential Licensure with a		
	Residential Census	· 39			Complaints (IN00364234,		
	Residential Census	. 37			IN00374615) and Annual Surv	ev.	
	These State Reside	ential Findings are cited in			was conducted at the above	-,	
	accordance with 41	_			referenced facility by the Divis	ion	
					of Long-Term Care. Please fin		
	Quality review con	npleted on April 12, 2022			the Statement of Deficiencies		
	` •				our facilities Plan of Correction		
					for the alleged deficiency.		
					Please consider this letter and		
					Plan of Correction to be the		
					facility's credible allegation of		
					compliance.		
					We respectfully request a desl	<	
					review that the facility has		
					achieved substantial complian		
					with the applicable requiremen		
					as of the date set forth in the F	Plan	
					of Correction of May 02,2022		
					Please feel free to call me with	•	
					any further questions at 1 (317	')	
					-546-2846.		
					Respectfully submitted,		
					I .		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		04/08/	_{/2022}
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\ \ #\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DE EODT !!! DD!O	0.11			OUBLEDAY DRIVE		
WICKSHI	IRE FORT HARRIS	ON		INDIAN	IAPOLIS, IN 46216		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Romeo Behl (Executive Direct	or)	
					Wickshire Fort Harrison		
					8025 Doubleday drive		
R 0091	410 IAC 16.2-5-1.3	,					
	Administration and	l Management -					
Bldg. 00	Noncompliance						
		ll establish and implement					
		anual to ensure that					
		facility objectives are					
	attained, to include						
	(1) The range of s						
	(2) Residents' righ						
	(3) Personnel adm						
	(4) Facility operation						
		be made available to					
	residents upon red	quest.	D 0	001	D0004 Administration and		05/02/2022
	Događan aksamistic	on, interview, and record	R 0	J91	R0091 Administration and		05/02/2022
		failed to implement the			management The facility requests paper		
	-	es Policy by not timely			compliance for this citation.	Thie	
		munity narcotics count form			Plan of Correction is the	1113	
		affect 39 of 39 residents			center's credible allegation o	ıf	
	residing at the facili				compliance.	•	
	residing at the facili	.,			Preparation and/or execution	of	
	Findings include:				this plan of correction does r		
	8				constitute admission or		
	On 4/7/22 at 3:09 p.	m., the facility medication			agreement by the provider of	F	
	•	vith QMA (Qualified			the truth of the facts alleged		
		The narcotic count binder			conclusions set forth in the		
	· ·	led Substance Community			statement of deficiencies. The	1е	
		rm, which instructed that the			plan of correction is prepared	d	
	signatures of the one	coming and off going			and/or executed solely becau	ıse	
	individuals would si	gn the form at each shift			it is required by the provisior	าร	
	change. The form c	ontained no signatures for			of federal and state law.		
	the following days:	4/3/22 and 4/6/22.					
					1) Immediate actions taken	for	
	The form contained	the signature of 1 QMA on			those residents identified:		
		4/52/22 at 6:00 a.m. and			Count verified and narcotic she		
	6:00 p.m., and 4/7/2	2 at 6:00 a.m. and 6:00 p.m.			corrected by RDCO on 4/7/22.		

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PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2022
	PROVIDER OR SUPPLIEF		8025 D	ADDRESS, CITY, STATE, ZIP CODE OUBLEDAY DRIVE NAPOLIS, IN 46216	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	2 indicated that she the medication cart her shift. She did n was not 6:00 p.m. During an interview RNC (Regional Nu the form should be time the medication the outgoing and or On 4/8/22 at 8:50 a Controlled Substant 11/01/2019, which handling, storage, do controlled substance regulatory standard shift the authorized duty will count the the authorized assorbuty. 6. The counts forms listed above and sign the form vecorrect"	c.m., the RNC provided the ces Policy, effective read "to ensure the special disposal, and record keeping of es according to applicable5. Prior to the end of each associate that is reporting off controlled substances with ciate who is reporting on a will be recorded on the a. Both associates will initial erifying that the count is		New sheets printed so the category is legible and added the narcotic binder on 4/7/22 the RDCO. Education with Completed by RDCO 4/7/22 a 4/8/22 then again by HWD or 4/28/22. 2) How the facility identified other residents: Any resident residing in the facility had the potential to be affected. Narcotic count audit be completed by HWD/desig starting 4/20/22 and then wex 4 weeks then monthly x 5 months. 3) Measures put into place/System changes. Narcotic coaudit to be completed by HWD/designee starting 4/28/ and then weekly x4 weeks the monthly x5 months. 4) How the corrective actions will be monitored: The HWD/design will be responsible for complianty issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance. Meeting monthly for 6 months until 90% compliance is achie x3 consecutive months. QA Committee will determine if changes need made to the procrection. 5) Date of compliance: 05/02/2022	by DMAs and
R 0117	410 IAC 16.2-5-1. Personnel - Defici	` '			

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 3 of 37

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
			B. W	NG		04/08/	2022
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WICKSH	IRE FORT HARRIS	ON			OUBLEDAY DRIVE APOLIS, IN 46216		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ſΈ	DATE
Bldg. 00	(b) Staff shall be s	sufficient in number,					
2.49.00	· ,	training in accordance					
	-	ate laws and rules to meet					
		4) hour scheduled and					
	unscheduled need	ls of the residents and					
	services provided.	The number,					
	qualifications, and	training of staff shall					
	-	equired to provide for the					
	-	he residents. A minimum					
	` '	staff person, with current					
		certificates, shall be on site					
	-	(50) or more residents of					
		y receive residential					
	_	r administration of					
		h, at least one (1) nursing be on site at all times.					
	-	es with over one hundred					
		gularly receiving residential					
	, ,	r administration of					
	_	h, shall have at least one					
		ing staff person awake and					
	, ,	s for every additional fifty					
	-	rsonnel shall be assigned					
	, ,	or which they are trained					
	to perform. Emplo	yee duties shall conform					
	with written job de	scriptions.					
			R 0	117	R 0117 Personnel - Deficiency		05/02/2022
		and record review, the			The facility requests paper		
	_	ure a Licensed Nurse or			compliance for this citation.T	'his	
		on Aide was available, at all			Plan of Correction is the	_	
	r r	scheduled and as needed			center's credible allegation o	f	
		lents at the facility for 4 of 6			compliance.		
	residents reviewed t				Preparation and/or execution		
		to ensure a staff person was that was certified in			this plan of correction does r	IUL	
		suscitation (CPR) and first			agreement by the provider of	,	
	-	ntial to effect 39 of 39			the truth of the facts alleged		
	•	in the facility. See R0240			conclusions set forth in the	٠.	
		nation regarding Resident F			statement of deficiencies. The	ne l	
		esidents' C, D, F, H and			plan of correction is prepared	-	
	(22	, , , . .					

