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	155735	A. BUILDING 00 B. WING	05/01/2024

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ASHFORD PLACE HEALTH CAMPUS	2200 N RILEY HWY SHELBYVILLE, IN 46176

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00430913. This visit included a State Residential Licensure Survey. Complaint IN00430913- Federal/State deficiencies related to the allegations are cited at F0585. Survey dates: April 25, 26, 29, 30, and May 1, 2024. Facility number: 004268 Provider number: 155735 AIM number: 200504460 Census Bed Type: SNF/NF: 35 SNF: 20 Total: 55 Census Payor Type: Medicare: 14 Medicaid: 27 Other: 14 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 3, 2024	F 0000	On 5/1/24, Ashford Place health campus participated in an annual survey, Event ID: V1UT11. The submission of this Plan of Correction does not indicate an admission by Ashford Place Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Ashford Place Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for Ashford Place Health Campus for our annual survey conducted on 5/1/24. We initiated immediate interventions when concerns were identified on this date. We respectfully request desk review with paper compliance for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at 317-398-8422. Sincerely, Zach Simpson	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zachary Simpson	Executive Director	05/17/2024

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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			Executive Director	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her			

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	name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the			

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	resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to timely address a grievance for 1 of 1 resident reviewed for dignity (Resident B). Findings include: The clinical record for Resident B was reviewed on 4/25/24 at 12:03 p.m. The Resident's diagnosis included, but were not limited to, hypertension. A Quarterly MDS (Minimum Data Set) Assessment, completed 2/5/24, indicated she was cognitively intact, frequently incontinent of bowel and bladder, and needed maximal assistance of staff for toileting. During an interview on 4/25/24 at 12:03 p.m., FM	F 0585	**1** Resident B was affected by the alleged deficient practice. **2** All residents have the potential to be affected. The grievance was resolved, and all other grievances were resolved in the correct time frame. **3** An audit will be conducted by ED or designee 5xs weekly for 1 month to ensure that the grievances are followed up and resolved timely. Then 3xs weekly for 1 month and then 1x weekly for 4 months. 4 As a quality measure, the	05/17/2024

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	(Family Member) 20 indicated that approximately a week and a half ago, they had filed a grievance because Resident B had been brought to an appointment on the facility bus after being incontinent of bowel. The facility bus driver had gone back to the facility to get new clothing so that FM 20 could clean Resident B before the appointment. FM 20 was concerned that Resident B had not been toileted prior to leaving the facility. During an interview on 4/30/24 at 2:39 p.m., AS (Activity Assistant) 12 indicated that she had been the bus driver that transported Resident B to her appointment on 4/17/24. Resident B had attended an out of facility activity for approximately 30 minutes prior to her the appointment. AS 12 had taken Resident B from the out of facility activity to the appointment. When AS 12 took Resident B into the building for the appointment AS 12 had heard Resident B tell FM 20 that she had not been cleaned up before she left. FM 20 had taken Resident B into the bathroom and then come back and informed AS 12 that Resident B was a "complete mess" and asked AS12 to go the facility and get Resident B clean clothes. AS 12 had gone to the facility and informed ED (Executive Director) 1 about the incident and taken clean clothing back to the appointment for Resident B. AS 12 had not noted any odors or visible soiling of Resident B's clothing when she transported her to the appointment. During an interview on 4/30/24 at 3:00 p.m., the SSD (Social Services Director) indicated she had found grievance involving Resident B on the grievance log. The grievance was dated 4/17/24 and did not have a resolved date. SSD was unsure why it was not resolved.		Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	On 4/30/24 at 3:23 p.m., the SSD provided a grievance, dated 4/17/24, that indicated Resident B had arrived at a doctor's appointment on 4/17/24 "covered" in BM. AS 12 had been sent back to the facility for a change of clothes. FM 20 was concerned that Resident B was not toileted after lunch or before appointments. The resolution was dated 4/30/24 and indicated the SSD had contacted FM 20 and informed them that education had been provided to the staff on the importance of cleanliness and hygiene prior to going to appointments. On 4/30/24 at 3:26 p.m., ED 3 provided the Resident Concern Process Policy, last reviewed 12/31/23, which read "...To provide a process for handling, tracking and resolving customer concerns to provide excellence in customer service...5. Enter the concern using the desktop icon labeled 'Resident Concern Form'. All concerns should be entered electronically...6. Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution. 7. Follow up from the department leader will occur within 24-48 [sic] with resolution entered in KeyStats..." This Federal Tag relates to complaint IN00430913. 3.1-7(a)(2)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility			

