STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 00 B. WING	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(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. This visit included the Investigation of Complaint IN00416022. Complaint IN00416022 - No deficiencies related to the allegations are cited. Survey dates: August 24, 25, 28, 29, 30, & 31, & September 1, 2023. Facility number: 001127 Provider number: 155771 AIM number: 200247220 Census Bed Type: SNF/NF: 35 NF: 107 Residential: 149 Total: 291 Census Payor Type: Medicare: 14 Medicaid: 98 Other: 30 Total: 142 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 7, 2023.	F 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as			

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

Shannon Logan | Administrator | 09/27/2023

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.

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	defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self medication administration assessment was completed for residents with medications at bedside for 1 of 1 random observations. (Resident 82) Finding includes: During an observation on 8/24/23 from 12:03 p.m. to 12:07 p.m., Resident 82's room door was open. The resident's door was in full view of the hall. Resident 82 was up in her recliner with a bedside table over her lap. No staff were observed to be in the room or in hallway. The following items were observed to be sitting on top of the bedside table: - One clear plastic pill cup was filled with miscellaneous tablet and capsules. - One clear plastic pill cup was observed with unidentifiable medications. - One clear plastic pill cup was observed approximately half-filled with a pink-colored liquid. On 8/30/23 1:03 p.m., Resident 82's clinical record was reviewed. The clinical record lacked a self-administration of medications assessment for Resident 82. On 8/30/23 at 1:26 p.m., a record review of the Minimum Data Set (MDS), dated 6/21/23, indicated, " ...administer medications per Physician's order and keep safe and secure within facility." During an interview on 8/24/23 at 12:10 p.m.,	F 0554	F554 – Resident Self-Admin Meds-Clinically Approp **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents found to have been affected by the deficient practice. Resident 82 has a BIMS of 15. When LPN 3 took the medication into her, the resident asked that the nurse go get something for her. The nurse walked out of the room to retrieve what the resident requested. LPN 3 did not move on with her med pass until she returned to Resident 82's room. Residents roommate is chair fast most of the time and is a two-person assist; therefore, would not have been able to get the medication. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents residing on HC3 have the potential to be affected. On 8/24/2023, LPN 3 was educated by the Unit Manager and counseled on not leaving medications unattended unless the resident has a self-administer of medication assessment completed. On 8/25/2023, all licensed nurses received an	09/22/2023

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	Licensed Practical Nurse (LPN 3) indicated staff were not supposed to leave medications at the bedside. On 8/29/23 at 1:00 p.m., the Executive Director provided a policy titled Medication Administration Policy, dated 11/21/17, and indicated it was the policy currently in use for the facility. The policy indicated, "documented medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice". 3.1-11(a)		in-service given by the DON regarding not leaving medications unattended unless the resident has a self-administer of medication assessment completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All residents residing on HC3 with a BIMs of 12 or higher were assessed as to whether or not they can self-administer medication. All new admissions who wish to self-administer his or her own medication will be given a self-administer medication assessment upon admission. The Unit Manager and/or her designee will do random audits to check that no medications have been left unattended. This audit will be completed three times a day for one week, then three times a day, three different days for one week, and then randomly once a week for two weeks. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Unit Managers will bring the results of these audits to the monthly Quality Assurance Meeting. The QA committee will identify any trends or patterns and	

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			make recommendations to revise the process as indicated. Once 100% compliance has been achieved, the Committee may decide to stop the written audits. The DON and Unit Managers are responsible for implementing and monitoring this plan. **By what date the systemic changes for each deficiency will be completed?** 9/22/2023	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for 2 of 3 random observations. Two resident's call lights were not within reach. (Resident 109, Resident 81) Finding includes: 1. On 8/24/23 at 11:34 a.m., observed Resident 109 sitting in a chair in his room facing his TV. The call light was attached to his bed directly behind him and was out of reach. On 8/25/23 at 9:23 a.m., Resident 109 was observed sitting in a chair facing the TV with the call light attached to the bed. The call light was observed to be behind the resident out of reach. Resident 109 indicated that he wanted brown	F 0558	F558 – Reasonable Accommodations Needs/Preferences **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 109 has a tendency to throw his call light cord on the floor stating that he does not want it. Resident 81 was brought back to her room after working with Therapy. The therapist failed to give her the call light cord. Both residents were immediately given their call light cords. **How other residents having the**	09/22/2023