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 4 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
			B. WI	NG		04/08/2022	
				CED FEE	A DDDDGG GITYL GTA TO GID GODE		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON		INDIAN	IAPOLIS, IN 46216		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	N
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	Certified Nursing A	Assistant (CNA) 3 and 4)			and/or executed solely becar	ıse	
					it is required by the provision	•	
	Findings include:				of federal and state law.		
	C						
	1. The clinical reco	ord for Resident C was			1) Immediate actions taken	for	
	reviewed on 4/7/22 at 2:10 p.m. The Resident's				those residents identified:		
	diagnosis included,	but were not limited to,			In servicing on medication		
	-	d legal blindness. She was			administration was initiated or		
	admitted to the faci	lity on 11/25/2019.			4/8/22 by RDCO. HWD will		
					complete 100% QMA education	on	
	The physician's ord	lers for March and April 2022			by 4/28/22.		
	indicated she was t	o receive the following			MD was notified for residents	C,	
	medications:				D, F, H missing signatures.		
	- levothyroxine sod	lium (thyroid medication) 75			2) How the facility identified		
	mcg (Micrograms)	by mouth each morning at			other residents:		
	6:00 a.m.				Any resident residing in the		
	-Janumet tablet (dia	abetic medication) 50-100 mg			facility had the potential to be		
	(Milligram) by mo	uth two times daily at 6:00			affected.		
	a.m. and 4:00 p.m.				3)Measures put into place/		
	-Erythromycin oint	ment 5mg/gm (gram) 1 inch			System changes.		
	of ointment to left	eye every 6 hours at 12:00			ED to schedule CPR training f		
		00 p.m., and 6:00 p.m., and			all leadership team, care partr		
	`	sterol medication) 20 mg by			dietary and QMAs. Each shift	•	
	mouth daily at 8:00) p.m.			have minimum of 1 CPR certif		
					associate on staff by 5/2/22. A	*	
	_	ril 2022 MARs (Medication			new nursing hire will complete		
		cord) did not contain initials,			CPR/First aide training by end	of	
	_	on had been administered, as			orientation.		
	follows:				HWD will review 6 residents		
	-	lium 75 mcg- not signed off			MARS weekly x 4 weeks ,4		
		3/2/22 through 3/11/22,			residents MARS weekly x 4		
	_	31/22 and 4/1/22 through			weeks and then 2 residents		
	4/7/22,	100			MARS weekly x 4 months.		
		-100 mg- not signed off as			4) How the corrective actions	•	
		0 a.m. on 3/2/22 through			will be monitored:		
	3/11/22, 3/13/22 through 3/31/22 and 4/1/22 through 4/7/22,				The BOM/HWD/designee will		
					responsible for compliance. B		
		tment 5mg/gm- not signed off			will audit employee files week	•	
		12:00 a.m. and 6:00 a.m.			weeks then monthly x5 month	S IO	
	on3/2/22 through 3	/11/22, 3/13/22 through			ensure compliance.		

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 5 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG <u>00</u>		COMPLETED	
			B. WING	<u> </u>		04/08/2022	
						0 1/00/2022	
NAME OF I	PROVIDER OR SUPPLIEI	R		EET ADDRESS, CITY, ST			
				25 DOUBLEDAY DF			
WICKSH	IRE FORT HARRIS	SON	INI	DIANAPOLIS, IN 46	216		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S	S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREF	CROSS-REFEREN	TVE ACTION SHOULD BE CED TO THE APPROPRIAT	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	,	EFICIENCY)	DATE	
		2 through 4/7/22, 3/3/22,			iew 6 residents		
		nd 4/1/22 at 6:00 p.m., and			y x 4 weeks ,4		
	3/5/22 and 4/4/22 at 12:00 p.m., and				RS weekly x 4		
	- Simvastatin 20mg	-			en 2 residents		
	administered at 8:0	0 p.m. on 3/3/22, 3/25/22,		-	y x 4 months.		
	3/28/22, 4/1/22 and	1 4/4/22.			entified will be		
				1	addressed. The		
		ord for Resident D was			se audits will be		
		at 2:50 p.m. The resident's			uality Assurance		
	_	but were not limited to,			thly for 6 months		
	diabetes and hypert	tension. He was admitted to		until 90% com	npliance is achiev	/ed	
	the facility on 12/2	3/2017.		x3 consecutiv	e months. QA		
				Committee wi	ill determine if		
	The physician's ord	lers for March and April 2022		changes need	d made to the pla	n of	
	indicated he was to	receive the following		correction.5)	Date of		
	medications:			compliance:	05/02/2022		
	-glimepiride (diabe	tic medication) 1 mg daily by					
	mouth before break	tfast at 6:00 a.m.,					
	- carvedilol (heart r	nedication) 3.125 mg two					
	times daily at 9:00	a.m. and 9:00 p.m., and					
	-simvastatin 40 mg	by mouth daily at 7:00 p.m.					
	The March and Apr	ril 2022 MARs did not contain					
	_	medication had been					
	administered, as fol						
	- glimepiride 1mg-						
		2/22 through 3/11/22,					
		31/22, and 4/1/22 through					
	4/7/22,	Č					
	-carvedilol 3/125 m	ng- not signed off as					
		0 p.m. on 3/3/22, 3/25/22,					
	3/28/22, 4/1/22 and	-					
	-simvastatin 40 mg						
	administered on 3/3/22, 3/25/22, 3/27/22,						
	4/1/22 and 4/4/22.						
	3 The clinical reco	rd for Resident E was					
	3. The clinical record for Resident F was reviewed on 4/7/22 at 1:45 p.m. The diagnoses						
	included, but were not limited to, depression,						
		ipidemia, and anxiety.					
	neuropamy, mypern	ipiucinia, anu anxicty.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION		ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
			B. WING		04/08	3/2022
NAME OF F	PROVIDER OR SUPPLIER	3	STREET	T ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	RO VIDER OR SOTTEEL	•	8025	DOUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON	INDIA	NAPOLIS, IN 46216		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE
		ers indicated to administer				
		of duloxetine once daily,				
		e 400 mg capsule of				
	_	eals, effective 4/18/20; two				
		Gabapentin at bedtime,				
		ne 20 mg tablet of Lipitor				
	I -	e 4/1/20; one 20 mg tablet of				
	I -	effective 4/1/20; and one 5				
	1	a at bedtime, effective				
	4/1/20.					
	The February, Marc	ch, and April 2022 MARs				
		stration records) indicated				
	`	the Duloxetine on the				
		11/22, 2/24/22, 3/4/22,				
	1	1/22, 4/2/22, 4/4/22, and				
		receive the Gabapentin after				
		ving dates and times: 2/6/22				
		2 after lunch, 2/24/22 after				
		dinner, 2/28/22 after dinner,				
	3/4/22 after lunch, 3	3/5/22 after lunch, 3/21/22				
	after dinner, 3/25/22	2 after lunch, 3/28/22 after				
	dinner, 4/1/22 after	dinner, 4/2/22 after lunch,				
	4/4/22 after breakfa	st and lunch, and 4/5/22 after				
	lunch. She did not	receive the Gabapentin at				
	bedtime on the follo	owing dates: 2/15/22,				
	2/16/22, 2/22/22, 2/	/23/22, 2/25/22, 2/26/22,				
	2/27/22, 2/28/22, 3/	/1/22, 3/2/22, 3/6/22,				
		/14/22, 3/20/22, 3/23/22,				
		/1/22, and 4/4/22. She did				
		tor on the following dates:				
		/22/22, 2/23/22, 2/25/22,				
		28/22, 3/1/22, 3/2/22,				
		3/22, 3/14/22, 3/20/22,				
		/28/22, 4/1/22, and 4/4/22.				
		the Xarelto on 2/6/22 and				
		t receive the Zyprexa on the				
	_	25/22, 2/26/22, 2/28/22,				
	4/1/22, and 4/4/22.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		00	COMPL	
			B. WING			04/08/	2022
NAME OF D	ROVIDER OR SUPPLIER		S	STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIER		8	3025 DC	OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON		NDIANA	APOLIS, IN 46216		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	7	ΓAG	DEFICIENCY)		DATE
	An interview was co. 4/7/22 at 2:30 p.m. administered her more received them, and staff did not always definitely missed so administrations. 4. The clinical recorreviewed on 4/7/22 diagnosis included, hypertension. Reside facility on 7/6/21. A physician order diresident was to receded docusate at bedtime. A physician order distaff was to administration metoprolol at bedtime. A physician order diresident was to recede in the facility of the february 2022 medications and data her medications: metoprolol 50 milli 2/26/22, mirtazapine 15 milli 2/26/22, and	onducted with Resident Ton She indicated staff edications. Sometimes she sometimes she did not, as administer them. She ome Gabapentin ord for Resident H was at 2:30 p.m. Resident H's but was not limited to, lent H was admitted to the lated 10/11/21 indicated the eive 100 milligrams of c. lated 2/3/22 indicated the ster 50 milligrams of me. lated 10/11/21 indicated the eive 15 milligrams of					
		AR indicated the following tes Resident H did not receive					

