STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00407499. Complaint IN00407499 - State deficiencies related to the allegations are cited at R0216, R0217, R0241, R0242, R0243, R0246, and R0349. Survey dates: May 24, 25, and 26, 2023. Facility number: 014548 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 1, 2023	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to ensure the results of the most recent survey were available to the residents. This had the potential to affect all 44 residents who resided in the facility. Findings include:	R 0042	POC for R042 ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The most recent survey was added to the Survey Results binder and placed in a prominent location while the survey was still underway. ¿ How	06/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Crystal L Werner	Administrator	06/16/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	An interview with Resident C, on 5/25/2023 at 10:45 a.m., indicated she has been looking for the survey book. She always reads the surveys after the surveyors visit, but they have moved the book around. She indicated it was kept in the library, but then they moved the binder to be by the fish tank then to the nurses' station and now is back at the fish tank. She stated the sign says it is in the library, but it is not and that the most recent visit from a surveyor is not in there. During an observation, on 5/25/23, at 3:00 p.m., a binder that contained the state surveys was located in a wall mounted holder, to the right of the fish aquarium. The binder included surveys dated 11/4/2021 and earlier, but did not contain the most recent survey, dated 3/23/23. A framed note, on the left side of the survey binder, indicated the surveys were in a desk drawer in the library. Further observation in the library, failed to locate a survey binder in any of the drawers. On 5/26/23, at 2:05 p.m., the binder with the state surveys, was observed in the wall holder beside the fish aquarium and the latest survey, dated 3/23/23 was not in the binder. On 5/26/23, at 2:24 p.m., the Corporate Nurse Consultant indicated they have the survey form the last survey, and provided the survey with the plan of correction. She said she didn't know when they had received it or why it wasn't in the binder, and indicated she would put it in the binder. 3.1-3(b)(1)		the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. Immediately upon receipt of the current survey results, a copy of those results was placed in the binder. Additionally, an 8 X 11 sign was posted in a prominent location indicating the specific location of the Survey Results binder. A smaller directional sign was placed above the specific location to further ensure appropriate access and a note was added to the binder cover requesting that the binder be returned to that location to ensure consistent availability of the Survey Results for all. ¿ What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The administrator will provide a written notice to residents regarding the location of the Survey Results binder as well as a request that the Survey Results binder consistently be returned to that location. The Administrator will conduct an “All-Staff” training on Resident Rights as well as the specific location of the Survey Results binder. ¿ How the corrective action(s) will be monitored to ensure the deficient practice will	

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			not recur, i.e., what quality assurance program will be put into place: The administrator (or designee) will conduct an audit 4 times weekly for 2 weeks, then 2 times weekly for 2 weeks then 1 time weekly for 2 weeks, then monthly on an ongoing basis to confirm the Survey Results Binder, as well as the appropriate signage remains accessible for all.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal			

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	representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to report an unusual occurrence of a burn surrounded by dead skin within 24 hour of discovery for 1 of 1 residents reviewed for unusual occurrences. (Resident F) Findings include: The clinical record for Resident F was reviewed on 5/24/2023 at 2:15 p.m. The medical diagnosis included diabetes. A progress note, dated 3/19/2023, indicated that Resident F reported spilling hot water on his foot/ankle three days prior and upon examination, the area had "dead skin around this 1/2" x 1 1/2"	R 0090	p paraid="1618038198" paraeid="{6cc15442-b163-4777-be30-3d62a9b24141}{179}" >POC for R090 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: DON assessed Resident F's ankle to confirm the skin of the affected area was healed and fully intact, though there is evidence of scarring. Further, the resident stated no	06/15/2023

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	[1/2 inch by 1 and 1/2 inch] area". An interview with Director of Nursing and Wellness on 5/25/2023 at 11:45 a.m., indicated that Resident F had dropped water on his ankle/foot and sustained a burn with some dead skin surrounding it. She had applied first aid treatment. The burn was talked about the next day in morning meeting, 3/20/2023. An interview with the Administrator on 5/26/2023 at 1:35 p.m. indicated she could not find where this event was reported to the state department of health for Resident F's burn. She indicated it would be an unusual occurrence to have dead skin around a burn and would have expected it to be reported. 3.1-13(g)(1)(D)		current pain or discomfort in the area. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. Administrator reviewed Morning Meeting notes and Incident Report log for past 30-days to ensure no additional recent incidents have been overlooked for reporting unusual occurrences, as defined by IDOH and Indiana Residential Regulations. No incidents were found that required an Unusual Occurrence report. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator will conduct an “All-Staff” training on Unusual Occurrence reporting requirements. ul class="BulletListStyle1 SCXW72436656 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible;	

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			cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator (or designee) will review progress notes for 5 residents, all Morning Meeting notes and all Incident Reports weekly for , then monthly for 6 months to ensure all Unusual Occurrences have been appropriately identified and reported.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be			

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	documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to conduct fire drills every month for 9 of 12 months, during the last year. This had the potential to affect all 44 residents who resided in the facility. Findings include: During an interview, on 5/26/23, at 11:30 a.m., the Corporate Nurse Consultant indicated she could not find any fire drills for the last 12 months. On 5/26/25, at 12:08 p.m., the Corporate Nurse Consultant indicated she had found some of the fire drills that were conducted in the last year, and provided fire drills dated 6/8/22 at 2:30 p.m., 2/1/23 at 7:05 p.m., and 3/17/23 at noon, and said that is all they could locate. 3.1-51(c)	R 0092	p paraid="1715713359" paraeid="{311799e2-27fa-43df-b820-1ad833243f79}{206}" >POC for R092 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Administrator planned a Fire Drill in-service and posted a notice on June 5 regarding the date and time of the in-service. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. Administrator developed a Fire Drill calendar to properly manage the execution of fire drills. The calendar has a fire drill scheduled quarterly on each shift with the local fire department invited to attend 2 fire drills per calendar year. ·What measures will be put into place or what systemic changes the facility will make to ensure	06/30/2023

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			that the deficient practice does not recur: The Administrator will conduct an “All-Staff” training on Fire Drill requirements. ul class="BulletListStyle1 SCXW117111813 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator (or designee) will conduct fire drills quarterly on each shift with the local fire department invited to attend 2 fire drills each calendar year. A monthly audit will be conducted on the last Tuesday of each month for one year to confirm the fire drill scheduled for that month has been completed, as planned. The audit will monitor documentation of each months’ fire drill, which will be placed in both the POC Audit Binder as well as the Maintenance Binder.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but			

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	is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to have required dementia training for 3 of 5 employee records reviewed. (QMA 6, Dietary Manager, and Maintenance 7) Findings include:	R 0120	POC for R120 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A video-based	07/15/2023

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		A. BUILDING 00 B. WING	05/26/2023

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TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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	Employee records were reviewed, on 5/26/23 at 11:00 a.m., and indicated: QMA 6 was hired on 8/22/22. Six hours of dementia training was not completed on the employee record after hire. The Dietary Manager was hired on 3/28/20. No dementia training was indicated in the last 12 months on the employee record. Maintenance 7 was hired on 3/26/22. No dementia training was indicated in the last 12 months on the employee record. On 5/26/23, at 11:30 a.m., the Corporate Nurse Consultant indicated she could not find any dementia training for the employees reviewed on the employee record form. A Policy for "Orientation/Training/Health Screenings/TB" was provided by the Corporate Nurse Consultant, on 5/26/23 at 2:20 p.m. The policy indicated, but was not limited to: "Employee orientation and training will be provided to employees before they are assisted responsibilities in assisting residents...Each new employee shall complete orientation prior to working independently...Annual Training: Nursing personnel must have 8 hours of in-service per calendar year. Non-Nursing personnel who have contact with residents should have 4 hours of in-service per year. All staff should have 6 hours of dementia specific training within first 6 months of hire and then 3 hours annually thereafter...." 5.1-4(e)(2)		dementia education program was purchased for staff training purposes. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. The administrator developed an in-service calendar to appropriately plan and track ongoing staff training. The calendar has a different training topic to be presented at each monthly "all-staff" meeting. The calendar incorporates each in-service training topic specified in the Residential Regulations, including dementia training. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator will audit all employee files to ensure dementia training is completed for all current employees and will assign new employees the required 6 hours of dementia specific training within their first 6 months of employment. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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			quality assurance program will be put into place: The Administrator or designee will conduct monthly "All-Staff" meetings to include 3 hours of dementia specific training throughout the year. A quarterly audit will be conducted for one year to confirm all employees have completed all required dementia training.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with			