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	sugar for his grits. During an interview on 8/25/23 at 9:26 a.m., CNA 1 indicated Resident 109 used his call light. On 8/30/23 at 8:54 a.m., Resident 109's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 6/6/23, indicated Resident 109 had moderate cognitive impairment and required limited assistance of one person for transfers. 2. On 8/24/23 at 12:13 p.m., observed Resident 81 up in recliner. Resident 81's call light was observed on her bed, out of reach. At that time, Resident 81 indicated she used the call light when needed. During an interview on 8/24/23 at 12:16 p.m., CNA 2 indicated most residents used their call light when assistance was needed. On 8/30/23 at 10:10 a.m., Resident 81's clinical record was reviewed. The Quarterly Minimum Data Set (MDS) assessment, dated 8/2/23, indicated the resident was dependent on staff for toileting. During an interview on 8/29/23 at 12:55 p.m., the Administrator indicated that the facility lacked a policy regarding call lights being within reach of the resident. The Administrator indicated call lights should have been within reach of the residents. 3.1-3(v)(1)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents were found to not have their call light cord within reach. On 8/24/2023, the Unit Manager checked all rooms on the Rehab Unit to verify that each resident had their call light cord within reach. On 8/24/2023, the Therapy Manager was notified of the incident and she immediately educated the therapist who left the resident without giving her the call light cord. On 8/25/2023, the Unit Manager checked all rooms on Unit 2 to verify that each resident had their call light cord within reach. On 8/25/2023, all staff on Unit 2 were educated by the Unit Manager and the DON on ensuring that all residents have their call light cord within reach regardless of cognitive status or behaviors of refusing to use the call light cord. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Unit Manager and/or her designee will do random audits to check that residents have their call light cords within reach. This audit will be completed once daily at random times for one week, then at random times, on three different days for one week, and then randomly once a week for	

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			two weeks. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Unit Managers will bring the results of these audits to the monthly Quality Assurance Meeting. The QA committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once 100% compliance has been achieved, the Committee may decide to stop the written audits. The DON and Unit Managers are responsible for implementing and monitoring this plan. **By what date the systemic changes for each deficiency will be completed?** 9/22/2023	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00416022. Complaint IN00416022 - No deficiencies related to the allegations are cited. Survey dates: August 24, 25, 28, 29, 30, 31, and September 1, 2023 Facility number: 001127	R 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	

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	Residential Census: 149 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure that potentially hazardous materials were kept secure behind locked doors to prevent resident access for 1 of 2 observations. (Air Handler Room, Resident 531) Finding includes: On 8/31/23 from 9:00 a.m. to 9:35 a.m., during a facility tour with the Assisted Living Manager, the following was observed on the locked memory care unit of the facility. An air handler room was observed to be located	R 0148	R148 – Sanitation and Safety Standards **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 8/31/2023 between 9:00 a.m. and 9:35 a.m., while touring the air handler room was found to be unlocked. The surveyors walked into the room and felt the pipes to determine they were not hot and proceeded to look around the	09/22/2023