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PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C		(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETE	
			B. WING		04/08/202	.22
NAME OF E	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD	E	
NAME OF F	ROVIDER OR SUFFLIER		8025 [OOUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	ON	INDIA	NAPOLIS, IN 46216		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL	D BE CO	OMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	OPRIATE	DATE
	docusate 100 millig	grams - 3/6/22, 3/13/22,				
	3/25/22. 3/26/22,	,				
		grams - 3/13/22, 3/25/22,				
	3/28/22, and					
	· ·	igrams - 3/13/22, 3/25/22,				
	2328/22					
	An interview was c	onducted with Resident H on				
	4/7/22 at 2:39 p.m.	She indicated she has missed				
	evening medication	s, because there were no				
	nursing staff availal	ble to give them.				
		onducted with the RNC				
		onsultant) on 4/7/22 at 2:55				
	-	she was unaware there was a				
	_	ents not getting their				
	medications.					
	On 4/8/22 at 3:16 p	.m., the Executive Director				
	-	Schedule, as worked, for				
	-	ough April 2, 2022, which				
		was not a QMA (Qualified				
		r a Licensed Nurse scheduled				
	· · · · · · · · · · · · · · · · · · ·	n the following days:				
	-	om 3:00 a.m. till 6:00 a.m.,				
	3/29/22, 3/30/22, 3/	/31/22, 4/1/22 from 12:00				
	a.m. till 6:00 a.m., a	and 4/2/22.				
	_	on 4/8/22 at 3:30 p.m., the				
		indicated that there was not				
		the night shift and, at times,				
		p.m., The facility had been				
	-	at DON (Director of Nursing)				
		February 2022, so there was				
		who could have come in and				
		d medications during the				
		l been told there were not				
		ded passed between 9:00 p.m.				
		re had not been a staff member				
	available for as nee	ded medications to have been				

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 9 of 37

PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	A. BUILDING 00 B. WING			COMPLETED 04/08/2022	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WICKSH	IRE FORT HARRIS	ON			DUBLEDAY DRIVE APOLIS, IN 46216		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
		esidents had requested them.					
	A Pharmaceutical S	ervices policy was provided					
		rse Consultant on 4/8/22 at					
		ed "3. If the community					
	-	nd administers medications					
		ommunity will do the					
	following for that re	esident: a. Make					
	arrangements to ens	ure, that pharmaceutical					
	services are availab	le to provide residents with					
	-	ons in accordance with					
	applicable laws of I						
		scheduled dated 3/27/22 -					
	· ·	that were CPR and first aid					
	_	ed by the Executive Director					
	, ,	16 p.m. It indicated CNA 3 out did not include first aid.					
		d in CPR and first aide. The					
		fts, there were no staff					
	_	ling CPR and/or first aide					
	certified:	ing of K and of this aide					
	-	ay, evening and night shift, -					
	no staff CPR/first ai						
	•	lay shift - no first aide,					
	certified,	shift - no staff CPR/first aid					
		day shift - no first aide, night					
	shift - no staff CPR						
	-	2 - day shift - no first aide,					
		CPR/first aid certified,					
	• •	day shift - no first aide, night					
	shift - no staff CPR						
		shift - no first aide, evening staff CPR/first aid certified,					
	_	ay and night shift - no staff					
	CPR/first aid certifi						
	An interview was co	onducted with the ED 4/8/22					
		licated she was only able to					
	_	•	1				I

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 10 of 37

PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00 B. WING			COMPLETED 04/08/2022	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WICKSHI	RE FORT HARRIS	ON			DUBLEDAY DRIVE APOLIS, IN 46216		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
mo		CNA 3 certification in CPR		mo			DITIE
		fication. CNA 3's CPR card					
	only indicated she ha	ad completed CPR not first					
	aid.						
	This Residential tag IN00374615 and IN	relates to Complaints 00364234.					
R 0121	410 IAC 16.2-5-1.4 Personnel - Nonco	, , ,					
Bldg. 00		shall be required for each					
		lity prior to resident					
		n shall include a tuberculin					
	-	Mantoux method (5 TU,					
	•	eviously positive reaction ed. The result shall be					
		eters of induration with the					
	date given, date re						
	-	facility must assure the					
	following:						
		employment, or within one					
		employment, and at least					
		r, employees and nonpaid ies shall be screened for					
	•	irst tuberculin skin test					
		to the employee starting					
	•	are workers who have not					
		l negative tuberculin skin					
	test result during th	ne preceding twelve (12)					
		ne tuberculin skin testing					
		two-step method. If the					
	•	ve, a second test should be					
	. , ,	to three (3) weeks after					
	-	frequency of repeat testing risk of infection with					
	tuberculosis.	HOR OF HIROGROTT WILLT					
		who have a positive					
		n test shall be required to					
		and other physical and					
	laboratory examina	ations in order to complete					

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 11 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED	
			B. W	B. WING			04/08/2022	
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	2						
		-01			OUBLEDAY DRIVE			
WICKSH	IRE FORT HARRIS	SON		INDIAN	IAPOLIS, IN 46216			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	DE CAMPLEDIG DE ANI OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE	
	a diagnosis.							
	_	all maintain a health record						
	· ,	that includes reports of all						
		ed health screenings.						
		with symptoms or signs of						
		mptoms suggestive of						
	, ,	s, including, but not limited						
		ight sweats, and weight						
		permitted to work until						
	tuberculosis is rule							
		and record review, the	l _D o	121	R0121 Personnel -		05/02/2022	
		sure Mantoux tuberculin skin	R 0	121			05/02/2022	
	•				noncompliance			
		ssments were conducted			The facility requests paper	Thia		
		v hire staff for 3 of 5 staff			compliance for this citation.T	nis		
	-	wed. (Certified Nursing			Plan of Correction is the			
	· · ·	and 6 and Dietary Manager			center's credible allegation o	ıτ		
	(DM) 7)				compliance.			
	TO 11 1 1 1				Preparation and/or execution			
	Findings include:				this plan of correction does r	10t		
					constitute admission or	_		
	_	were provided by the			agreement by the provider of			
		(ED) on 4/8/22 at 3:16 p.m.			the truth of the facts alleged	or		
		and CNA 6 were full time			conclusions set forth in the			
	employees.				statement of deficiencies. The			
					plan of correction is prepared			
	_	for CNA 6 was reviewed. It			and/or executed solely becau			
		ad a start date of 9/26/17. The			it is required by the provision	าร		
		berculosis was dated on			of federal and state law.			
		e no additional screenings in						
	her file.				1) Immediate actions take	n		
					for those residents			
	•	for DM was reviewed. It			identified:Audit all associates	for		
		start date of 5/16/19. It did			missing job items. Send all			
		step tuberculin skin test or			associates missing their comp			
	an annual risk asses	ssment.			2 step TB screening to Concer	ntra.		
					All TB's to be completed by			
	The personnel file f	for CNA 5 was reviewed. It			5/2/22.2) How the facility			
	indicated CNA 5 ha	nd a start date 12/27/21. It did			identified other residents:			
	not include 1st; 2nd	step of tuberculin skin test			Any resident residing in the			
	or a risk assessment	t completed for CNA 5.			facility had the potential to be			

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 12 of 37

PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2022
	PROVIDER OR SUPPLIER IRE FORT HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	An interview was conducted with the ED on 4/8/22 at 3:30 p.m. She indicated she was unable to provide tuberculin skin tests that were conducted, or annual risk assessments completed for CNA 6, DM, and CNA 5.		affected. 3)Measures put into place/ System changes. Send all associates missing their comp 2 step TB screening to Conce All new hires TB screening wil completed and reviewed by Be before start date. 4) How the corrective actions will be monitored: The BOM/designee will be responsible for compliance. Be will audit employee files week weeks then monthly x5 month ensure compliance. Any issue identified will be immediately addressed. The results of thes audits will be reviewed in Qua Assurance Meeting monthly for months or until 90% compliance achieved x3 consecutive mont QA Committee will determine changes need made to the pla correction.5) Date of compliance: 05/02/2022	ntra. I be OM S OM by x 4 s to s See lity or 6 ce is ths. iif
R 0216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance			
Bldg. 00	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident 's physical, cognitive, and mental status. (2) The resident 's independence in the activities of daily living.			