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	unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a			

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	resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of			

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	care. Based on interview and record review, the facility failed to ensure the required medical and contact information was sent to the hospital for 1 of 1 resident reviewed for discharge. (Resident 54) Findings include: The clinical record for Resident 54 was reviewed on 4/29/24 at 10:28 a.m. Her diagnoses included, but were not limited to, stage 4 chronic kidney disease and stage 4 pressure ulcer of the sacral region. She was discharged from the facility to the hospital on 1/27/24. The 1/27/24, 10:06 p.m. nurse's note read, "Res [Resident] has no output in catheter and was flushed x [times] 2. IV [Intravenous] 1L [liter] finished this morning and has drank fluids this shift. Per [name of physician] and spouse send to ed [emergency department] for eval [evaluation.]" The 1/28/24 Clinical Discharge Observation, recorded and completed on 2/2/24, indicated a paper-based reconciled medication list was sent to the hospital with Resident 54. There was no information in the clinical record to indicate the contact information of the practitioner responsible for the care of Resident 54, Resident 54's representative information including contact information, advance directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals, and all other necessary information was sent to the hospital to ensure a safe and effective transition of care. An interview was conducted with the DON (Director of Nursing) on 4/29/24 at 11:20 a.m. She indicated when a resident was sent to the hospital, they sent a bed hold policy, continuity	F 0622	1 Resident 54 was affected by alleged deficient practice. 2 All like residents have the potential to be affected by alleged deficient practice. Health Care Center audit of like residents was completed to ensure proper paperwork was sent with each resident. Licensed staff were in-serviced on proper discharge paperwork. 3 As a measure of ongoing compliance, the DHS or designee will review each discharged resident 5 times per week to ensure compliance with sending required documentation for 4 weeks, then review 3x per week for 4 weeks, then weekly x4 months.- 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	05/17/2024

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	of care documentation, and code status with the resident in a packet given to the EMTs (emergency medical technicians.) Most of the time, nursing documented that in a progress note, but not all of the time. The DON reviewed Resident 54's clinical record and indicated she did not see any documentation to verify that information was sent to the hospital for Resident 54. 3.1-12(a)(3)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the			

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	interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to timely revise a resident's care plans for refusal of showers and depression with individualized interventions for 1 of 5 residents reviewed for unnecessary medications (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 4/26/24 at 9:18 a.m. The Resident's diagnosis included, but were not limited to, depression and anxiety. A care plan, with a start date of 5/5/22 and last reviewed 4/17/24, indicated Resident 20 demonstrates symptoms of depression as evidenced by a score of on the PHQ-9 (depression assessment) sadness and tearfulness. The goal was that the resident will not demonstrate an increase in depressive symptoms. The approaches were GDR (Gradual Dose Reduction) of anti-depressant 4/3/24. Inform psych of an adverse effects noted or any changes in mood/ behavior, initiated 4/8/24, anti-depressant increased 2/5/24 due to failed GDR. Inform psych of any changes in mood/ behavior, initiated 2/5/24, anti-depressant decreased per GDR on 10/20/23 per psych, initiated 10/23/23, assess symptoms of depression with PHQ-9 as needed, initiated 5/5/22, encourage family to visit and participate in the resident's plan of care, initiated 5/5/22, encourage resident to participate in structured group activity and individual leisure activities per choice, initiated 5/5/22, encourage resident to remain actively involved in the plan of	F 0657	1 Resident 20 was affected by the alleged deficient practice. Resident care plan was updated with preferences on showers in the evening. 2 All like residents have the potential to be affected. DHS or designee will complete an audit of all Health Center residents for preferences on shower times. 3 As a measure of ongoing compliance, the Director of Health Services or designee will audit resident preferences upon admission for preferred shower times. Audit will be completed 3 times a week x 4 weeks, 2 times a week x 8 weeks, and then weekly x 3 months. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	05/17/2024