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	tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure staff had an annual Tuberculin (TB) skin test and/or tuberculosis risk assessment for 5 of 5 employee records reviewed. (QMA 6, QMA 3, Dietary Manager, QMA 8, and Maintenance 7) Findings include: Employee records were reviewed on 5/26/23 at 11:00 a.m., and indicated: QMA 6 was hired on 8/22/22. No first step TB skin test or second step TB skin test was found in the employee record. QMA 3 was hired on 1/17/23. No second step TB skin test was found in the employee record. The Dietary Manager was hired on 3/28/20. No annual risk assessment was found in the employee record. QMA 8 was hired on 2/14/23. No first or second	R 0121	p="" paraid="259049428" paraeid="{6104bafc-5340-4291-85f8-4e142decb528}{197}">POC for R121 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit of all employee files was conducted to identify which employees were missing appropriate health screenings, specifically the Two-Step TB screening and/or an annual risk assessment How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. A TB screening session for all-staff was planned for June 15, 2023. What measures will be put into place or what systemic changes the facility will make to	07/15/2023

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		A. BUILDING 00 B. WING	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	step TB skin test was found in the employee record. Maintenance 7 was hired on 3/26/22. No annual risk assessment was found in the employee record. On 5/26/23, at 11:30 a.m., the Corporate Nurse Consultant indicated she could not find any documentation of TB skin tests or annual risk assessments for these employees. A Policy for "Orientation/Training/Health Screenings/TB" was provided by the Corporate Nurse Consultant on 5/26/23 at 2:20 p.m. The policy indicated, but was not limited to: "Employee orientation and training will be provided to employees before they are assisted responsibilities in assisting residents...Health Screenings: All staff must undergo a health evaluation prior to resident contact. Evaluation must include immunization status and include a physical examination. TB Testing: Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code. This test must be completed at the time of employment or no more than 1 month prior to employment. The first TB test must be read prior to employee starting work. For healthcare workers who have not had documented negative TB test result during the preceding 12 months, they need a 2 step TB test. If first TB is negative, the 2nd test should be performed 1-3 weeks after the first step...Annually all employees and non-paid personnel shall be screened for TB." 5.1-4(f)(1)		ensure that the deficient practice does not recur: The DON will conduct 1 step TB skin tests at the time of hire, to be read prior to the new employee beginning work. The 2 step TB skin test will be scheduled by the DON during the first 3 weeks of employment. An annual TB risk assessment will be scheduled on the employment anniversary date for each employee. ul="" role="list" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will conduct monthly audits on 25% of all employee files to confirm employees have completed all required TB screenings.	
R 0123	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance			

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		A. BUILDING 00 B. WING	05/26/2023

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Bldg. 00	(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure new employees had a specific job orientation checklist completed for 2 of 5 employees reviewed. (QMA 6 and QMA 3) Findings include: Employee records were reviewed on 5/26/23 at 11:00 a.m., and indicated: QMA 6 was hired on 8/22/22. The employee record did not have a specific job orientation checklist. QMA 3 was hired on 1/17/23. The employee record did have a specific job orientation checklist.	R 0123	p paraid="408167940" paraeid="{5d6dbb2f-cefd-4dff-9da2-646cdb70458f}{197}" >POC for R123 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A QMA job specific training checklist was developed. ·How the facility will identify other residents having the potential to be affected by the	07/15/2023

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	During an interview, on 5/26/23, at 11:30 a.m., the Corporate Nurse Consultant indicated she could not find any specific job orientations for the employees listed on the employee record form. A Policy for "Orientation/Training/Health Screenings/TB" was provided by the Corporate Nurse Consultant on 5/26/23 at 2:20 p.m. The policy indicated, but was not limited to: "Employee orientation and training will be provided to employees before they are assisted responsibilities in assisting residents...Each new employee shall complete orientation prior to working independently...6. Documentation of the orientation in the employee's personnel record by the person supervision (sic) the orientation...." 5.1-4(h)(7)		same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. All current QMAs were provided with job specific training and a checklist was utilized to indicate completion of the training. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator will audit all QMA employee files to ensure job-specific training is completed. ul class="BulletListStyle1 SCXW257516974 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will provide job specific QMA training to all newly hired QMAs prior to the new employee working independently.	
R 0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency			

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Bldg. 00	(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 interview and record review, the facility failed to ensure the heating and ventilation system was inspected at least annually. This had the potential to affect 44 residents residing in the facility. Findings include: Annual inspection report or invoice for heating and ventilation was requested from the facility on 5/25/2023. An interview with the Administrator and Maintenance on 5/26/2023 at 2:05 p.m. indicated that the facility had the heating and ventilation system repaired over the last year, but did not have a full inspection in the last 12 months. The Maintenance was unaware of this needing to be completed yearly, but he would work on getting an inspection set up. 5.1-5(e)(4)	R 0148	p paraid="23251769" paraeid="{5926b9cc-171f-4cb8-bc6d-e8767d3c24f2}{206}" >POC for R148 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A licensed HVAC vendor/service provider was contacted to request a complete inspection of the building heating and ventilation system. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what	07/15/2023

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			corrective action will be taken: All residents had the potential to be affected by the deficient practice. An inspection of the facility heating and ventilation system was scheduled. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator will schedule an annual follow-up heating and ventilation system inspection and inform the vendor/service provider that this inspection must be scheduled and conducted consistently on an annual basis. This annual expectation will be added to the communities' preventative maintenance calendar. ul class="BulletListStyle1 SCXW9924165 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will set an electronic calendar alert for 11 months from	

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			the most recent heating and ventilation system inspection to ensure the next annual inspection is scheduled with the vendor/service provider in a timely manner.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain dishwasher temperatures high enough to ensure sanitary dishes, failed to maintain temperature logs on the dishwasher, walk in refrigerator, and walk in freezer, and failed to keep the floor of the walk in refrigerator clean and free of debris for 2 of 2 kitchen observations. This deficient practice had the potential to affect all 44 residents who resided in the facility. Findings include: On 5/24/23, at 10:35 a.m., the dishwasher temperatures were observed with Dietary Assistant 5. The wash cycle temperature registered 150 degrees. The rinse cycle temperature didn't register due to the needle on the gauge did not move. The Dietary Manager was interviewed at that time and indicated they did not have any other way to check the temperatures of the dish machine. She said the gauge has not been working off and on. The Dietary Manager used a hand held food thermometer and tested the water temperature,	R 0154	p paraid="1932736529" paraeid="{caeeb550-9248-40d5-8410-83d24fefb845}{206}" >POC for R154 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Administrator confirmed that disposable tableware was utilized for 100 % of all meal services while the dish machine rinse temperature was unable to be determined. The Dining Services Manager was asked to clean the floor of the walk-in refrigerator. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what	07/15/2023

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	after the rinse cycle, from a cup that was turned right side up, and went through the dishwasher wash and rinse cycles. The water tested 145.5 degrees. The Dietary Manager attempted to find the temperature logs for the dishwasher but the test logs did not have temperatures written on them for May, 2023. The Dietary Manager indicated they would use styrofoam plates and plastic utensils at lunch and indicated she would use would not use the dishes from the dishwasher. The sanitizing part of the 3 compartment sink was in use, and tested by the Dietary Manager between 200 to 400 parts per million (PPMs). The Dietary Manager said they could use the sanitizing compartment of the 3 compartment sink to sanitize some dishes. On 5/24/23, at 10:42 a.m., observed the walk in refrigerator with the Dietary Manager. On the right side, under the bottom metal wire shelves were 2 areas of fresh blood on the floor. One area was approximately 4 inches by 4 inches, and the other area was slightly smaller. The Dietary Manager indicated the blood was from hamburger that was thawing. A box of hamburger, in large rolls, was on the bottom metal wire shelf. On the left side, under the lowest metal wire shelf, were scattered areas of a black substance and the Dietary Manager indicated it looked like mold but she wasn't sure. Around the black substance was a rust/brown colored substance, and scattered onion skins on the floor. On 5/24/23, at 12:20 p.m., lunch was observed served in the dining room, and residents were utilizing styrofoam plates and cups, and plastic utensils. Residents were also using porcelain coffee cups, glass cups, and square glass bowls. On 5/24/23, at 1:15 p.m., Dietary Aide 5 indicated		corrective action will be taken: All residents had the potential to be affected by the deficient practice. The dish machine was repaired and returned to service after confirming the rinse cycle consistently reached the appropriate sanitizing temperatures. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Dining Services manager has implemented a kitchen cleaning schedule to be used by all dining services team members and is monitoring the dish machine temperature logs daily. ul class="BulletListStyle1 SCXW263911438 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will conduct an audit of dish machine temperature logs 3 times weekly for 3 weeks and 1	