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 13 of 37

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILD B. WING		JILDING	00		(X3) DATE SURVEY COMPLETED 04/08/2022		
	PROVIDER OR SUPPLIEF			8025 D	ADDRESS, CITY, STATE, ZIP CODE OUBLEDAY DRIVE JAPOLIS, IN 46216		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
	(4) If applicable, the self-administer medical competency of appropriate box bell listed. The resident Record. Pappropriate box bell listed. The resident point appropriate or self-administration will be responsible or self-administration wi	miannually thereafter. The resident 's ability to edications. The shall be documented in the facility. In the facility.	R 0	216	R0216 EVALUATION The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions take for those residents identified QMAs were educated and trait by clinical specialist on screenings (self-med if they githeir own meds, skin (monthly mini mental, elopement, fall rismobility on 3/23/22. Schedule created and assigne by RDCO on 3/31/22. Updated 4/12/22 QMAs In-service and training scheduled on screenings, schedule, and expectations by HWD by 4/28/22 2) How the facility identified of residents:	en i: ined ive c), sk, ed d on	05/02/2022

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 14 of 37

PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/08/2022
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8		OUBLEDAY DRIVE	
WICKSH	IRE FORT HARRIS	SON		NAPOLIS, IN 46216	
	Т			T	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		
	_	ninistration of medications,		Any resident residing in the	
	_	s a guide. An evaluation should		facility had the potential to	be
		lly, quarterly or per state		affected.	
	regulations, and wit	th a change of condition"		3)Measures put into place/	
				System changes.	
		for Resident 27 did not		Screening audit to be comp	
		elf-medication assessments		by HWD/designee on all re	
	completed for the re	esident.		by 4/26/22, and then 7 resi	dents
				weekly x 4 months then 7	
	An interview was conducted with the Regional			residents every other mont	n x 5
	Nurse Consultant 4/8/22 on 2:16 p.m. She			months	
	indicated the residents that self-medicate should			4) How the corrective acti	ons
	be evaluated quarterly. She was unable to locate a			will be monitored:	
	quarterly self-medication assessment conducted			The HWD/designee will be	
	for Resident 27.			responsible for compliance	
				will audit 7 residents weekl	-
		tion of Medication" policy		months then 7 residents ev	· I
		e Executive Director on		other month x 5 months to	
	_	It indicated "Policy"3.		compliance. Any issues ide	
	Review of the resid	-		will be immediately addres	
		lications will take place at a		The results of these audits	
	minimum semi-ann	uany"		reviewed in Quality Assura	
	A 1170 ' 1 4 NT 1	A 48 15		Meeting monthly for 6 mon	
		Assessment" policy was IC on 4/8/22 at 8:45 a.m. It		until 90% compliance is ac x3 consecutive months. QA	
	l ^	e Self administration of		Committee will determine in	
		vill only be required to be		changes need made to the	
		or upon an acute change in		correction.	pian or
	1 1 1	residents that self-administer		5) Date of compliance:	
	their medications'			05/02/2022	
		rd for Resident 6 was		0010212022	
		at 12:06 p.m. Resident 6's			
	diagnoses included,	-			
		porosis (weak bones),			
	essential tremor, an				
	2550mar tromor, an				
	Resident 6's last out	arterly Mini Mental State			
		onducted on 7/20/21 and			
		6 had a moderate cognitive			
	· ·	acility did not conduct Mini			
		timi, ala not conduct mini			

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PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 B. WING			COMPLETED 04/08/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216					
	•			<u> </u>				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Mental State Exams	s quarterly.						
	A Behavior note da indicated, Resident facility by herself walso been found in telothes on. The nor intervention was to day an [sic, and] if alone we might not she forgets". Resident 6's last quassessment was confacility did not concassessment quarterlincident. Resident 6's last quawas completed on 7 Resident 6 was a hinot conduct quarter assessments. According to Resident	ted 10/13/2021 at 12:15 a.m. 6 was found outside the vithout an escort. She had the hallway without any n-pharmacological remind "her she fell the other she we[sic, were] outside find her for a while however arterly Elopement Risk mpleted on 7/20/21. The duct an Elopement Risk y, nor after the 10/13/21 arterly Fall Risk assessment 7/20/21. It indicated; gh fall risk. The facility did ly Mobility/Fall Risk ent 6's progress notes, she						
		owing dates: 8/22/21,						
	10/3/21, 12/17/21, a	and 2/11/22.						
	Consultant) was con a.m. RNC indicated Assessment was rec bi-annually to quart facility's triggering	RNC (Regional Nurse nducted on 4/8/22 at 10:20 d, the Resident Needs cently changed from terly which resulted in the mechanism for the needed off". She indicated; she had weeks ago.						
	received from RNC	Assessment policy was 5 on 4/8/22 at 8:45 a.m. The completed Resident Needs						

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 16 of 37

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. I		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2022	
	ROVIDER OR SUPPLIER		8025 D	ADDRESS, CITY, STATE, ZIP CODE OUBLEDAY DRIVE IAPOLIS, IN 46216	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	admission then quar condition of level of forms for elopement status were to be con an acute change in c				
R 0217	410 IAC 16.2-5-2(Evaluation - Defici	, , ,			
Bldg. 00	facility, using appremembers, shall ideservices to be provided services or resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services or and revised as appeter the may request a ser (3) The agreed up signed and dated copy of the service resident upon requivalence (4) No identification services provided subsequent to the no need for a char (5) If administration	ffered shall be reviewed propriate and discussed by acility as needs or desires a facility or the resident vice plan review. on service plan shall be by the resident, and a pe plan shall be given to the uest. on and documentation of is needed if evaluations initial evaluation indicate			
	both, is needed, a involved in identific of the services to be	licensed nurse shall be cation and documentation	R 0217	R0217 EVALUATION	05/02/2022