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	care and treatment plan, initiated 5/5/22, meds per order, initiated 5/5/22, observe for overt signs and symptoms of increased depression, initiated 5/5/22, observe mood, affect and behaviors, initiated 5/5/22, provide support and reassurance to resident daily and validate resident's feelings, initiated 5/5/22, provide supportive counseling contacts as needed and refer to psych services as needed, initiated 5/5/22. A care plan, with a start date on 1/17/23 and last reviewed 4/17/24, indicated Resident 20 demonstrated non-compliance with physician orders and/ or plan of care as evidenced by refusing showers at times. The goal was that her preferences will be honored to the extent that non-compliance with physician orders will not result in injury to self or others. The approaches, initiated 1/17/23, were to educate resident regarding physician orders and risk and benefits of compliance, encourage resident to actively participate in care plan and decision making, encourage resident to participate in decision making by offering choices and discussion of advanced directives, observe resident's ability to give informed consent and fluctuations in decision making, and offer alternatives to showers. An Annual MDS (Minimum Data Set) Assessment, completed 1/11/24, indicated she was cognitively intact, needed maximal assistance of staff for showers, and received an anti-depressant daily. A Nursing Home Psychiatric Subsequent Visit Form, dated 3/22/24, indicated that Resident 20's medication history included a reduction on her Lexapro (anti-depressant) to 10 mg (milligram) on 10/20/23 as a GDR. Lexapro was increased to 20			

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	mg on 1/26/24 because the GDR failed. Current psychotropic medications included Lexapro 20 mg each morning. The presenting problem and patient interview on 3/22/24 indicated Resident 20 denied difficulty with sleep at that time. She reported that her depression was no longer a problem. The treatment plan indicated Resident 20 reported her depression had not been a difficulty for her since her Lexapro was increased. She had no side effects with Lexapro. A gradual dose reduction was contraindicated due to her symptoms improving. The March and April 2024 Medication Administration Record indicated she had taken her Lexapro 20 mg daily, as prescribed by the physician, until 4/3/24. A progress note, dated 4/3/24, read "...resident refused Lexapro this am, stating it makes her feel weird and is having weird dreams. Resident does not want to take this med anymore. Notified [psychiatric nurse practitioner] and order to d/c Lexapro." During an interview on 04/26/24 at 9:18 a.m., Resident 20 indicated that she did not get her showers as she should. The staff would say that she refused the shower, but she just wanted them right before bed because the shower helped her relax. She went to bed at different times depending on how she felt and what was on television. She felt bad that she couldn't clean up and was having trouble moving around. She had a counselor when she was at home to talk to but did not have one here. She was observed to be tearful during the interview. She was going to go to bingo later in the day, which she really enjoyed. During an interview on 4/30/24 at 10:02 a.m., the DNS (Director of Nursing Services) indicated			

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	155735	A. BUILDING 00 B. WING	05/01/2024

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	Resident 20's Lexapro had been discontinued because she had been refusing the medication and said it made her feel funny in the head. Resident 20 was tearful often, even when taking the Lexapro. Resident 20 had multiple health issues, including a large cyst on her left ovary. She saw multiple specialists. She has good days and bad days and was seen by the psychiatric nurse practitioner. Staff tried to get her out of the room as much as they could to the dining room or to bingo. The care plan for symptoms of depression had not been updated to reflect that Resident 20 had requested the Lexapro to be discontinued, multiple health concerns which may affect her depression, or to encourage Resident 20 to go to bingo and the dining room for meals. During an interview on 4/30/24 at 2:49 p.m., CNA (Certified Nursing Assistant) 13 and COTA (Certified Occupational Therapy Assistant) 14 indicated that Resident 20 preferred her showers in the evening. There were 3 or 4 CNA's who Resident 20 really liked to shower her and she would refuse showers at times if she didn't like the CNA who was assigned to her. If one of the CNA's she preferred was working, then staff would have that CNA shower her. COTA 14 indicated that she would also assist Resident 20 with showers sometimes. The care plan for refusal of showers at times had not been updated to offer alternate care givers which Resident 20 preferred. On 4/30/24 at 3:45 p.m., the Regional Nurse Consultant provided the Comprehensive Care Plan Guidelines Policy, dated 5/22/18, which read "...To ensure appropriateness of services and			