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	they had used the cups, coffee cups and bowls because they were already in the dining room before lunch. She said she didn't know if those dishes had been sanitized. On 5/24/23, at 1:25 p.m., Cook 2 indicated the pots and pans used to cook the meal had been sanitized in the 3 compartment sink prior to lunch, but he didn't know if the dishes in the dining room had been sanitized. Observation of the glass dishes used from lunch that were beside the 3 compartment sink included: 35 small porcelain bowls, 5 larger porcelain bowls, 28 glasses that were a mix of 8 ounce and 16 ounce glasses, and 9 porcelain coffee cups. On 5/25/23, at 11:35 a.m., the walk in refrigerator floor was observed. On the right side, under the metal shelves, the 2 blood spills remained on the floor and the the scattered brown/rust and black areas remained on the left side under the metal shelves. There were scattered onion skins on the floor also. On 5/25/23, at 11:36 a.m., Cook 2 indicated no one person mops the floor, just whoever gets to it. On 5/26/23, at 3:19 p.m., the Administrator indicated they have not found documentation for the dish machine, freezer or fridge temperatures having been taken. A policy for "Kitchen Equipment maintenance" was provided by the Corporate Nurse Consultant on 5/26/23 at 2:20 p.m. The Policy included, was not limited to: "Maintain all major kitchen equipment in good working condition by ensuring regularly scheduled and as-needed servicing...1. Perform regularly scheduled maintenance and		time weekly for 3 months. The Administrator or designee will conduct a kitchen inspection 3 times weekly for 3 weeks and 1 time weekly for 3 months to ensure cleanliness is maintained in all kitchen areas, to include the walk-in refrigerator. The Administrator or designee will audit the Kitchen Sanitation binder to confirm appropriate utilization of the kitchen cleaning schedule.	

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	cleaning on kitchen equipment (freezers, stoves, coolers, etc.) on a regular basis...4. Ensure high temperature (dish) ware washing machine reaches a minimum of 180 degree F during rinse cycle. a. If required temperature is not reached, the Food Services Director will notify the Administrator immediately to ensure repairs can be scheduled in a timely manner. B. Disposable plates, bowls, and utensils can be used until machine is returned to service OR c. All dishes may be sanitized by utilizing a 3-Compartment Sink with appropriate QUAT sanitizer as final step in the ware washing process." A policy for "Dietary Staff Policies" was provided by the Corporate Nurse Consultant on 5/26/23 at 12:08 p.m. The policy included, but was not limited to: "...Refrigeration and Freezer temperatures must be recorded daily...Dishwasher and kitchen water temperatures must be recorded daily. If temperatures are above or below Health Department guidelines, then adjustments must be made to units to correct...."			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure each resident had an an evaluation of the resident's condition updated at least every six (6) months and with any known substantial change in the resident's status, with a licensed nurse evaluating the nursing need of the	R 0214	p paraid="670629941" paraeid="{20866d29-87b4-492e-9304-4afd774866b7}{206}" >POC for R214	07/30/2023

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	resident, for 2 of 7 residents reviewed for evaluations and service plans. (Residents B and D) Findings include: 1. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. His 2-22-22, initial "Level of Care Assessment," indicated he was of normal cognition. His 12-7-22, "Level of Care Assessment," indicated he had minimal cognitive impairment, requiring occasional remainders and guidance. His 2-20-23, "Service Plan," indicated he displayed "good" judgement. A "Mini Mental Status Examination (MMSE)", dated 2-20-23, indicated he had a score of 22 out of 30, which could indicate possible cognitive impairment. At some point, date unknown, Resident B, elected to have the facility begin to administer his medications. In an interview with Resident B on 5-24-23 at 2:40 p.m., he indicated he previously administered his own medications and prefers for the staff to administer his medications as he cannot see well enough to safely administer his medications. A nursing note, dated 4-28-23, indicated the POA (power of attorney) for Resident B indicated she wished "to take over resident's med administration." An updated self-administration assessment was not located in the clinical record, prior to the resident resuming self-administering his medications for 1 to 2 days. In an interview with the Administrator on 5-25-23		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit was conducted to identify additional residents who may need updated semi-annual assessments completed. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. All residents identified as needing updated assessments were evaluated by the DON or designee. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The DON has developed and implemented a calendar/schedule to track resident assessments, ensuring evaluations are completed on a semi-annual basis. ul class="BulletListStyle1 SCXW86319677 BCX8" role="list" style="margin: 0px; padding: 0px;	

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	at 9:50 a.m., she indicated when the POA approached the staff with wanting Resident B to self-administer his medications, one of his medical care providers provided an order for him to do so. She indicated the facility staff did not feel he could safely administer his medications due to being legally blind, as well as the resident saying he did not wish to do this as he cannot see well enough to administer his medications. An updated self-administration assessment was not located in the clinical record, prior to the resident self-administering his medications for 1 to 2 days for on/around 4-28-23. An updated service plan was not located in the clinical record to reflect Resident B had resumed self-medication administration for on/around 4-28-23. 2. The clinical record for Resident D was reviewed on 5/24/2023 at 11:40 a.m. The medical diagnoses included chronic obstructive pulmonary disease and emphysema. The most recent semi-annual nursing assessment for Resident D was dated for September 2022. Per an interview with the Director of Nursing and Wellness on 5/25/2023 at 1:55 p.m. indicated that the last semi-annual nursing assessment for Resident D was documented in September 2022. She stated she would expect the nursing assessments be completed every 6 months or as needed. A policy entitled, "Resident Assessment/Service/Care Plan", was provided by the Corporate Nurse on 5/26/2023 at 2:20 p.m. The policy indicated, "...The service plan must be updated at least SEMI ANNUALLY or when a significant change occurs..."		user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will conduct an audit of 25% of all resident charts monthly for 3 months, then 10% of all resident charts monthly for 3 months to ensure semi-annual assessments are complete and present in the resident chart.	

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R 0216 Bldg. 00	2-5-2(a) 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. (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 an evaluation or assessment for the resident's ability to safely self-administer medications, if the resident desires to do so, is accurately documented at least annually and with any significant change in condition for 2 of 7 residents reviewed for medications (Residents B and C) Findings include: 1. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. A "Self-Administration of Medication Assessment," dated 2-22-22, indicated, "Can self-medicate r/t [related to] VA [Veteran's Administration] nurse sets all meds up in daily	R 0216	p paraid="1129071297" paraeid="{a13a3f62-01c7-4767-8588-1d66d80c4e84}{206}" >POC for R216 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit was conducted of all residents currently self-administering their medications. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what	07/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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	container. Nursing staff to monitor Res [resident] r/t res legally blind & may drop meds. If does res cannot see to find dropped meds. Needs assist [sign for with] eye gtts [drops]." At some point, date unknown, Resident B, elected to have the facility begin to administer his medications. In an interview with Resident B on 5-24-23 at 2:40 p.m., he indicated he previously administered his own medications and prefers for the staff to administer his medications as he cannot see well enough to safely administer his medications. A nursing note, dated 4-28-23, indicated the POA (power of attorney) for Resident B indicated she wished "to take over resident's med administration." An updated self-administration assessment was not located in the clinical record, prior to the resident resuming self-administering his medications for 1 to 2 days. In an interview with the Administrator on 5-25-23 at 9:50 a.m., she indicated when the POA approached the staff with wanting Resident B to self-administer his medications, one of his medical care providers provided an order for him to do so. She indicated the facility staff did not feel he could safely administer his medications due to being legally blind, as well as the resident saying he did not wish to do this as he cannot see well enough to administer his medications. An updated self-administration assessment was not located in the clinical record, prior to the resident self-administering his medications for 1 to 2 days for on/around 4-28-23. An updated service plan was not located in the clinical record to reflect Resident B had resumed self-medication administration for on/around 4-28-23.		corrective action will be taken: All residents who self-administer their medications had the potential to be affected by the deficient practice. Any residents currently self-administering their medications were evaluated by the DON or designee to ensure they are able to safely continue self-administration. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The DON or designee will conduct self-administration assessments with all residents who wish to self-administer their medications. ul class="BulletListStyle1 SCXW255534332 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will audit 25% of residents who self-administer their medications monthly for 3 months and 10% of residents who	

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		A. BUILDING 00 B. WING	05/26/2023

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	2. The clinical record for Resident C was reviewed on 5/25/2023 at 3:40 p.m. The medical diagnoses included chronic fatigue and Elher's-Danlos Syndrome. An individualized service plan, dated 12/22/2022, indicated that Resident C needed moderate to total assistance with medications and that she self administered only some medications. No self administration assessment was in the clinical record to identify which medications she could safely self administer. An interview with Resident C on 5/25/2023 at 10:45 a.m. indicated that staff prepare all her medications for her and will deliver them to her room, but they will leave her night time sleeping pill and early morning thyroid pill for her to self administer. She assures her door is always locked and she utilized an alarm on her phone for exact medication times for those two medications. A policy entitled, "Resident Assessment/Service/Care Plan", was provided by the Corporate Nurse on 5/26/2023 at 2:20 p.m. The policy indicated, "...The service plan must be updated at least SEMI ANNUALLY or when a significant change occurs...If the administration of medications or the provision of residential nursing services, or both is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided..." This Residential tag relates to Complaint IN00407499. 2-5-2(c)(4)		self-administer their medications for 3 months to ensure self-medication administration assessments are completed and present in the residents' chart.	
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