State Form Event ID: U55M11 Facility ID: 014109 If continuation sheet Page 17 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING			04/08/	2022
						0 1/00/	LULL
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLITEIER		8025 DOUBLEDAY DRIVE				
WICKSH	IRE FORT HARRIS	SON		INDIAN	APOLIS, IN 46216		
			,			,	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	facility failed to ensure service plans were				The facility requests paper		
	signed by the reside	-			compliance for this citation.	his	
		of 6 residents reviewed.			Plan of Correction is the		
	(Residents' 27, C, E				center's credible allegation of	.f	
	(Residents 27, C, L), and 0)				'•	
	F: 1: : 1 1				compliance.		
	Findings include:				Preparation and/or execution		
					this plan of correction does i	not	
		rd for Resident 27 was			constitute admission or		
	reviewed on 4/7/22	at 11:30 a.m. Resident 27's			agreement by the provider of	F	
	diagnosis included,	but was not limited to,			the truth of the facts alleged	or	
	chronic kidney disease. Resident 27 was				conclusions set forth in the		
admitted to the facility on 9/4/21.				statement of deficiencies. The	ne		
					plan of correction is prepare		
	A resident evaluation/service plan for Resident				and/or executed solely becau		
	27 was completed on, 9/3/22. There was no				it is required by the provision		
	-				of federal and state law.	15	
	-	or resident representative			of federal and State law.		
	-	vice plan. 2. The clinical			l		
		C was reviewed on 4/7/22 at			Immediate actions take	n	
	-	ident's diagnosis included, but			for those residents		
	were not limited to,	hypothyroidism and legal			identified:Concierge will sche	dule	
	blindness. She was	admitted to the facility on			all residents for a care		
	11/25/2019.				conference starting the week of	of	
					4/25/22. All residents will have	a	
	The clinical record	did not contain a service plan			current care conference		
		d by her or her representative.			scheduled by 5/2/22. ED/HWD	or or	
	8	J I			designee will hold care		
	3. The clinical reco	ord for Resident D was			conference and ensure Service	e	
		at 2:50 p.m. The resident's			plan is signed by resident, PO		
		but were not limited to,			or 2 associates present during		
	-					uie	
		ension. He was admitted to			care conference.2) How the		
	the facility on 12/23	3/2017.			facility identified other		
					residents:		
		did not contain a service plan			Any resident residing in the		
	signed by him or hi	s representative.			facility had the potential to be		
	4. The clinical reco	rd for Resident 6 was			affected.		
	reviewed on 4/7/22 at 12:06 p.m. Resident 6's				3)Measures put into place/		
	diagnoses included,				System changes.Care		
	_	porosis (weak bones),			Conference audit will be		
	essential tremor, an				completed by ED/designee ea	ch	
	- 1350man nomon, an				month for 7 months.		
					monunioi / monuns.		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2022	
WICKSH	PROVIDER OR SUPPLIER	ON	STREET ADDRESS, CITY, STATE, ZIP CODE 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DA		
D 0040	Examination was co indicated, Resident impairment. Resident 6's clinical Service Plan/Level 3/30/22 and was no POA (Power of Atto During an interview RNC (Regional Nurshe could not find s clinical records for Resident 27 or Resident 27 or Resident 28 with the RN indicated "11. The Service/Support pla by all appropriate in Resident Individual then uploaded into the service of	Assessment" policy was C on 4/8/22 at 8:45 a.m. It Residents Individualized In is then generated and signed Idividuals. 12. The signed Ized Service/Support plan is The resident chart"		4) How the corrective action will be monitored: The ED/designee will be responsible for compliance. A will be completed by ED/designeach month for 7 months. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 7 months until 90% compliance is achie x3 consecutive months. QA Committee will determine if changes need made to the placorrection.5) Date of compliance: 05/02/2022	udit gnee / e or ved	
R 0240 Bldg. 00		Deficiency and assistance with ving, shall be provided				
	Based on interview facility failed to adr medication, as order medications review randomly observed administration, and elopement/missing conducting quarterly	red, for 4 of 6 residents' ed and 2 of 5 residents for medication	R 0240	R 0240 Health Services – Deficiency The facility requests paper compliance for this citation. Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or	of n of	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
			B. W	B. WING 04/08/2022			
				CTREET	ADDRESS SITU STATE ZIR SORE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
			8025 DOUBLEDAY DRIVE				
WICKSH	IRE FORT HARRIS	SON		INDIAN	IAPOLIS, IN 46216		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROWIDEBIG BY AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	notifying the reside	ent representative of			agreement by the provider o	f	
	elopement behaviors timely; not implementing				the truth of the facts alleged	or	
	the Fall and Mobili	ty Management policy by not			conclusions set forth in the		
	conducting fall risk	assessment after every fall			statement of deficiencies. T	he	
	episode and/or ever	ry six months and not placing			plan of correction is prepare	d	
	additional fall inter	ventions in the			and/or executed solely beca	use	
	Service/support pla	n for 1 of 5 residents whose			it is required by the provisio	ns	
	clinical records we	re reviewed. (Residents' C, D,			of federal and state law.		
	F, H, L, M and 6)				1) Immediate actions taken	for	
					those residents identified:		
	Findings include:				Education completed by Clini	cal	
					specialist with QMAs on 3/23/	22	
	1. The clinical record for Resident F was				and Re-education will be		
	reviewed on 4/7/22	at 1:45 p.m. The diagnoses			completed by HWD on 4/28/2	2. 2)	
	included, but were	not limited to: depression,			How the facility identified ot	her	
	neuropathy, hyperl	ipidemia, and anxiety.			residents:		
					Any resident residing in the		
	An interview was o	conducted with Resident T on			facility had the potential to be		
	4/7/22 at 2:30 p.m.	She indicated staff			affected.		
	administered her m	edications. Sometimes she			3)Measures put into place/		
	received them, and	sometimes she did not, as			System changes.Incident Re	port	
	staff did not always	s administer them. She missed			audit to be completed by		
	some Gabapentin a	dministrations.			HWD/designee on 4/28/22, and		
				then weekly x 4 weeks then			
	The physician's ord	lers indicated to administer			monthly x 5 months for accura	acy.	
	one 60 mg capsule	of duloxetine once daily,			4) How the corrective action	s	
	effective 4/1/20; or	ne 400 mg capsule of			will be monitored:		
	Gabapentin after m	eals, effective 4/18/20; two			The HWD/designee will be		
	400 mg capsules of	f Gabapentin at bedtime,			responsible for compliance. A	udit	
	effective 4/18/20; of	one 20 mg tablet of Lipitor			will be completed by		
	once daily, effectiv	re 4/1/20; one 20 mg tablet of			HWD/designee weekly x 4 we	eks	
	Xarelto once daily,	effective 4/1/20; and one 5			then monthly x5 months to en	sure	
	mg tablet of Zypres	xa at bedtime, effective			compliance. Any issues identi		
	4/1/20.				will be immediately addressed	i.	
					The results of these audits wil	l be	
	The February, Mar	ch, and April 2022 MARs			reviewed in Quality Assurance	e	
	(medication admin	istration records) indicated			Meeting monthly for 6 months	or	
	she did not receive	the Duloxetine on the			until 90% compliance is achie	ved	
	following days: 2/	11/22, 2/24/22, 3/4/22,			x3 consecutive months. QA		
		31/22, 4/2/22, 4/4/22, and			Committee will determine if		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	_	PLETED
			b. wind		04/0	8/2022
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP C	ODE	
				OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON	INDIAN	IAPOLIS, IN 46216		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DDOVIDEDIS DI ANI OF CORD	PECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			DATE
	4/5/22. She did not	receive the Gabapentin after		changes need made to	the plan of	
	meals on the follow	ring dates and times: 2/6/22		correction.5) Date of		
	after dinner, 2/11/22	2 after lunch, 2/24/22 after		compliance: 05/02/202	22	
	i i	dinner, 2/28/22 after dinner,				
	· ·	3/5/22 after lunch, 3/21/22				
	· ·	2 after lunch, 3/28/22 after				
	· ·	dinner, 4/2/22 after lunch,				
		st and lunch, and 4/5/22 after				
		receive the Gabapentin at				
		owing dates: 2/15/22,				
		23/22, 2/25/22, 2/26/22,				
	· · · · · · · · · · · · · · · · · · ·	/1/22, 3/2/22, 3/6/22,				
	· · · · · · · · · · · · · · · · · · ·	14/22, 3/20/22, 3/23/22,				
		1/22, and 4/4/22. She did				
	•	tor on the following dates:				
		/22/22, 2/23/22, 2/25/22,				
		28/22, 3/1/22, 3/2/22,				
		3/22, 3/14/22, 3/20/22,				
	· · · · · · · · · · · · · · · · · · ·	28/22, 4/1/22, and 4/4/22.				
		the Xarelto on 2/6/22 and				
		t receive the Zyprexa on the				
	_	25/22, 2/26/22, 2/28/22,				
	4/1/22, and 4/4/22.					
	An interview was co	onducted with the RNC				
		onsultant) on 4/7/22 at 2:55				
		she was unaware there was a				
	•	ents not getting their				
	medications.					
		rd for Resident H was				
	reviewed on 4/7/22	at 2:30 p.m. Resident H's				
	diagnosis included,	but was not limited to,				
	hypertension. Resid	lent H was admitted to the				
	facility on 7/6/21.					
	A nhysician order d	ated 10/11/21 indicated the				
		eive 100 milligrams of				
	docusate at bedtime	_				
	docusaic at beutillie	··				
	A physician order d	lated 2/3/22 indicated the				
1			1	1		1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A		A. BU	A. BUILDING 00 B. WING			COMPLETED 04/08/2022	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WICKSH	IRE FORT HARRIS	ON			APOLIS, IN 46216		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	staff was to adminis metoprolol at bedtin	ter 50 milligrams of ne.					
		ated 10/11/21 indicated the ive 15 milligrams of me.					
	Record (MAR) indice medications and dather medications: docusate 100 millign 1/18/22, 1/20/22, and medications are supported by the medication of the medication and the medication and the medication are supported by the medication and the m	es Resident H did not receive rams - 1/8/22, 1/16/22,					
		note dated, 1/12/22 indicated ns missed"					
	medications and dat her medications: metoprolol 50 millig 2/26/22,	MAR indicated the following es Resident H did not receive grams - 2/22/22, 2/25/22,					
	2/26/22, and docusate 100 millign 2/26/22	rams - 2/22/22, 2/25/22,					
	medications and dat her medications: docusate 100 millige 2/25/22. 2/26/22, metoprolol 50 millige 2/28/22, and	AR indicated the following es Resident H did not receive rams - 2/6/22, 2/13/22, grams - 2/13/22, 2/25/22, igrams - 2/13/22, 2/25/22,					
	An interview was co	onducted with Resident H on					