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	communication that will meet the resident's needs, severity/ stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines...Care plan interventions should be reflective of risk area[s] or disease processes that impact the individual resident...Should new identified area of concern arise during the resident's stay, they should be addressed on the care plan..." 3.1-35(b)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of			

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	records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to administer a resident's medication, as ordered, and to timely address an issue with a physician's order for a new eye medication for a resident whose insurance did not cover the costs of the medication for 2 of 3 residents reviewed for pharmacy services and medication administration. (Resident E and Resident 16) Findings include: 1. The clinical record for Resident E was reviewed on 4/25/24 at 11:55 a.m. Her diagnoses included but were not limited to, type 2 diabetes mellitus and metastatic bone cancer. She was admitted to the facility from the hospital on 4/19/24. An interview was conducted with Resident E on 4/25/24 at 12:00 p.m. She indicated she was discharged from the hospital on a "whole list of medications." Because she was admitted to the facility on a Friday, she did not start getting some of the medications until the following Monday. The 4/19/24 hospital discharge medication list indicated to administer one 75 mg capsule of Glucofunction twice daily and one 950 mg Nutrient capsule twice daily. The April, 2024 MAR (medication administration record) indicated the Nutrient capsule was not	F 0755	1 Resident E was affected by the alleged deficient practice. Order was previously changed to ensure delivery of medication. 2 All like residents have the potential to be affected. DHS or designees will complete an audit of new admissions to ensure all ordered medication is available or changed to a different order. 3 As a measure of ongoing compliance, the Director of Health Services or designee will audit new admissions to ensure all medications ordered are delivered or changed to a new order. Audit will be completed 3 times a week x 4 weeks, 2 times a week x 8 weeks, and then weekly x 3 months. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until	05/17/2024

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	administered on the following dates due to the drug/item being unavailable: once on 4/20/24, twice on 4/23/24, and once on 4/26/24. The Glucofunction capsule was not administered on the following dates due to the drug/item being unavailable: once on 4/20/24, once on 4/22/24, twice on 4/23/24, and once on 4/26/24. An interview was conducted with the DON (Director of Nursing) on 4/29/24 at 10:59 a.m. She called the pharmacy during this interview to inquire as to why the Nutrient and Glucofunction were unavailable for administration on the above dates. After speaking with the pharmacy, the DON indicated neither the Glucofunction nor the Nutrient was delivered from pharmacy. The only thing she could think of was that since both items were over the counter, they were in the medication cart on the assisted living side of their facility, where Resident E resided prior to her being hospitalized, and staff literally walked over and got them, but not until after the above administrations were missed. The Admissions Checklist was provided by the RNC (Regional Nurse Consultant) on 4/29/24 at 12:07 p.m. There was a column to check yes or no as to whether medications were delivered and a column to check yes or no as to whether a second check of the orders was completed. 2. The clinical record for Resident 16 was reviewed on 4/30/24 at 9:31 a.m. Resident 16's diagnoses included, but not limited to, diabetes type II, gout, chronic kidney disease, anxiety disorder, and retention of urine. A physician's order dated 4/10/24 for Resident 16 indicated to administer 1 drop of 0.1% Nevanac ophthalmic solution (a nonsteroidal anti-inflammatory medication used to treat eye		100% compliance is maintained.	