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		A. BUILDING 00 B. WING	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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Bldg. 00	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to develop a complete Individual Service Plan for 3 of 7 residents reviewed for Individual Service Plans. (Residents G, D, and B) Findings include: 1. Resident G's record was reviewed on 5/24/23 at 2:00 p.m. and indicated Resident G was admitted	R 0217	p paraid="262834459" paraeid="{c5f5682e-4897-438f-bb1b-5576c1e96d18}{251}" >POC for R217 What corrective action(s) will be accomplished for those residents	07/30/2023

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TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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	on 2/24/23, with a diagnosis of fluid on the brain. There was no individualized service plan in the clinical record for Resident G. 2. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. In an interview with the Administrator on 5-25-23 at 9:50 a.m., she indicated when the POA approached the staff with wanting Resident B to self-administer his medications, one of his medical care providers provided an order for him to do so. She indicated the facility staff did not feel he could safely administer his medications due to being legally blind, as well as the resident saying he did not wish to do this as he cannot see well enough to administer his medications. An updated service plan was not located in the clinical record to reflect Resident B had resumed self-medication administration for on/around 4-28-23. 3. The clinical record for Resident D was reviewed on 5/24/2023 at 11:40 a.m. The medical diagnoses included chronic obstructive pulmonary disease and emphysema. A physician letter for Resident D, dated 12/20/2022, indicated that the facility and outside provider would take responsibility for managing Resident D's coumadin monitoring and labs. Coumadin monitoring was not reflected on the most recent Individualized Service Plan for Resident D, dated 5/12/2022. A nursing progress note, dated 4/6/2023, indicated for Resident D to use non-invasive		found to have been affected by the deficient practice: An audit was conducted to identify additional residents who may need updated service plans completed. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. The DON or designee updated service plans for all residents whose service plan had not been updated within the past 6 months. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The DON has developed and implemented a calendar/schedule to track resident service plans, ensuring updates are completed on a semi-annual basis or at change of condition. ul class="BulletListStyle1 SCXW250115030 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible;	

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	ventilation. The most recent individualized service plan for Resident D was dated for 5/12/2022. The service plan did not reflect coumadin monitoring, testing, or management or the use of non-invasive ventilation. This service plan indicated under oxygen as "...2 LPM [liter per minute] @ rest 4 LPM..." A policy entitled, "Resident Assessment/Service/Care Plan", was provided by the Corporate Nurse on 5/26/2023 at 2:20 p.m. The policy indicated, "...The service plan must be updated at least SEMI ANNUALLY or when a significant change occurs...A copy of all services provided to each resident will be kept in the facility office..." This Residential tag relates to Complaint IN00407499. 2-5-2(2) 2-5-2(3)		cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will conduct an audit of 25% of all resident charts monthly for 3 months, then 10% of all resident charts monthly for 3 months to ensure service plans are updated semi-annually and present in the resident chart.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered for 2 of 12 residents reviewed for medications. (Residents B and M)	R 0241	p paraid="719604552" paraeid="{0a2f20a5-0a9f-46af-9d5f-6802bc802bcc}{206}" >POC for R241	08/01/2023

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	Findings include: 1. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. In an interview on 5-26-23 at 11:00 a.m., with the Administrator, she indicated the preferred medical provider for Resident B was identified as the VA (Veteran's Administration) home care services. In a review of the medication orders for Resident B, the following medications were prescribed, by the VA home care services, as of 5-20-23, and how administered as documented on the May, 2023, medication administration record (MAR) as follows: -Tylenol PM Extra Strength 25/500 mg (milligrams) 1 or 2 tablets at HS (bedtime) for sleep was ordered and documented as "Tylenol PM Extra Strength 1 tablet po [by mouth] at HS." The medication was documented as administered from 5-2-23 through 5-25-23 of one tablet each evening. -Melatonin 10 mg, take 1 tablet every day po at bedtime. The MAR indicated "melatonin 3 mg, take 2 tabs po every evening 2 [sign for hours] prior to bedtime." This medication was documented as administered from 5-2-23 through 5-25-23 of two tablets each evening. -Multivitamin, take 1 tablet twice daily po for 30 days. The MAR indicated "multivitamin with minerals, Gummies 2 [gummies] daily." This medication was documented as administered from 5-2-23 through 5-25-23 of two gummies once daily. -Albuterol sulfate 2.5 mg/3 ml [milliliters] or 0.083% solution for nebulization, inhale 3 ml every 6 hours by nebulization route as needed for 30 days. The MAR indicated "Albuterol SO4 0.83% Inhalation 3 ml, use 1 ampule via nebulizer every 6		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Clarification of physician orders was obtained for residents affected and MAR was updated to align with clarified physician orders. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents on the communities' medication administration program had the potential to be affected by the deficient practice. An audit was conducted comparing the MAR with current physician orders and appropriate corrections were made to ensure orders were accurately reflected on the MAR. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: A new protocol is being established to have all physician orders electronically sent to our new LTC pharmacy directly for their inclusion on the printed MAR, reducing the possibility of error.	

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TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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	hours as needed." This medication was documented as administered over 30 times, without times indicated of administration, from 5-2-23 through 5-25-23. -"Guaifenestin [sic] 400 mg, one tablet po every 8 hours as needed for cough," was documented on the MAR and administered over 10 times from 5-2-23 through 5-25-23. There was not a corresponding order from the VA listed on the 5-20-23 order list. -"Finasteride 5 mg, take 1 tablet oral daily," was documented as administered from 5-2-23 through 5-25-23 of one tablet each evening. There was not a corresponding order from the VA listed on the 5-20-23 order list. -Cholecalciferol (vitamin D3) 125 mcg (micrograms) (5,000 units) capsule, take 1 capsule every day po for 30 days. The MAR indicated, "Cholecalcif 50 mcg (D3 2,000 units), take 1 tab oral daily." This medication was documented as administered from 5-2-23 through 5-25-23 of one tablet once daily. -Aspirin 81 mg chewable tablet, chew one tablet daily po for 30 days. The MAR indicated, "Aspirin 81 mg EC [enteric coated] tab, take 1 tab oral daily." This medication was documented as administered from 5-2-23 through 5-25-23 of one tablet once daily. -Atorvastatin 40 mg, take 1 tablet po for 30 days. This order was not found on the MAR. -Dicyclomine 10 mg, take 1 capsule po twice daily. This order was not found on the MAR. -Furosemide 20 mg, take 1 tablet po every day. This order was not found on the MAR. -Ibuprofen 400 mg, take 1 tablet po every day. This order was not found on the MAR. -Loratadine 10 mg, take 1 tablet po every day. This order was not found on the MAR. -Senna with docusate sodium 8.6/50 mg, take 2 tablets po every day for thirty days. The MAR		ul class="BulletListStyle1 SCXW78665898 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee is a full review of all residents' medication orders within the transition process as we move to our new LTC pharmacy provider.	

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		A. BUILDING 00 B. WING	05/26/2023

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	indicated, "Docusate NA 50 mg/Sennosides 8.6 mg, 2 tabs po daily as needed for constipation." This medication was documented as not administered from 5-1-23 through 5-25-23. -Acetaminophen 325 mg tablet, take 2 tablets three times a day po for 30 days. The MAR indicated, "Acetaminophen 325 mg tab, take 2 tablets three times a day as needed, not to exceed 3,000 mg per day of all acetaminophen products." This medication was documented as not administered from 5-2-23 through 5-25-23. 2. The clinical record of Resident M was reviewed on 5-25-23 at 2:30 p.m. Her diagnoses included, but were not limited to type 2 diabetes. During 1 of 3 medication pass observations with 1 of 1 staff members for 5 of 5 residents on 5-25-23 at 9:15 a.m., Resident M was observed to prepare a Humulin Kwikpen, dial the pen to 48 units of insulin, have QMA 3 observe the dial for accurate dosage and then self-administer her insulin. QMA 3 was observed to document on the May, 2023, MAR (medication administration record), Resident M had drawn up 48 units of Novolin insulin and self-administered the insulin. During an interview with QMA 3 at this time, she indicated "[I] think the resident has an order that she can use Humulin or Novolin insulin because her insurance no longer covers the Novolin." In an interview on 5-25-23 at 2:45 p.m., with the Director of Nursing (DON), she indicated the facility received a physician's order via fax on 5-9-23 to change the insulin from Novolin to Humulin insulin. She provided a copy of the faxed order at this time, which indicated, "Humulin N NPH U-100 insulin, KwikPen 100 unit/ml [milliliter]...Directions: 48 units (0.48 ml) subcutaneously two times a day for 30 days." This order did not clarify if this order was in			