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 B. WING		COMPLETED 04/08/2022	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WICKSH	IRE FORT HARRIS	ON			DUBLEDAY DRIVE APOLIS, IN 46216		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	4/7/22 at 2:39 p.m. evening medication nursing staff available 3. The clinical recoreviewed on 4/7/22 diagnosis included, hypothyroidism and admitted to the faciliary the physician's order indicated she was to medications: - levothyroxine sodi mcg (Micrograms) be 6:00 a.m. -Janumet tablet (dia (Milligram) by moutan. and 4:00 p.m. -Erythromycin ointrof ointment to left et a.m., 6:00 a.m., 12:00-3-3-3-3-3-3-3-3-3-3-3-3-3-3-3-3-3-3-	She indicated she has missed is because there were no ole to give them. In the resident C was at 2:10 p.m. The Resident's but were not limited to, at legal blindness. She was lity on 11/25/2019. The resident C was at 2:10 p.m. The Resident's but were not limited to, at legal blindness. She was lity on 11/25/2019. The resident C was at 2:10 p.m. and the resident C was at 2:10 p.m. and the resident C was at 2:10 p.m. and the resident C was at 2:10 p.m., and the resident C was at 2:10 p.m		IAU	DEL KERNETT		DATE
	3/31/22, and 4/1/22	through 4/7/22, 3/3/22,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	i i	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	CON	MPLETED
			B. WING		04/	08/2022
			STRE	ET ADDRESS, CITY, STATE, 2	ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	8		DOUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON		ANAPOLIS, IN 46216		
WICKOII	INE FORT HARRING		INDI			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	ION SHOULD BE THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC	CY)	DATE
	3/21/22, 3/28/22, ar	nd 4/1/22 at 6:00 p.m., and				
	3/5/22 and 4/4/22 a	t 12:00 p.m., and				
	- Simvastatin 20mg	-				
	administered at 8:00	0 p.m. on 3/3/22, 3/25/22,				
	3/28/22, 4/1/22 and	4/4/22.				
		ord for Resident D was				
		at 2:50 p.m. The resident's				
	-	but were not limited to,				
		ension. He was admitted to				
	the facility on 12/23	3/2017.				
	The physician's orders for March and April 2022					
	indicated he was to receive the following					
	medications:					
		tic medication) 1 mg daily by				
	mouth before break					
	· ·	nedication) 3.125 mg two				
	-	a.m. and 9:00 p.m., and				
	-simvastatin 40 mg	by mouth daily at 7:00 p.m.				
	The March and An	ril 2022 MARs did not				
	-	icating medication had been				
	administered, as fol	_				
	- glimepiride 1mg-					
		2/22 through 3/11/22,				
		31/22, and 4/1/22 through				
	4/7/22.	77722, and 777722 throagh				
	-carvedilol 3/125 m	g- not signed off as				
		0 p.m. on 3/3/22, 3/25/22,				
	3/28/22, 4/1/22 and	-				
	-simvastatin 40 mg-					
	_	3/22, 3/25/22, 3/27/22,				
	4/1/22 and 4/4/22.	, , ,				
	5. The clinical reco	ord for Resident M was				
		at 10:35 a.m. The Resident's				
	diagnosis included,	but were not limited to,				
	hypertension and he					
			1			

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	G 00	COMPLETED 04/08/2022	
	ROVIDER OR SUPPLIER		8025	EET ADDRESS, CITY, STATE, ZIP CODE 5 DOUBLEDAY DRIVE IANAPOLIS, IN 46216		
(X4) ID PREFIX	SUMMARY S	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	BE .	(X5) COMPLETION
TAG	A physician's order,	LSC IDENTIFYING INFORMATION) dated 5/5/2021, indicated mlodipine besylate (blood	TAG			DATE
	pressure medication hypertension. It wa pressure) was less th	s to be held if her B/P (blood				
	Medication Aide) 3 medications to Resi medications, including from the medication of and obtained her blood 94/68. She then adminer. She left the roop pressure reading on off the medications 6. The clinical reconveries of 4/8/22 diagnosis included, hypertension and ed. A physician's order,	m., QMA (Qualified was observed administering dent M. She removed the ing the amlodipine besylate, a cart and placed them into a up. She entered the room ood pressure reading as ministered the medications to om and wrote the blood a piece of paper and signed as given on the MAR. rd for Resident L was at 10:45 a.m. The Resident's but were not limited to, lema (swelling). dated 10/28/2021, indicated asix (water pill) 20 mg daily				
	for edema. On 4/8/22 at 9:45 a. administering medic removed the pre-paramedication cart and listed on the packag indicated that the parameter was a container for her to use. She container of Lasix 2 sometimes medicati pre-packaged doses	m., QMA 3 was observed cations to Resident L. She ckaged medications from the compared the medications ing to the MAR. She ckaged medications did not g. She then looked to see if er of Lasix 20 mg available indicated that there was not a 0 mg for her and that ons get left out of the . She would call the ldress it. She placed the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
			B. WING			04/08/	2022
				TDEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
W(1014011	IDE EODT LIADDIO				OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON	l ir	NDIANA	APOLIS, IN 46216		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	D	PROVIDENCE WAY OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T.	AG	DEFICIENCY)	IE	DATE
	pre-packaged medic	cations into a plastic					
		administered them to her.					
	_	ster the Lasix 20 mg.					
	She did not adminis	ster the Lasix 20 mg.					
	During on intervious	v on 4/8/22 at 12:30 p.m., the					
	_	_					
		rse Consultant) indicated that					
		lipine besylate should have					
		red due her blood pressure					
		0/90 and that Resident L					
		ed her Lasix as ordered by the					
	physician.						
	During an interview on 4/8/22 at 3:30 p.m., the RNC indicated that Resident C and D should have received their medications as ordered.						
		Services policy was provided					
		rse Consultant on 4/8/22 at					
	_	ed "3. If the community					
		nd administers medications					
		ommunity will do the					
	following for that re	esident: a. Make					
	arrangements to ens	sure, that pharmaceutical					
	services are availab	le to provide residents with					
	prescribed medicati	ons in accordance with					
	applicable laws of I	ndiana"					
	7. The clinical reco	rd for Resident 6 was					
	reviewed on 4/7/22	at 12:06 p.m. Resident 6's					
	diagnoses included,	, but not limited to,					
	hypertension, osteo	porosis (weak bones),					
	essential tremor, an	d anxiety.					
		-					
	Resident 6's last qu	arterly Mini Mental State					
	•	onducted on 7/20/21 and					
		6 had a moderate cognitive					
	impairment.	6					
	1						
	Resident 6's latest F	Resident Evaluation/Service					
		indicated, in the behavior and					
		following was noted: "Went					
	barety section, the i	ono and was noted. Went					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL	
11112 12111	or condition.		B. W		00	04/08/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE	0 1,700,	
NAME OF F	PROVIDER OR SUPPLIER	2			OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON			APOLIS, IN 46216		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	-					
	was easily redirected. A Behavior note day indicated, Resident facility by herself walso been found in the clothes on. The not intervention was to day an [sic, and] if alone [sic] we migh however[sic] she for the alone [sic] we migh however[sic] she for the alone [sic] we migh however[sic] she for the alone [sic] we migh however[sic] she for a.m. RNC indicated the 3/30/22 evaluated a few months ago a from 10/13/22. Resident 6's last quassessment was confacility did not confacility	ted 10/13/2021 at 12:15 a.m. 6 was found outside the vithout an escort. She had the hallway without any n-pharmacological remind "her she fell the other she we[sic, were] outside at not find her for awhile orgets". RNC (Regional Nurse inducted on 4/8/22 at 10:20 d, the incident mentioned in ion/Service plan occurred just ind is not the same incident matterly Elopement Risk inpleted on 7/20/21. The duct an Elopement Risk y, nor after the 10/13/21 Resident 6's representative was 2 at 3:27 p.m. She indicated; formed of her mother being incility on 10/13/21.					
	received from RNC policy indicated, a c Assessment should admission then qua condition of level o forms for elopemen	Assessment policy was an an area of the completed Resident Needs be done at the time of a reerly or when resident's a frage changes. The ancillary and minimental completed quarterly and/or with					
	an acute change in	condition.					