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	around the corner from the nursing station and near the elevator and next to resident rooms G10 and G11. The air handler room door was observed to be unlocked. Inside the room were multiple pipes, valves, nozzles, and machines with exposed wiring along much of the back side. No staff were visible in the area. Resident 531 was observed self-ambulating in the hall and near the unlocked air handler room. On 9/1/23 at 10:30 a.m., Resident 531's clinical record was reviewed. The diagnoses included, but were not limited to, vascular dementia, unspecified cerebrovascular disease, and osteoporosis. During an interview on 8/31/23 at 9:22 a.m., the Assisted Living Manager indicated that the air handler room should have been kept locked. During an interview on 8/31/23 at 1:45 p.m., the Administrator indicated that the air handler room should have been kept locked. On 9/1/23 at 10:05 a.m., the Administrator provided a policy titled Housekeeping Services Policy, dated 12/8/1997, and indicated it was the policy currently in use by the facility. A review of the policy indicated that equipment shall be stored in a safe and secure manner and that hazardous substance and materials should be kept locked.		room. The Residential Manager immediately locked the door upon exit. There were no residents found to have been affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents residing on the unit have the potential to be affected. The Residential Manager immediately locked the door upon exit. It was determined that maintenance had been in the room working. An in-service was given by the Director of Maintenance to the maintenance crew on 9/1/2023. An audit of doors to be kept locked on the unit began on 9/1/2023 and will continue daily until an alternate lock is installed on mechanical doors. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An in-service regarding the importance of mechanical doors being kept locked was given to the maintenance crew by the Director of Maintenance on 9/1/2023. An audit of doors to be kept locked on the unit began on 9/1/2023. All mechanical doors in AL memory care have been replaced with automatic locking doors. The doors will automatically lock and	

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			not be able to be opened without a key on the outside; however, doors will be able to open from the inside. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Director of Maintenance and/or his designee will bring the results of these audits to the monthly Quality Assurance Meeting. The QA committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once 100% compliance has been achieved, the Committee may decide to stop the written audits. The Director of Maintenance and Maintenance Supervisor are responsible for implementing and monitoring this plan. **By what date the systemic changes for each deficiency will be completed?** 9/22/2023	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.			

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	Based on observation, interview, and record review, the facility failed to ensure medications were administered per physician's orders for 1 of 13 residents reviewed. This resulted in the resident receiving the wrong insulin medication. (Resident 479) Finding includes: On 8/31/23 at 10:45 a.m., Resident 479's clinical record was reviewed. The diagnosis included, but was not limited to, type 2 diabetes. The Physician Orders included, but were not limited to: -Humalog (fast/rapid-acting /short acting insulin which works quickly and for a few hours to help prevent high blood sugar after meals) Kwik (flex) pen subcutaneous (below the skin) solution pen injector, inject 12 units subcutaneously before meals related to type 2 diabetes. Initiated on 7/12/23. -Tresiba (Long-acting insulin which takes longer to start working but provides a baseline level of insulin for most of the day) flex touch subcutaneous pen-injector, inject 80 units subcutaneously at bedtime for diabetes. Initiated on 7/7/23. A progress note, dated 8/17/23 at 7:30 p.m., indicated "...Pt [Resident 479] was given 53 units of Tresiba and 27 units of Humalog instead of 80 units of Tresiba...on call [physician] was notified immediately, [Resident 479] BS [blood sugar] was 256 at this time. Order received ..." On 8/31/23 at 1:45 p.m., the DNS (Director of	R 0241	R241 – Health Services **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The said incident occurred on 8/17/2023. The physician was immediately notified. The attending Physician gave the orders to check Resident 479 BS every 30 minutes. Blood Sugars never dropped below 150. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Residents who have insulin pens have the potential to be affected by the same deficient practice. No other residents were identified as being affected. On 8/18/2023, the DON completed an audit to ensure that all insulin orders matched available insulin. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All licensed nursing staff and QMAs were in-serviced on 9/1/2023 regarding the importance of double-checking medications prior to administering them to the resident. An audit to ensure the accuracy of insulin administered to residents receiving insulin will be conducted	09/22/2023