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	addition to the previous Novolin order or if the Novolin order was to be discontinued. The DON indicated she would seek further clarification from the ordering physician. The MAR indicated the Novolin insulin order had been documented as administered twice daily from 5-1-23 through 5-25-23. However, there had been no documentation of Humulin insulin administration from 5-9-23 through 5-25-23. This Residential tag relates to Complaint IN00407499. 2.5-4(e)(1)			
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on interview and record review, the facility failed to ensure residents were monitored for the effects of PRN (as needed) medications received from facility staff for 4 of 12 residents reviewed for medications. (Residents B, C, D and N) Findings include: 1. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. A review of Resident B's PRN medications for	R 0242	p paraid="1003639583" paraeid="{f0069bb6-f1fa-47e2-bf5c-8fd46044cd87}{206}" >POC for R242 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The DON implemented the use of a PRN Log Binder and provided training to staff regarding the appropriate protocols related to PRN	08/01/2023

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TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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	April, 2023 indicated he received the following: -Albuterol Nebulizer 0.083%, 1 ampule (3 milliliter or ml) in nebulizer every 6 hours PRN. The medication administration record (MAR) indicated this PRN medication was administered over 30 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. The order on the MAR for this medication did not indicate the specific reason for why the medication was to be administered, such as shortness of breath or wheezing. There was an absence of documentation on the MAR or the nursing notes for monitoring for improvement or decline in the resident's health status, related to the receipt of this medication. -"Fiber gummies (2) po [by mouth] as needed. The MAR indicated this PRN medication was administered 2 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. The order on the MAR for this medication did not indicate the specific reason for why the medication was to be administered, such as constipation. There was an absence of documentation on the MAR or the nursing notes for monitoring for improvement or decline in the resident's health status, related to the receipt of this medication. A review of the May, 2023 MAR of Resident B's PRN medications indicated he received the following: -Albuterol SO4 0.83% inhalation 3 ml Use 1 ampule via nebulizer every 6 hours as needed. The MAR indicated this medication was documented as administered over 30 times during the month. The MAR and nursing notes failed to		medications, specifically the documentation of potential adverse effects of PRN medications. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who are on the community medication administration program had the potential to be affected by the deficient practice. All residents with PRN medication orders were reviewed for documentation potentially indicating an adverse effect. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator and DON conducted an in-service with all staff who administer medications to re-educate them on the processes related to the appropriate administration of PRN medications, including the expectation to call the DON or designee prior to administration, appropriate documentation of the time the PRN medication was administered, the reason PRN medication was requested as well as documenting the effects of the PRN medication, any potential	

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		A. BUILDING 00 B. WING	05/26/2023

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TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

(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
	acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. The order on the MAR for this medication did not indicate the specific reason for why the medication was to be administered, such as shortness of breath or wheezing. There was an absence of documentation on the MAR or the nursing notes for monitoring for improvement or decline in the resident's health status, related to the receipt of this medication. -Guaifenesin 400 mg, take 1 tablet every 8 hours as needed for cough. The MAR indicated this medication was documented as administered over 10 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. There was an absence of documentation on the MAR or the nursing notes for monitoring for improvement or decline in the resident's health status, related to the receipt of this medication. -Immodium A-D 2 tabs at first diarrhea and 1 tab after each loose stool with a maximum of 4 tablets daily. The MAR indicated this medication was documented as administered 8 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. There was an absence of documentation on the MAR or the nursing notes for monitoring for improvement or decline in the resident's health status, related to the receipt of this medication. 2. The clinical record of Resident N was reviewed on 5-25-23 at 3:15 p.m. His diagnoses, included, but were not limited to, unspecified pain. A review of Resident N's PRN (as needed) pain		adverse effects and DON following up for sign off on the administration of the PRN medication. ul class="BulletListStyle1 SCXW51805295 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON will audit 25% of resident charts for those receiving PRN medication administration monthly for 3 months and 10% monthly for 3 months.	

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	medications, indicated he received the following for May, 2023: -Tramadol 50 mg (milligram) tablet, take 1 to 2 tablets every 4 hours as needed, not to exceed 8 tablets per day for unspecified pain. The medication administration record (MAR) and narcotic log indicated he had received 2 tablets four times daily. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. There was an absence of documentation on the MAR or the nursing notes for monitoring for improvement or decline in the resident's health status, related to the receipt of this medication. -Hydrocodone and acetaminophen 5/325 mg, give 2 tablets every 4 hours as need for pain, not to exceed 8 tablets daily, for a maximum of 8 tablets daily. The medication administration record (MAR) and narcotic log indicated he had received 2 tablets four times daily. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. There was an absence of documentation on the MAR or the nursing notes for monitoring for improvement or decline in the resident's health status, related to the receipt of this medication. In an interview with the Director of Nursing on 5-25-23 at 3:20 p.m., she indicated she did not locate any follow-up documentation to indicated if the PRN medications were beneficial for the resident in nursing notes or on the MAR. 3. The clinical record for Resident C was reviewed on 5/25/2023 at 3:40 p.m. The medical diagnoses included chronic fatigue and Elher's-Danlos Syndrome. Review of the May 2023 medication administration			

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	record (MAR) for Resident C indicated she had received her as needed (PRN) narcotic pain medication two times (5/5/2023 and 5/26/2023). The administration on 5/5/2023 had an indication of complaint of pain with no results documented. The administration 5/26/2023 did not have an indication nor results documented. Resident C's MAR also indicated an as needed order for Tylenol to be given for pain or fever. This medication was administered 20 times without indication nor results documented. 4. The clinical record for Resident D was reviewed on 5/24/2023 at 11:40 a.m. The medical diagnoses included chronic obstructive pulmonary disease and emphysema. The most recent semi-annual nursing assessment for Resident D, dated for September of 2022, indicated that Resident D needed total assistance with medications. The May 2023 MAR for Resident D indicated an order for narcotic pain medications to be given up to three times a day as needed for pain. This medication was signed off as administered 45 times on this MAR, 18 of these administrations listed it was given for complaints of pain, 27 of these administrations did not include an indication for use, and all 45 did not list a result of the PRN administration. A policy entitled, "Medication Program", was provided by the Corporate Nurse on 5/26/2023 at 11:00 a.m. The policy indicated, "...For each PRN and administered, staff will documented the date, time, their initials and the effectiveness of the medication..."			

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	This Residential tag relates to Complaint IN00407499. 3.1-50(a)(1)			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure the time of PRN (as needed) were administered to resident B and a dose of coumadin had an adminsitration time for Resident D for 2 of 12 residents reviewed for medications. (Residents B and D) Findings include: 1. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. A review of Resident B's PRN medications for April, 2023 indicated he received the following: -Albuterol Nebulizer 0.083%, 1 ampule (3 milliliter or ml) in nebulizer every 6 hours PRN. The medication administration record (MAR) indicated this PRN medication was administered over 30 times during the month. The MAR and nursing notes failed to acknowledge the specific time the	R 0243	p paraid="1003639583" paraeid="{f0069bb6-f1fa-47e2-bf5c-8fd46044cd87}{206}" >POC for R243 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The DON implemented the use of a PRN Log Binder and provided training to staff regarding the appropriate protocols related to PRN medications. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All	08/01/2023

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	medication was administered to the resident. -"Fiber gummies (2) po [by mouth] as needed. The MAR indicated this PRN medication was administered 2 times during the month. The MAR and nursing notes failed to acknowledge the specific time the medication was administered to the resident. A review of the May, 2023 MAR of Resident B's PRN medications indicated he received the following: -Albuterol SO4 0.83% inhalation 3 ml Use 1 ampule via nebulizer every 6 hours as needed. The MAR indicated this medication was documented as administered over 30 times during the month. The MAR and nursing notes failed to acknowledge the specific time the medication was administered to the resident. -Immodium A-D 2 tabs at first diarrhea and 1 tab after each loose stool with a maximum of 4 tablets daily. The MAR indicated this medication was documented as administered 8 times during the month, with 3 of 8 times having the time administered being omitted from the MAR or nursing notes. 2. The clinical record for Resident D was reviewed on 5/24/2023 at 11:40 a.m. The medical diagnoses included chronic obstructive pulmonary disease and emphysema. The most recent semi-annual nursing assessment for Resident D, dated for September of 2022, indicated that Resident D needed total assistance with medications. A medication administration record (MAR) for April of 2023 indicated an order for coumadin 2 milligrams (mg) by mouth daily Sunday, Monday, Tuesday, Wednesday, and Thursday. This medication was initialed as given on 4/30/2023		residents who are on the community medication administration program had the potential to be affected by the deficient practice. All residents with PRN medication orders were reviewed for documentation of the time of administration. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator and DON conducted an in-service with all staff who administer medications to re-educate them on the processes related to the appropriate administration of PRN medications, including the expectation to call the DON or designee prior to administration, appropriate documentation of the time the PRN medication was administered, the reason PRN medication was requested as well as documenting the effects of the PRN medication and DON following up for sign off on the administration of the PRN medication. ul class="BulletListStyle1 SCXW109114314 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color:	