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 04/08/2022
	ROVIDER OR SUPPLIER		8025 D	ADDRESS, CITY, STATE, ZIP CODE OUBLEDAY DRIVE IAPOLIS, IN 46216	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	received on 4/8/22 a policy indicated, res assessed for elopem change in condition identify risk factors elopement. Once id risk, interventions sl to minimize the risk missing resident was informed, and a phy been completed. The Health and Wellness all notifications, cor on an Elopement/M. Resident 6's last qua was completed on 7. Resident 6 was a hig not conduct quarterl assessments. According to Resident faller on the fol 10/3/21, 12/17/21, a record for Resident fall risk assessments mentioned. A Falls and Mobility received 4/8/22 at 8 policy indicated, a falve been done at leastfer every fall episot the community show of the analysis of cirinterventions that we reduce the risk of fur	gh fall risk. The facility did y Mobility/Fall Risk ent 6's progress notes, she lowing dates: 8/22/21, nd 2/11/22. The clinical 6 did not contain completed 6 for the dates previously y Management policy was 245 a.m. from RNC. The fall risk assessment should feast every six months and fode. If the resident had a fall, fall have had documentation froumstances of the fall and fore initiated to prevent or			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2022
	PROVIDER OR SUPPLIER		8025 D	ADDRESS, CITY, STATE, ZIP CODE OUBLEDAY DRIVE NAPOLIS, IN 46216	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0299 Bldg. 00	at 10:20 a.m. RNC intervention that had 12/17/21 fall was to medication however any pain medication contributed to her fainterventions were a plan after the fall or This Residential tag IN00374615. 410 IAC 16.2-5-6(Pharmaceutical Sc (3) The medication recommendations physician, if necessin accordance with Based on interview facility failed to time recommendations for pharmacy recommendati	RNC was conducted on 4/8/22 indicated, the fall d been put in place after the monitor Resident 6's pain r, Resident 6 did not receive as which could have all. No additional fall added to Resident 6's service in 2/11/22. It relates to Complaint c)(3) ervices - Noncompliance on review, and notification of the seary, shall be documented in the facility 's policy. and record review, the elely complete pharmacy or 3 of 5 residents reviewed amendations (Resident C, D) ard for Resident C was at 2:10 p.m. The Resident's but were not limited to, I legal blindness. She was lity on 11/25/2019. m., the RNC (Regional	R 0299	R0299 Pharmaceutical Service The facility requests paper compliance for this citation. Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by the provision of federal and state law. 1) Immediate actions take	This of n of not f or he d use ns

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
			B. W	ING		04/08/	2022
						0 1/00/	LULL
NAME OF E	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KO VIDEK OK SOI I EIEF			8025 D	OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON		INDIAN	APOLIS, IN 46216		
						,	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	signed by a physici	an.			for those residents		
					identified:Guardian Pharmacy	,	
	2 The clinical reco	ord for Resident D was			and My Mobile notified by ED		
					_		
	reviewed on 4/7/22 at 2:50 p.m. The resident's				about concerns and My mobile		
	_	but were not limited to,			PCP to address last 3 months		
		ension. He was admitted to			pharmacy recommendation by		
	the facility on 12/23	3/2017.			4/22/22. HWD will ensure orde	ers	
					are enter in EHR and		
	On 4/8/22 at 9:30 a	.m., the RNC (Regional			resident/POA notified of chang	jes.	
	Nurse Consultant)	provided the Note to			2) How the facility identified		
	Attending Physician	n/ Prescriber forms, printed			other residents:		
		nt D. The forms had not been			Any resident residing in the		
	signed by a physici				facility had the potential to be		
	signed by a physici	uii.			affected.		
	3. The clinical record for Resident F was						
					3)Measures put into place/	1:4	
		at 1:45 p.m. The diagnoses			System changes.Pharmacy a	uait	
		not limited to: depression and			to be completed no later than		
	neuropathy.				5/2/22 by HWD/designee and		
					then monthly x 5 months.		
	The current physici	an's orders indicated to			4) How the corrective actions	;	
	administer one 60 n	ng capsule of duloxetine once			will be monitored:		
	daily, effective 4/1/	20; one 400 mg capsule of			The HWD/designee will be		
		eals, effective 4/18/20; and			responsible for compliance. At	udit	
	_	es of Gabapentin at bedtime,			will be completed by		
	effective 4/18/20.	,			HWD/designee no later 5/2/22		
	170720.				and then monthly x 5 months.		
	The 2/19/22 Note to	a Attending			issues identified will be	, uly	
	The 2/18/22 Note to	er read, "Please evaluate signs			immediately addressed. The		
	-	_			-		
		epression to determine if a			results of these audits will be		
		ppropriate at this time. If not			reviewed in Quality Assurance		
		document rationale.			Meeting monthly for 6 months		
	Duloxetine 60 mg o	once daily - Recommend			until 90% compliance is achiev	/ed	
	decreasing to: dulo	exetine 30 mg once daily." The			x3 consecutive months. QA		
	Physician/Prescribe	er Response section of the			Committee will determine if		
	note was blank.				changes need made to the pla	n of	
					correction.5) Date of		
	The 2/18/22 Note to	o Attending			compliance: 05/02/2022		
		er read, "This resident has an					
		in 400 mg with meals + 800					
	_	_					
	mg at bedtime. This	s resident has a most recent					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COM	PLETED 08/2022
	ROVIDER OR SUPPLIER		8025 D	ADDRESS, CITY, STATE, ZIP O OUBLEDAY DRIVE APOLIS, IN 46216	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
R 0302 Bldg. 00	check how well the mL/min [minute.] Gand recommended to function. Please evaluation of the function of the fun	onducted with the RNC onsultant) on 4/8/22 at 8:50 he February 2022 pharmacy ad not been addressed by the m., the RNC provided the vices Policy, effective ad "b. A consultant employed, or under contract, e drug regimen of each nese services at least once as. c. The medication review and notifications of the ary, will be documented in e community's policy" c)(6) ervices - Deficiency ter medications must be following: e. e.				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		04/08/	2022
						0 1/00/	2022
NAME OF F	ROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVIVIL OF I	RO VIDER OR SCI I EIEI			8025 D	OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON		INDIAN	IAPOLIS, IN 46216		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(D) Name of drug						
	(E) Strength.						
			R O	302	R0302 OTC		05/02/2022
	Based on observation	on, interview and record	10302				03/02/2022
					compliance for this citation.	Thio	
	review, the facility failed to adequately label over the counter medications for 3 of 39 residents.				<u> </u>	1115	
					Plan of Correction is the	_	
	(Resident 15, 35, ar	nd F)			center's credible allegation of	rt	
	F. P. C. L.				compliance.		
	Findings include:				Preparation and/or execution	of	
					this plan of correction does i	not	
	On 4/7/22 at 3:10 p	.m., the facility medication			constitute admission or		
	cart was observed v	vith QMA (Qualified			agreement by the provider of	Ŧ	
	Medication Aide) 2. It contained the following:				the truth of the facts alleged		
	a bottle of Tylenol 500 mg (milligrams) with				conclusions set forth in the		
	Resident 15's room number written on the top of				statement of deficiencies. The	20	
		-					
		preservision (vitamin) and a			plan of correction is prepare		
	-	200 mg with Resident 35's			and/or executed solely becau		
		en on the top of the lid, and a			it is required by the provision	าร	
		nins labeled with Resident F's			of federal and state law.		
	room number. The	bottles were not labeled with					
	the name of the resi	ident or the physician's name.			1)Immediate actions taken for	r	
					those residents identified:		
	During an interview	v on 4/8/22 at 9:00 a.m., the			New labels ordered by 4/15/22	<u>2</u> .	
	RNC (Regional Nu	rse Consultant) indicated that			Education with all QMAs will b	е	
	` •	edications should be labeled			completed by HWD by 4/28/22	<u>)</u> .	
		name and prescribing			All OTCs labeled with Physicia		
		th the room number.			name, resident name, and		
	physician, along wi	til the room number.			medication name. Label will no	nt.	
	0 4/9/22 4 9 50	4 DNG 11.14				JL	
		.m., the RNC provided the			cover original label showing		
		vices Policy, effective			medication name and strength	or	
		ead "6. Over- the- counter			expiration date.2) How the		
		e identified with the			facility identified other		
	following: a. Resid	dent name. b. Physician			residents:		
	name. c. Expiration	n date. d. Name of the drug.			Any resident residing in the		
	e. Strength"				facility had the potential to be		
	-				affected.		
					3)Measures put into place/		
					System changes.OTC audit to	b be	
					completed by HWD/designee		
					all carts and every OTC bottle	ιO	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	-	LETED 8/2022
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	DDE	
WICKSH	IRE FORT HARRIS	ON		OUBLEDAY DRIVE JAPOLIS, IN 46216		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				ensure compliance and weekly x 4 weeks then months. 4) How the corrective a will be monitored: The HWD/designee will responsible for complia will be completed by HWD/designee weekly and then monthly x5 may issues identified will be immediately addressed results of these audits were viewed in Quality Ass Meeting monthly for 6 muntil 90% compliance is x3 consecutive months. Committee will determine changes need made to correction.5) Date of compliance: 05/02/202	actions be nce. Audit x 4 weeks onths. Any . The will be urance nonths or achieved achieved achieved achieved the plan of	
R 0354	410 IAC 16.2-5-8. Clinical Records -					
Bldg. 00	(1) Identification d(2) Name of the tra(3) Name of the reof transfer.(4) Resident's petransferred to an a	ansferring institution. ceiving institution and date rsonal property when cute care facility. relating to the resident 's:				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		04/08/	2022
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
MICKOLI	IDE EODT LIADDIO	ON			OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	ON		INDIAN	IAPOLIS, IN 46216		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(C) medications;						
	(D) treatment; and	I					
	(E) current diet and condition on transfer.(6) Diagnosis.						
	(7) Date of chest	c-ray and skin test for					
	tuberculosis.	•					
			R 0	354	R0354 Transfer forms		05/02/2022
	Based on interview	and record review, the	110		The facility requests paper		00,02,2022
		sure a transfer form was			compliance for this citation.T	his	
	-	eiving facility that included			Plan of Correction is the		
	-	g institution, the resident's			center's credible allegation o	f	
	functional abilities and physical limitations,				compliance.		
	nursing care needed, the resident's condition at				Preparation and/or execution	of	
	transfer, date of chest x-ray and skin test for 1 of				this plan of correction does r		
	2 residents closed charts reviewed. (Resident				constitute admission or		
	63)	(agreement by the provider of	:	
					the truth of the facts alleged		
	Findings include:				conclusions set forth in the		
	8				statement of deficiencies. The	ne	
	The clinical record	for Resident 63 was reviewed			plan of correction is prepared	d	
		m. Resident H's diagnosis			and/or executed solely becau		
	_	ot limited to, hypertension.			it is required by the provision		
		mitted to the facility on			of federal and state law.		
	7/27/15.	Ž					
					1) Immediate actions taken for	or	
	A nursing progress	note dated 2/25/22 indicated,			those residents identified:		
		arged to another assisted			Transfer sheets will have		
		medications provided along			Identification data, name of		
		uctions and paperwork."			transferring institution, name o	f	
		• •			receiving institution and date of		
	The transfer form for	or Resident 63 was provided			transfer, personal property,		
		rse Consultant on 4/8/22 at			medications, diet orders,		
		wing information was not			diagnosis, and functional abilit	у	
	included on the tran	_			printed at front desk by 5/2/22.	-	
					Education with care partners,		
	Transferring institut	tion, functional abilities and			leadership, and QMAs on whe	re	
	_	, nursing care needed,			to grab the transfer sheet and		
		nformation, the resident's			what section to complete at tin	ne of	
		r, date of chest x-ray and skin			transfer held by HWD by		
	test.	-			04/28/2022 2) How the facility		
			1				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/08/2022
	ROVIDER OR SUPPLIER		8025 D	ADDRESS, CITY, STATE, ZIP CODE OUBLEDAY DRIVE NAPOLIS, IN 46216	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Nurse Consultant of	onducted with the Regional n 4/8/22 at 2:45 p.m. She naware the information sfer form.		identified other residents: Any resident residing in the facility had the potential to be affected. 3)Measures put into place/ System changes. Transfer for audit will be completed by HWD/designee on all current residents weekly x 4 weeks the monthly x5 months to ensure compliance. 4) How the corrective actions will be monitored: The HWD/designee will be responsible for compliance. A will be completed by HWD/designee weekly x 4 we and then monthly x 5 months. issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months until 90% compliance is achie x3 consecutive months. QA Committee will determine if changes need made to the placorrection.5) Date of compliance: 05/02/2022	en s udit eks Any
R 0414 Bldg. 00	their hands after e	Deficiency st require staff to wash each direct resident contact ashing is indicated by			
		on, interview, and record	R 0414	R0441- Infection Control The facility requests paper	05/02/2022