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	pain, irritation, and inflammation) into eye twice a day. This order was discontinued on 4/19/24. A copy of Resident 16's April 2024 MAR (medication administration record) provided by DON (Director of Nursing) on 4/30/24 @ 4:15 p.m. indicated, on the following dates and times, Resident 16 did not receive the Nevanac eye medication: 4/11/24 - morning and evening doses 4/12/24 - morning dose 4/14/24 - morning and evening doses 4/15/24 - morning dose 4/16/24- morning and evening doses 4/17/24 - morning dose 4/18/24 - morning dose 4/19/24- morning dose A nursing note dated 4/10/2024 at 10:22 p.m. indicated, Resident 16 was seen by the eye doctor that day and a new order for Nevanac eye drops was received and noted. A nursing note dated 4/17/2024 at 2:36 p.m. indicated, the facility had attempted to reach Resident 16's eye doctor due to the new order for Nevanac eye drops was not covered by Resident 16's insurance. The nursing note also indicated a voicemail was left asking for the eye doctor to return the phone call to facility. A nursing note dated 4/18/2024 at 6:14 p.m. indicated, Resident 16's eye doctor had called the facility back regarding the Nevanac not being covered by the resident's insurance and inquired if another eye medication, Xibrom 0.9% would be covered by Resident 16's insurance as a substitution for the Nevanac. The nursing note indicated, facility's pharmacy was called and was to call the facility back regarding coverage and			

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	possible other substitutions that would be covered by the resident's insurance. An interview with the facility's pharmacy conducted on 4/30/24 at 9:44 a.m. with Pharm T (Pharmacy Technician) 6 indicated, they had received the physician's order for Resident 16 for the Nevanac on 4/10/24. They further indicated, that on 4/10/24 at 9:42 p.m., they had sent an "unable to send medication communication form" regarding Resident 16's Nevanac eye drops not being covered by insurance and that it would be an out of pocket cost of over $300. An interview with DON conducted on 4/30/24 at 10:15 a.m. indicated, when the pharmacy faxes an "unable to send medication communication form", it goes to the fax machine at the nursing station and the expectation was for the resident's nurse on duty to contact the physician and get issue with the order addressed. DON indicated, she would have expected the resident's nurse that evening or at least the next day to resolve the pharmacy's "unable to fill medication communication". An interview with the facility's pharmacy conducted on 5/1/24 at 10:06 a.m. with Pharm T 7 indicated, Resident 16's eye medication, Nevanac, was never delivered to the facility because of the cost issue. Pharm T 7 indicated, on 4/11/24, they called the facility to inquire about what to do about Resident 16's eye medication, Nevanac, and at that time, the facility indicated, for them (the pharmacy) to place the medication on hold until they speak to the provider. When the pharmacy did not hear back from the facility by 4/16/24, they sent another faxed "unable to fill medication communication form" to the facility. Pharm T 7 indicated, they still had not heard back from the			

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	facility regarding Resident 16's medication issue by 4/19/24 so they faxed another "unable to fill medication communication form" to the facility. When they hadn't heard back from the facility by 4/24/24, they called the facility and were then notified that the order for Resident 16's eye medication was switched to a medication covered by her insurance. Pharm T 7 verified the Nevanac for Resident 16 was never delivered to the facility. A Guidelines for Medication Orders policy received on 4/30/24 at 4:17 p.m. from ED (Executive Director) 3 indicated, "Purpose to establish uniform guidelines in the receiving and recording of medication orders...Telephone/verbal orders...Telephone or verbal orders may be accepted by a licensed nurse only...Telephone or verbal orders shall be recorded in Matrix when received by the nurse receiving the order. 3.1-25(b)(1) 3.1-25(g) 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and			