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	without a medication time listed. A policy entitled, "Medication Program", was provided by the Corporate Nurse on 5/26/2023 at 11:00 a.m. The policy indicated, "...The licensed nurse of QMA will document the medication administration in the MAR, indicated time, name of the medications, dose and the person administering the medications..." This Residential tag relates to Complaint IN00407499. 2-5-4(e)(3)(A)		transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON will audit 25% of resident charts for those receiving PRN medication administration monthly for 3 months and 10% monthly for 3 months.	
R 0244 Bldg. 00	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on interview and record review, the facility failed to prepare only a single dose of a controlled substance at a time for 1 of 7 residents reviewed for narcotic medication compliance. (Resident C) Findings include: The clinical record for Resident C was reviewed on 5/25/2023 at 3:40 p.m. The medical diagnoses included chronic fatigue and Elher's-Danlos Syndrome. An individualized service plan, dated 12/22/2022, indicated that Resident C needed moderate to total assistance with medications and that she self administered only some medications. An interview with Resident C on 5/25/2023 at 10:45 a.m. indicated that staff prepare all her medications for her and will deliver them to her	R 0244	p paraid="111383756" paraeid="{fb2245a7-6bef-4add-8368-ac8c0f59b0d8}{206}" >POC for 244 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The DON implemented new protocols for managing narcotic medication administration to ensure only a single dose of a controlled substance is prepared at a time. ·How the facility will identify other residents having the	08/01/2023

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	room, but they will leave her night time sleeping pill and early morning thyroid pill for her to self administer. She assures her door is always locked and she utilized an alarm on her phone for exact medication times for those two medications. A physician's order, dated 11/17/2022, indicated for Resident C to receive provigil 100 mg (milligrams) by mouth one tablet in the morning and one tablet at noon. A narcotic count sheet for her provigil with a received date of 4/19/2023, indicated on 5/22/2023 that two 100 mg doses were signed out at 7:30 a.m. An interview with the Director of Nursing and Wellness on 5/26/2023 at 10:45 a.m. indicated that the staff signed out two doses on that morning at 7:08 a.m. The staff would carry the bottle with the second dose in their pocket until it was time to administer (noon). The staff did this to keep from having to get into the narcotic box a second time. 2-5-4(e)(4)		potential to be affected by the same deficient practice and what corrective action will be taken: All narcotic medication administration records for residents who are on the community medication administration program and have orders for controlled substances had the potential to be affected by the deficient practice. All residents with narcotic medication orders were reviewed to confirm only a single dose was prepared at a time. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator and DON conducted an in-service with all staff who administer medications to re-educate them on the processes related to the appropriate administration of controlled substances, specifically the expectation that only a single dose is to be prepared at a time. Medication carts with double locked narcotic medication storage boxes have been ordered as a part of the new LTC pharmacy agreement and transition to improve the efficiency of medication administration overall and specifically of controlled medications.	

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			ul class="BulletListStyle1 SCXW79100942 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON will audit the narcotic logbook 4 times weekly for 1 month, 2 times weekly for 3 months and 1 time weekly for 2 months to ensure only a single dose of any narcotic medication is prepared at a time.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure each QMA who administered a PRN (as needed) medication notified a facility licensed nurse prior to the administration of the medication and the licensed nurse failed to document the prior-authorization of the medication in the resident's clinical record for 4 of 12 residents reviewed for medications. (Residents	R 0246	POC for R246 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The DON implemented the use of a PRN Log Binder and provided training to staff regarding the appropriate	08/01/2023

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	B, C, D, N) Findings include: 1. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. A review of Resident B's PRN medications for April, 2023 indicated he received the following: -Albuterol Nebulizer 0.083%, 1 ampule (3 milliliter or ml) in nebulizer every 6 hours PRN. The medication administration record (MAR) indicated this PRN medication was administered over 30 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. The order on the MAR for this medication did not indicate the specific reason for why the medication was to be administered, such as shortness of breath or wheezing. -"Fiber gummies (2) po [by mouth] as needed. The MAR indicated this PRN medication was administered 2 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. The order on the MAR for this medication did not indicate the specific reason for why the medication was to be administered, such as constipation. A review of the May, 2023 MAR of Resident B's PRN medications indicated he received the following: -Albuterol SO4 0.83% inhalation 3 ml Use 1		protocols related to PRN medications. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who are on the community medication administration program had the potential to be affected by the deficient practice. All residents with PRN medication administrations are being reviewed by the DON for appropriate authorization and documentation of the prior authorizations, including time and date of contact. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator and DON conducted an in-service with all staff who administer medications to re-educate them on the processes related to the appropriate administration of PRN medications, including the expectation to call the DON or designee prior to administration, appropriate documentation of the reason PRN medication was requested as well as documenting the effects of the PRN medication	

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	ampule via nebulizer every 6 hours as needed. The MAR indicated this medication was documented as administered over 30 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. The order on the MAR for this medication did not indicate the specific reason for why the medication was to be administered, such as shortness of breath or wheezing. -Guaifenesin 400 mg, take 1 tablet every 8 hours as needed for cough. The MAR indicated this medication was documented as administered over 10 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. -Immodium A-D 2 tabs at first diarrhea and 1 tab after each loose stool with a maximum of 4 tablets daily. The MAR indicated this medication was documented as administered 8 times during the month. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. 2. The clinical record of Resident N was reviewed on 5-25-23 at 3:15 p.m. His diagnoses, included, but were not limited to, unspecified pain. A review of Resident N's PRN (as needed) pain medications, indicated he received the following for May, 2023: -Tramadol 50 mg (milligram) tablet, take 1 to 2 tablets every 4 hours as needed, not to exceed 8 tablets per day for unspecified pain. The medication administration record (MAR) and narcotic log indicated he had received 2 tablets four times daily. The MAR and nursing notes		and DON following up for sign off on the administration of the PRN medication. ·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON will audit 25% of resident charts for those receiving PRN medication administration monthly for 3 months and 10% monthly for 3 months.	

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	failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. -Hydrocodone and acetaminophen 5/325 mg, give 2 tablets every 4 hours as need for pain, not to exceed 8 tablets daily, for a maximum of 8 tablets daily. The medication administration record (MAR) and narcotic log indicated he had received 2 tablets four times daily. The MAR and nursing notes failed to acknowledge this medication had been discussed with the licensed nurse prior to being administered by the QMA. In an interview with the Director of Nursing on 5-25-23 at 3:20 p.m., she indicated, "The QMA's notify me before they give a PRN to a resident. I try to document in the nursing notes that a PRN was given. I haven't done that yet for [name of Resident N]. Unfortunately, I don't always document the QMA's told me about the PRN."3. The clinical record for Resident C was reviewed on 5/25/2023 at 3:40 p.m. The medical diagnoses included chronic fatigue and Elher's-Danlos Syndrome. An individualized service plan, dated 12/22/2022, indicated that Resident C needed moderate to total assistance with medications and that she self administered only some medications. No self administration assessment was in the clinical record to identify which medications she could safely self administer. An interview with Resident C on 5/25/2023 at 10:45 a.m. indicated that staff prepare all her medications for her and will deliver them to her room, but they will leave her night time sleeping pill and early morning thyroid pill for her to self administer. She assures her door is always locked and she utilized an alarm on her phone for exact			

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	medication times for those two medications. Resident C's medication administration record (MAR) for May of 2023 indicated an as needed order (PRN) for Tylenol to be given for pain or fever. This medication was administered 20 times by QMA's without documented prior authorization given by a licensed nurse. 4. The clinical record for Resident D was reviewed on 5/24/2023 at 11:40 a.m. The medical diagnoses included chronic obstructive pulmonary disease and emphysema. The most recent semi-annual nursing assessment for Resident D, dated for September of 2022, indicated that Resident D needed total assistance with medications. A medication administration record (MAR) for May of 2023 indicated an order for an narcotic pain medications to be given up to three times a day as needed for pain (PRN). Review of this MAR indicated QMA giving this medications 31 times with no documented prior authorization from a licensed nurse. An interview with the Director of Nursing and Wellness on 5/25/2023 at 11:35 a.m. indicated she gives verbal authorization when the QMA call her regarding as needed medications, but she is not documenting these authorizations. A policy entitled, "Medication Program", was provided by the Corporate Nurse on 5/26/2023 at 11:00 a.m. The policy indicated, "...PRN medications administered by a QMA will be authorized by a licensed nurse prior to administration. The licensed nurse will sign off on the PRN administration the next time they are			