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	Nursing Services) provided a copy of a facility incident report, dated 8/17/23 at 9:03 p.m. A review of the report indicated: "...[Resident 479] was supposed to get 80 units of Tresiba, instead got 53 units of Tresiba and 27 units of Humalog in a different pen. [Resident 479] BS [blood sugar] was 256 at this time, on call [Physician] was notified of error and order to check BS every 30 minutes...[Resident 479] states that she only had 53 units of Tresiba in 1st pen then got another shot with another pen..." QMA (Qualified Medication Aide) 6 was identified as the staff member who administered the wrong medication. Resident 479 was cognitively intact. On 8/31/23 at 1:45 p.m., the DNS provided a copy of an internal email dated 8/17/23 at 9:42 p.m. A review of the email indicated House Supervisor sent the email to the Assisted Living Manager and DNS on 8/17/23 at 9:42 p.m. The email indicated, "subject: med error...[Resident 479] got the wrong dose of insulin instead of 80 units of Tresiba. [Resident 479] got 53 units of Tresiba and 27 units of Humalog. Order received to check BS [blood sugar]..." During an interview on 8/31/23 at 2:00 p.m., the DNS indicated QMA 6 had not followed the Physician's order for insulin administration. QMA 6 gave the wrong insulin type and dosage to Resident 479 on 8/17/23. During an interview on 9/1/23 at 9:20 a.m., Resident 479 indicated about 2 weeks ago QMA 6 administered both the Tresiba and Humalog insulin. The Physician order was for 80 units of Tresiba insulin at that time. QMA 6 felt really "awful" when he realized the wrong insulin was given. QMA 6 reported the error and they took my blood sugars every 30 minutes for several		by the residential nurse at random three times for two weeks, two times for one week, and then one time for one week. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residential Manager will bring the results of these audits to the monthly Quality Assurance Meeting. The QA committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once 100% compliance has been achieved, the Committee may decide to stop the written audits. The DON and Residential Manager are responsible for implementing and monitoring this plan. **By what date the systemic changes for each deficiency will be completed?** 9/22/2023	

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OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

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	hours. Resident 479 indicated having "felt really bad and it took a while to feel better...they kept telling me to eat eat eat!" During an interview and observation on 9/1/23 at 9:45 a.m., QMA 7 opened the medication cart. Inside the medication cart, Resident 479's Tresiba and Humalog insulins were observed. The medications were clearly marked with Resident 479's name, medication name, the scheduled time and dosage for the medication. QMA 7 indicated the medication labels were visible and easy to read so that the correct medication was given at the right dosage and at the right time based on the Physician's orders. During an interview on 9/1/23 at 10:07 a.m., the House Supervisor indicated on 8/17/23 QMA 6 contacted the supervisor to report the insulin medication error. QMA 6 reported 53 of 80 units of Tresiba was administered to Resident 479. QMA 6 then retrieved another insulin pen from the medication cart and administered 27 units of insulin. After the administration of the insulin, QMA 6 realized the second injection was Humalog, a short-acting insulin, rather than the Tresiba, a long-acting insulin. The on-call physician was notified, and they began monitoring the blood sugar levels every 15-30 minutes. Resident 479's blood sugar levels had not fallen below 150. During an interview on 9/1/23 at 1:00 p.m., QMA 6 indicated 2 insulin flex-pens were carried into Resident 479's room. Resident 479 was to be given 53 units of Tresiba from one flex-pen and then 27 units of Tresiba from the second flex-pen, for a total of 80 units as indicated by the Physician's orders. However, QMA 6 indicated the second flex-pen was the Humalog flex-pen			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 00 B. WING	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

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	rather than the Tresiba flex-pen. QMA 6 indicated he "had not re-read the insulin label to ensure he had the correct insulin flex-pen." As soon as the error was identified, QMA 6 notified the House Supervisor. On 9/1/23 at 1:11 p.m., the Administrator provided a copy of QMA 6's Qualified Medication Aide Orientation Checklist with Insulin document. A review of the document indicated QMA 6 successfully completed the insulin administration training as indicated by the signature of QMA 6 and the Trainer on 2/27/23. The skills checklist document indicated, "...this checklist outlines the information the employee needs to know in order to perform the responsibilities of the position of Qualified Medication Aide...has demonstrated sufficient knowledge to perform duties in accordance with the assigned job description...Rights for medication administration...right medication, right dose..." On 8/31/23 at 3:00 p.m. the Administrator provided a copy of the Medication Administration Policy, dated 7/9/21, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...medications will be administered to residents/elders as prescribed. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication...prior to administration, the medication and dosage schedule on the MAR [medication administration record] is compared with the medication label...the physician's orders are checked for correct dosage schedule...medications are administered in accordance with written orders of the attending physician..."			