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	permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure: an ophthalmic (eye) medication was labeled with the date it was opened (Resident 24); the timely destruction of medications for an expired resident (Resident 272); and the controlled medication lock box was permanently affixed within the medication refrigerator (Facility) when reviewed for medication storage and labeling. Findings include: A medication storage observation was conducted on 4/30/24 starting at 4:02 p.m. and ending at 4:37 p.m. During the observation, the following was witnessed: 1. In the medication cart on Hendricks hallway with RN (Registered Nurse) 8, inside a drawer was an opened bottle of Timolol eye drops for Resident 24 with an opened date of 3/21. 2. An observation of the medication room on the healthcare side made with RN 9 found inside a cabinet, an opened bottle of Tylenol contained 10 tablets. The Tylenol bottle was labeled for Resident 272 and according to RN 9, Resident 272	F 0761	1 No resident was affected by the alleged deficient practice. Expired medications were disposed of, and lock box was affixed to the refrigerator. ~~2~~ All residents have the potential to be affected. No other residents were affected. The Executive Director, the Director of Health Services or designee will ensure lock box is stored appropriately and that no expired meds are in the med carts. 3 As a measure of ongoing compliance, the Executive Director, Director of Health Services, or designee will audit med carts to ensure all meds are within their expiration date. Audit will be completed 3 times a week x 4 weeks, 2 times a week x 8 weeks, and then weekly x 3 months. 4 As a quality measure, the	05/17/2024

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	was no longer a resident at the facility. Also, inside the medication room, was a medication refrigerator with a metal, locked box which contained controlled medications. The metal locked box was not permanently affixed within the fridge. An observation of the metal lock box for controlled medications inside the refrigerator was made with DON (Director of Nursing) on 4/30/24 at 4:37 p.m. It was observed a metal wire that, according to DON, had been attached to the metal locked medication box was broken and was no longer attached to the metal box. She indicated, she had not been made aware of the controlled medication lock box was no longer tethered to the fridge and was not sure how long it had been like that. A clinical record review for Resident 272 conducted on 5/1/24 at 9:28 a.m. indicated, Resident 272 had expired on 12/24/23. Resident 272's tylenol tablets should have been destroyed/returned in a timely manner. The National Library of Medicine at https://pubmed.ncbi.nlm.nih.gov/Hanssens JM, Quintana-Giraldo C, Jacques S, El-Zoghbi N, Lampasona V, Langevin C, Bouchard JF. Shelf Life and Efficacy of Diagnostic Eye Drops. Optom Vis Sci. 2018 Oct;95(10):947-952. doi: 10.1097/OPX.0000000000001288. PMID: 30234830 last accessed 5/2/24 indicated, pharmaceutical companies recommend discarding ophthalmic drugs 28 days after opening. A Labeling of Medications and Biologicals policy received on 5/1/24 at 11:32 a.m. from RNC (Regional Nurse Consultant) indicated, "Facility staff should date the label of any multi-use vial		Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	when the vial is first accessed...The staff will check the expiration date of each medication before administering it...No expired medications will be administered to a resident..." 3.1-25(k) 3.1-25(n) 3.1-25(o) 3.1-25(r)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review, the facility failed to timely obtain a urinalysis, as ordered by the physician, for 1 of 5 residents reviewed for unnecessary medications (Resident 23). Findings include: The clinical record for Resident 23 was reviewed on 4/29/24 at 10:30 a.m. The Residents diagnosis included, but did were not limited to, diabetes and kidney failure. A Quarterly MDS (Minimum Data Set) Assessment, completed 3/6/24, indicated that she was cognitively intact. A Nurse Practitioner Nursing Home Visit note, dated 4/25/24, indicated that Resident 23 reported	F 0770	1 Resident 23 was affected by the alleged deficient practice. Resident urine was tested and sent to lab STAT. 2 All like residents have the potential to be affected. No other residents were affected. Director of health services or designee will audit all STAT lab orders by physician to ensure they are completed timely. 3 As a measure of ongoing compliance, Director of Health Services, or designee will audit STAT lab orders in clinical care meeting to ensure compliance with state guidelines. Audit will be	05/17/2024