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		A. BUILDING 00 B. WING	05/26/2023

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TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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	present in the community..." 2-5-4(e)(6) 3.1-35(b)(8) This Residential tag relates to Complaint IN00407499.			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to documented a medication error in the record for 2 of 2 residents reviewed for medications errors. (Resident N and Q) Findings include: 1. The clinical record for Resident N was reviewed on 5/26/2023 at 11:40 a.m. The medical diagnoses included weakness and chronic pain. An interview with Resident N on 5/26/2023 at 1:25 p.m. indicated that staff administer his medications and there was one evening he did not receive his medications in February of this year. No progress note or medication error report was located in Resident N's chart. A Medication Error Report, dated for 2/20/2023, was found in QMA 8's personnel file. This form indicated that Resident N did not receive his evening dose of nine medications ordered by the	R 0247	p paraid="846305689" paraeid="{4d1c4852-8ffd-45dd-b227-90257f96ff98}{206}" >POC for R247 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit of all resident charts was conducted to identify medication errors that may not have been appropriately addressed. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents on the communities'	08/01/2023

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	physician. 2. The clinical record for Resident Q was reviewed on 5/26/2023 at 11:30 a.m. The medical diagnoses included Parkinson's disease and atria fibrillation. An interview with Resident Q on 5/26/2023 at 2:05 p.m. indicated that staff administer his medications and in February this year, there was a time he received his medications late, over an hour when he is supposed to get them. He reported this to the staff and his medication times are improved since then. No progress note or medication error report was located in Resident Q's chart. A Disciplinary Action Form, dated for 2/21/2023, indicated that Resident N and Q had medications errors related to timeliness of medications. A policy indicated, "Indiana Residential Care Facility", was provided by the Corporate Nurse on 5/26/2023 at 2:20 p.m. The policy indicated, "...All medication errors that occur for residents receiving medications supervision from our facility are requested to be reported. A medication error includes: Wrong Medication, Wrong Dosage, Wrong Time (within 1 hour before or 1 hour after the prescribed time is acceptable), Wrong Route, Wrong Medication...If a medication error occurs, a company Medication Error form should be filled out...A copy needs to go into the resident's chart as well...A note in the resident's record muse also be made regarding the error..." 3.1-25(e)(9)		medication administration program had the potential to be affected by the deficient practice. The medication error policy was reviewed and updated to align with residential regulations. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The DON and Administrator will present an in-service training session for all staff who administer medication to re-educate on the medication error policy and procedures including expectations for documentation (progress notes) and notification of all parties as well as completion of a medication error report. ul class="BulletListStyle1 SCXW263504663 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will conduct monthly audits on 25% of all resident charts to confirm medication	

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			errors have been thoroughly and appropriately documented and all associated notifications were made (and documented).	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on interview and record review, the facility failed to ensure 5 of 7 residents reviewed for dietary orders had physician orders in place for their prescribed diet. (Residents B, C, D, G and H) Findings include: 1. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. A review of the clinical record failed to locate any physician's orders for Resident B's dietary needs. 2. The clinical record of Resident H was reviewed on 5-24-23 at 1:45 p.m. His diagnoses included, but were not limited to, congestive heart failure, atrial fibrillaltion and long-term use of anti-coagulation medications. A review of the clinical record failed to locate any physician's orders for Resident H's dietary needs.3. Resident G's record was reviewed on 5/24/23 at 2:00 p.m. and indicated Resident G had a diagnosis of fluid on the brain. The clinical record failed to indicate Resident G had a physician's order for his diet.	R 0275	p paraid="669087723" paraeid="{74f6948e-b7bd-4910-a1a2-ce44c6db765d}{206}" >POC for R275 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit was conducted to identify additional residents who may need diet orders. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. Requests for diet orders were sent to the PCP for all residents identified as needing diet orders ·What measures will be put into	07/30/2023

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	On 5/25/23 at 11:57 a.m., the Administrator indicated they did not have diet orders for Resident G. 4. The clinical record for Resident C was reviewed on 5/25/2023 at 3:40 p.m. The medical diagnoses included chronic fatigue and Elher's-Danlos Syndrome. No physician order for diet was on the medical record for Resident C. An interview with the Director of Nursing and Wellness on 5/26/2023 at 10:45 a.m., indicated she could not locate a physician order for Resident C's diet. 5. The clinical record for Resident D was reviewed on 5/24/2023 at 11:40 a.m. The medical diagnoses included chronic obstructive pulmonary disease and emphysema. No physician order for diet was on the medical record for Resident D. An interview with the Director of Nursing and Wellness on 5/25/2023 at 1:55 p.m. indicated that she could not locate a physician order for Resident D's diet. Her expectation is that each resident will have an updated diet order. 5-5.1(h)		place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator has revised the Physican Certification (plan of care) to include a section for the residents' PCP to include diet orders for all new residents prior to admission. ul class="BulletListStyle1 SCXW71533082 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will conduct an audit of 25% of all resident charts monthly for 3 months, then 10% of all resident charts monthly for 3 months to ensure diet orders are present in the resident chart.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility;			

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	(C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure the consultant pharmacist reviewed the drug regimen for each resident for 2 of 7 residents reviewed for medications. (Residents B and H) Findings include: 1. The clinical record of Resident B was reviewed on 5-24-23 at 11:35 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), legally blind, atrial fibrillation, peripheral vascular disease and history of a hip fracture. Documentation within the clinical record failed to identify any pharmacy reviews of his medication regimen had been conducted in the last year in the facility. 2. The clinical record of Resident H was reviewed on 5-24-23 at 1:45 p.m. His diagnoses included, but were not limited to, congestive heart failure, atrial fibrillaltion and long-term use of anti-coagulation medications. Documentation within the clinical record failed to identify any pharmacy reviews of his medication regimen had been conducted in the last year in the facility. In an interview with the facility's consultant pharmacist on 5-25-23 at 10:15 a.m., she indicated she has only been reviewing the clinical records	R 0298	p="" paraid="1003639583" paraeid="{f0069bb6-f1fa-47e2-bf5c-8fd46044cd87}{206}" >POC for R298 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Administrator set up a meeting with a LTC pharmacy to begin transition plans.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who are on the community medication administration program had the potential to be affected by the deficient practice. All residents missing a consultant pharmacist review will be reviewed by the new pharmacist and all recommendations will be promptly followed up on.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator has provided a contract for review and execution from the new LTC	08/01/2023

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	of residents at the facility whom receive their medications from the pharmacy she is employed by. She indicated she was not well-experienced with residential care and regulations. She clarified her statement to indicate she has not been conducting every 60 day drug regimens for residents who receive their medications from other pharmacy providers. 2.5-6(c)(e)		pharmacy for the home office. ul="" role="list" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The new LTC pharmacy will begin their comprehensive services on August 1. Transition meeting #2 is scheduled for June 22. Synchrony Pharmacy has confirmed the expectation that their consultant pharmacist will complete a full review of all residents on the community's medication administration program every 60 days, not only the residents that utilize their pharmacy for dispensing of their medication.	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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. Based on observation, interview and record review, the facility failed to ensure an over-the-counter (OTC) medication was properly labeled with the labeled with directions for use during 1 of 3 medication pass observations with 1 of 1 facility staff members for 1 of 5 residents reviewed during medication pass observation. (Resident K)	R 0300	p paraid="1988597429" paraeid="{a77a313b-54f3-4b81-8ede-efdbd5cb103f}{206}" >POC for R300 What corrective action(s) will be	08/01/2023

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	Findings include: During a medication pass observation on 5-25-23 at 8:52 a.m., with QMA 3, she was observed to prepare the morning medications for Resident K. The medication of "Caltrate 600 mg [milligrams] D3 Plus Minerals" was observed to be an OTC medication. The bottle for this medication was not labeled with the correct directions for use. The directions listed on the label indicated this medication was to be taken up to two times daily with or without food or as directed by your physician. The physician's order indicated for this medication for one tablet to be taken orally once daily with a meal or snack. In an interview with QMA 3 on 5-25-23 at 9:10 a.m., she indicated she was not aware of any labeling requirements for OTC medications. In an interview on 5-25-23 at 9:20 a.m., with the Director of Nursing, she indicated she was not familiar with labeling requirements for OTC medications. 2.5-6(c)(4)		accomplished for those residents found to have been affected by the deficient practice: An audit was conducted to identify additional residents whose OTC medication labeling may not include directions for appropriate use of the medication. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who are on the communities' medication administration program and take OTC medications had the potential to be affected by the deficient practice. All OTC medication labels missing instructions for appropriate use were updated with the appropriate accessory and cautionary instructions as well as expiration dates. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The DON or designee will review all OTC labels to ensure appropriate accessory and cautionary instructions as well as expiration dates are included on the labels prior to those OTC medications being administered to the resident.	