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IER/CLIA X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		1	B. W	NG		04/08/2022	
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
					OUBLEDAY DRIVE		
WICKSH	IRE FORT HARRIS	SON		INDIAN	IAPOLIS, IN 46216		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	N
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	review, the facility	failed to assure hand hygiene			compliance for this citation.	his	
	was performed prio				Plan of Correction is the		
		f 5 residents randomly			center's credible allegation o	f	
		ation administration			compliance.		
	(Resident M, 16, and L). Findings include:				Preparation and/or execution	of	
					this plan of correction does i		
					constitute admission or		
					agreement by the provider of	,	
	On 4/8/22 at 9:20 a	/8/22 at 9:20 a.m., QMA (Qualified			the truth of the facts alleged		
		ation Aide) 3 was observed administering			conclusions set forth in the	-	
	· ·	ident M. She removed the			statement of deficiencies. The	ne	
					plan of correction is prepare	-	
		dications from the medication cart and placed m into a plastic medication cup. She did not			and/or executed solely becau		
	_	perform hand hygiene prior to placing the			it is required by the provision		
	medications into the medication cup, she entered				of federal and state law.	.	
		ned her blood pressure					
		he then handed her the			1)Immediate actions taken fo	r I	
	_	d she took her medications.			those residents		
	_	r walker closer to her bed and			identified:Initiated handwash	ina	
		ns off the floor. She left the			and infection control in		
		blood pressure reading on a			servicing on 4/8/22. 2) How the	ne	
		signed off the medications as			facility identified other		
		She did not perform hand			residents:		
	_	ng the room. She then began			Any resident residing in the		
		16's medications. She			facility had the potential to be		
		the cart and opened them,			affected.		
		lastic medication cup without			3)Measures put into place/		
		giene first. She then entered			System changes.100% of		
		nanded the medication to her.			associates educated on		
	She touched her sho	oulder after administering the			handwashing and infection co	ntrol	
	medications and the	en left the apartment. She did			by 4/28/22. HWD/designee wil	ı	
	not perform hand h	ygiene after leaving the			audit 4 associates weekly on		
		ned off the medications in the			random shifts for 4 weeks, the	n 3	
		gan preparing Resident L's			associates a week x 3 months		
	-	lid not perform hand hygiene			and then 2 associates weekly	x2	
		he pre-packaged medications			months.		
	-	n cart and compared the			4) How the corrective actions	;	
		on the packaging to the MAR.			will be monitored:		
		packaged medications into a			The HWD/designee will be		
		cup. She then entered the			responsible for compliance. At	udit	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
			B. WING			04/08/2022		
				STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER				8025 DOUBLEDAY DRIVE				
WICKSHIRE FORT HARRISON				INDIANAPOLIS, IN 46216				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			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 APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE	
	apartment and administered them to her. She left			will be completed by				
	the apartment and performed hand hygiene.				HWD/designee for 4 associates			
					weekly on random shifts for 4	for 4		
	During an interview on 4/8/22 at 10:05 a.m.,			weeks, then 3 associates a week x 3 months, and then 2 associates				
	QMA 3 indicated she should have performed							
	hand hygiene after leaving each apartment and				weekly x2 months. Any issues identified will be immediately addressed. The results of these			
	before beginning to prepare medications for							
	administration.							
					audits will be reviewed in Qual	ity		
	On 4/8/22 at 12:30 p.m., the Executive Director				Assurance Meeting monthly for 6			
	provided the Handwashing Policy, effective 11/1/2019, which read "1. Handwashing should be completed before coming on duty, before and			months or until 90% compliance				
					achieved x3 consecutive mont	hs.		
					QA Committee will determine if			
after direct or indirect resident contact, before					changes need made to the plan of			
	and after performing any bodily functions, before				correction.5) Date of			
	preparing or serving food, before preparing or				compliance: 05/02/2022			
	administering medi	cations"						

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