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	urinary frequency, dysuria, and urgency. The plan was to complete a STAT (right away) urinalysis with culture and sensitivity. A physician's order, dated 4/25/24, indicated to obtain a STAT UA with C and S. During an interview on 4/29/24 at 12:44 p.m., the DNS (Director of Nursing Services) indicated that the UA had not been sent to the lab on 4/25/24. It should have been obtained on 4/25/24. On 4/29/24 at 4:01 p.m., the Regional Nurse Consultant provided the current Ordering Lab Test Policy which read "... Once the specimen has been collected...Lab Services Customer Care Team to arrange for transport of your STAT specimen[s] to the STAT partner with which we have contracted for you..." 3.1-49(a)		completed 3 times a week x 4 weeks, 2 times a week x 8 weeks, and then weekly x 3 months. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,			

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	identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	155735	A. BUILDING 00 B. WING	05/01/2024

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control policy by not performing hand hygiene prior to glove use and after dropping a pill onto a medication cart, picking up the pill with bare hands and administering it to the resident for 1 of 3 residents reviewed during the medication administration observation. (Residents 9 and 16) Findings include: 1. A medication administration observation with RN (Registered Nurse) 4 was conducted on 4/30/24 at 8:43 a.m. RN 4 was observed while she prepped and administered Resident 16's oral medications. After administering the oral medications, she turned around back to her medication cart; touched the medication cart and her keys to unlock the cart; opened a drawer and retrieved a pill bottle which contained Resident 16's eye drops bottle. RN 4 had, without performing hand hygiene, donned (put on) gloves and administered the eye drops to Resident 16. An interview with RNC (regional Nurse	F 0880	1 Resident 16 was affected by alleged deficient practice. Staff member was educated on proper handling of medication and medication administration. 2 All residents have the potential to be affected. Licensed staff have been educated on the following CDC and facility policy. The Executive Director (ED), Director of Health Services (DHS), Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same team will review the Long-Term Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. 3 As a measure of ongoing	05/17/2024

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	Consultant) conducted on 4/30/24 at 11:53 a.m. indicated, yes, RN 4 should have performed hand hygiene prior to donning clean gloves and administering Resident 16's eye medication since she had administered medication, touched her keys, unlocked the medication cart, and retrieved the medication out of the cart prior to donning the gloves. 2. A medication administration observation with LPN (Licensed Practical Nurse) 5 was conducted on 4/30/24 at 9:10 a.m. LPN 5 was observed preparing the medications for Resident 9. LPN 5 was opening the pill packets with scissors and then dumping them into a medication cup when one tablet from a pill packet had fell onto the medication carts top. LPN 5, with bare hands, quickly picked up tablet from the top of the medication cart and placed the tablet into the medication cup with Resident 9's other tablets and administered the medications to the resident. She had not performed hand hygiene prior to touching the tablet with her bare hands. An interview with LPN 5 was conducted after the medication administrations and when asked why she picked up the medication off the medication cart with her bare hands, she explained that with the pill packets, she didn't have another tablet (of the same medication) which to replace it. LPN 5 identified the medication she dropped as Resident 9's pantoprazole (acid reducing medication)tablet. LPN 5 indicated, she was unsure if the facility's emergency drug supply carried that medication. An Infection Prevention and Control General Guidelines policy received on 5/1/24 at 2:37 p.m. from ED (Executive Director) 3 indicated, the purpose of the policy was "To provide guidelines to prevent the spread of infection from one person to another...Hand washing is the most important		compliance, the following audits and/or observations for 3 residents will be conducted by the ED, campus IP, or designee. Audit will be completed 3 times a week x 4 weeks, 2 times a week x 8 weeks, and then weekly x 3 months. All findings from the RCA, if different from current audit, will result in additional audits. The ED, campus IP, or designee will round the campus daily to ensure appropriate infection control practices are maintained and for any needs as determined from RCA findings for a minimum of 6 weeks and will continue thereafter until compliance is maintained. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	method of infection prevention and control...Hands should be washed between direct contact with any resident, after doing cleaning tasks, after using the restroom or any other tasks that provides an opportunity for infection...Gloves should be worn when coming in contact with blood or body secretions..." The Centers for Diseases and Control website at https://www.cdc.gov/handhygiene/providers/index.html; Last Reviewed: January 8, 2021, Source: Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Healthcare Quality Promotion (DHQP) last accessed 5/1/24, Glove Use When and Where to use Gloves indicated, "Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves." 3.1-18(b) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00430913	R 0000	On 5/1/24, Ashford Place health campus participated in an annual survey, Event ID: V1UT11. The submission of this Plan of Correction does not indicate an	

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	Complaint IN00430913- Federal/State deficiencies related to the allegations are cited at F0585. Survey dates: April 25, 26, 29, 30, and May 1, 2024. Facility number: 004268 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 3, 2024		admission by Ashford Place Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Ashford Place Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for Ashford Place Health Campus for our annual survey conducted on 5/1/24. We initiated immediate interventions when concerns were identified on this date. We respectfully request desk review with paper compliance for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at 317-398-8422. Sincerely, Zach Simpson Executive Director	
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.			

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	Based on observation and interview, the facility failed to ensure medication and laboratory supplies were not expired as reviewed for medication storage and labeling. This had the potential to affect 29 of 29 residents residing on the facility's Assisted Living. (Facility) Findings include: A medication storage observation of the medication room on the Assisted Living was conducted with LPN (Licensed Practical Nurse) 12 on 5/1/24 at 2:03 p.m. Within the drawers and cabinets in the medication storage room the following was observed: 1. Four Monojet 1 ml (milliliter) TB (tuberculosis) syringes with an expiration date of 8/31/23. 2. One winged blood collection set with an expiration date of 12/31/22. 3. Two urine collection tubes with an expiration date of 8/22 and two other urine collection tubes with an expiration date of 4/23. An interview with DON (Director of Nursing) on 5/1/24 at 2:27 p.m. indicated, expired supplies should not be available for use and should be removed/thrown away from the available supply stock.	R 0145	**1** No residents were affected by the alleged deficient practice. **2** All residents have the potential to be affected. All expired supplies were disposed of immediately. **3** An audit will be conducted by ED or designee 3x weekly for 1 month to ensure that there are no expired supplies in the storage room. Then 2x weekly for 1 month. And once weekly for 4 months. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	05/17/2024
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (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.			

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	(2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure the resident needs assessment included an evaluation of the resident's ability to self-administer medications 1 of 2 residents reviewed for self-administration of medications. (Resident 14) Findings include: The clinical record for Resident 14 was reviewed on 5/1/24 at 11:47 a.m. Resident 14's diagnoses included, but were not limited to, hypertension, congestive heart failure, and atrial fibrillation (heart flutters). A physicians order for Resident 14 dated 4/18/24 indicated, Resident 14 may self-administer one puff twice a day of fluticasone propion-salmeterol (medication for allergies)113-14 mcg (micrograms)/actuation nasal spray and he may keep it at bedside. An interview with DON (Director of Nursing) conducted on 5/1/24 at 12:07 p.m. indicated, Resident 14 had been a resident on the facility's health care side prior to admitting to their Assisted Living. She further indicated, the self-administration assessments should be charted under the "Observations" section of the electronic health record and stated she would locate Resident 14's self-administration of medication assessments.	R 0216	1 Residents 14 was not affected by the alleged deficient practice. 2 All residents have the potential to be affected by the alleged deficient practice. Self-administration policy reviewed and updated on resident 14. 3 DHS or designee will audit residents who self-administer their own medications. Audit will occur 2x per week for 8 weeks, and 1 x per week for 4 months. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	05/17/2024

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	Two Self Administration of Medication assessments for Resident 14 were received on 5/1/24 at 2:13 p.m. from DON. One self-administration of medication assessment was dated 8/15/22 and the other was dated 10/26/22. A Self-Administration of Medications Guidelines policy received on 5/1/24 at 12:10 p.m. from RNC (Regional Nurse Consultant) indicated, " Procedures 1. Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed for safety by a licensed nurse. 2. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. a. The order should include the type of medication(s) the resident is able to self-medicate...4. The medication will be kept in a locked drawer in the residents' room...9. The Assessment will be reviewed bi-annually and PRN [sic, per required need] with change of condition. 10. The assessment will be recorded in the medical record."			