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			ul class="BulletListStyle1 SCXW34911333 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will conduct an audit of 25% of all residents on the communities' medication administration program to ensure appropriate accessory and cautionary instructions as well as expiration dates are included on OTC labels monthly for 3 months, then 10% of all residents on the communities' medication administration program monthly for 3 months.	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, interview and record review, the facility failed to ensure an over-the-counter (OTC) medication was properly	R 0302	p paraid="827556748" paraeid="{1f2dbbe0-f98c-40b9-b0ed-2ec9606735d4}{206}" >POC for	08/01/2023

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	labeled during 1 of 3 medication pass observations with 1 of 1 facility staff members for 1 of 5 residents reviewed during medication pass observation. (Resident K) Findings include: During a medication pass observation on 5-25-23 at 8:52 a.m., with QMA 3, she was observed to prepare the morning medications for Resident K. The medication of "Caltrate 600 mg [milligrams] D3 Plus Minerals" was observed to be an OTC medication. The bottle for this medication was not labeled with the resident's name, the physician's name or the correct directions for use. In an interview with QMA 3 on 5-25-23 at 9:10 a.m., she indicated she was not aware of any labeling requirements for OTC medications. In an interview on 5-25-23 at 9:20 a.m., with the Director of Nursing, she indicated she was not familiar with labeling requirements for OTC medications. 2.5-6(c)(6)(A) 2.5-6(c)(6)(B)		R302 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit was conducted to identify additional residents whose OTC medication labeling may not include resident name, physician name and directions for use. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who are on the communities' medication administration program and take OTC medications had the potential to be affected by the deficient practice. All OTC medication labels missing resident name, physician name and directions for use were updated with the appropriate information. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The DON or designee will review all OTC labels to ensure resident name, physician name	

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			and directions for use are included on the labels prior to those OTC medications being administered to the resident. ul class="BulletListStyle1 SCXW36109163 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will conduct an audit of 25% of all residents on the communities' medication administration program to ensure resident name, physician name and directions for use are included on OTC labels monthly for 3 months, then 10% of all residents on the communities' medication administration program monthly for 3 months.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete.			

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	(2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to document the reason medications were circled on a Medication Administration Record (MAR), failed to document anticoagulant labs in a Resident D's record, and failed to document when a physician was notified of Resident F's burn. This affected 3 of 7 residents reviewed for completeness of clinical records. (Residents D, E, and F) Findings include: 1. Resident E's record was reviewed on 5/24/23 at 11:41 a.m. The record indicated Resident E had diagnoses that included, but were not limited to, chronic obstructive pulmonary disorder, high blood pressure, high blood fats, insulin dependent diabetes mellitus, congestive heart failure, chronic kidney disease, and congestive heart failure. Current physician's orders indicated an order for polyethylene glycol powder 3350, mix 17 grams in 8 ounces of water, juice, soda, coffee, or tea and drink daily, with a start date of 10/24/22. Review of Medication Administration Records (MARs), dated May 2023, indicated the polyethylene glycol was scheduled to be administered every morning at 8:00. Documentation on the MARs from May 1 through May 24 indicated the nurse or QMA who had initialed the dose as given, had circled the initials, except for 5/6, 5/8, 5/9, 5/18 and 5/21, and on those days the initials of the nurse or QMA were not	R 0349	p paraid="1863034072" paraeid="{5d18635b-a8bd-4fb6-9aba-c9b0a6f65d04}{206}" >POC for R349 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The DON, Corporate Nurse Consultant and Administrator reviewed all resident charts for clinical record compliance for completeness, accuracy, accessibility and organization. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. All resident clinical records were audited. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator and DON conducted an in-service with all	08/01/2023

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	circled. There was no explanation on the back of the MARs why the initials had been circled. On 5/26/23, at 11:30 a.m., the Corporate Nurse Consultant indicated there was no documentation on the back of Resident E's MARs that explained why the medications were circled and that is where the explanation should have been documented. 2. The clinical record for Resident D was reviewed on 5/24/2023 at 11:40 a.m. The medical diagnoses included chronic obstructive pulmonary disease and emphysema. Resident D utilized coumadin for atrial flutter. A physician note, dated 12/20/2022, indicated that the facility and an outside provider were to manage the coumadin dosing and PT/INR level for Resident D. Per an interview with the Director of Nursing and Wellness on 5/25/2023 at 1:30 p.m., she indicated that Resident D's daughter will usually come in and obtain his PT/INR level via a coagucheck machine in his room and then call it into the provider's 1-800 number. She stated if the daughter is not able to come in, she calls the Director and she will go down and obtain the level. Usually the daughter will write the PT/INR down on a post-it note that Director then puts in stack in her office. She indicated she does not document these in the clinical record. The outside provider then will fax the new coumadin order into the pharmacy directly. A nursing progress note, dated 2/27/2023, indicated to check PT/INR in 1 week.		staff who have access to resident clinical records to re-educate all potential contributors to the clinical record on clinical documentation expectations, including appropriate documentation for PT/INR coumadin lab values, MAR documentation, medication refusal documentation and the documentation of physician notifications. ul class="BulletListStyle1 SCXW160449851 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON will audit 25% of resident charts to review all clinical record documentation monthly for 3 months and 10% monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/26/2023

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	A nursing progress note, dated 3/27/2023, indicated Resident D checked his own PT/INR with results of 2.6/21.5. A nursing progress note, dated 5/5/2023, indicated that Resident D's PT/INR was 1.5/16.8 A physician order, dated 5/5/2023, indicated that Resident D's INR was 1.5. A physician order, dated 5/9/2023, indicated Resident D's PT/INR was 1.7/18.6. A lab reported, dated for 5/23/2023, indicated Resident D's INR was 4.4 . No additional PT/INR's were documented in Resident D's record An interview with QMA 3 on 5/25/2023 at 11:25 a.m. indicated she did not check the Resident's INR before giving his coumadin because she did not know where it was located. She stated it will be in his progress notes "sometimes". She indicated she did not know what his target goal was his INR. 3. The clinical record for Resident F was reviewed on 5/24/2023 at 2:15 p.m. The medical diagnosis included diabetes. A progress note, dated 3/19/2023, indicated that Resident F reported spilling hot water on his foot/ankle three days prior and upon examination, the area had "dead skin around this 1/2" x 1 1/2" [1/2 inch by 1 and 1/2 inch] area". An interview with Director of Nursing and Wellness on 5/25/2023 at 11:45 a.m., indicated she had reported to the nurse practitioner from his			

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	home health company about the burn to his ankle on 3/20/2023, but she did not document the notification. She indicated he was not seen by home health until three weeks after reporting this. A policy entitled, "Resident Records", was provided by the Corporate Nurse on 5/26/2023 at 2:20 p.m. The policy indicated, "...Documentation will occur when an activity, event, or indicated that is not usual for the resident or change in level of care occurs..." This Residential tag relates to Complaint IN00407499. 5-8.1(a)(1) 5-8.1(a)(4)			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and			

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	laboratory examinations in order to complete a diagnosis. Based on record review, and interview, the facility failed to complete a second step Tuberculin (TB) Skin test for Resident G, failed to complete a first or second step TB Skin test for Resident E and F upon admission, and failed to complete annual risk assessment for Resident C. This affected 4 of 7 residents reviewed for infection control related to TB skin tests. Findings include: 1. Resident E's record was reviewed, on 5/24/23 at 11:41 a.m. The record indicated Resident E had diagnoses that included, but were not limited to, chronic obstructive pulmonary disorder, high blood pressure, high blood fats, insulin dependent diabetes mellitus, congestive heart failure, chronic kidney disease, and congestive heart failure. The clinical record failed to indicate Resident E had a Tuberculin skin test on or prior to admission, and failed to indicate Resident E had a second step TB skin test. On 5/25/23 at 3:32 p.m., the Director of Nurses indicated she didn't have a first or second step TB skin test for Resident E. 2. Resident G's clinical record was reviewed on 5/24/23 at 2:00 p.m., and indicated Resident G was admitted on 2/24/23, with a diagnosis of fluid on the brain. The record indicated Resident G had a first step TB skin test upon admission, but failed to indicate Resident G had a second step TB skin test.	R 0410	p paraid="853755971" paraeid="{25fe42f3-05c9-4415-8dd9-3944034abc5d}{251}" >POC for R410 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit of all resident charts was conducted to identify which residents were missing the Two-Step TB screening and/or an annual risk assessment ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. A TB screening clinic for all residents was planned for June 20, 2023. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The DON will conduct 1 step TB skin tests at the time of admission, to be read within 48-.	08/01/2023

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	On 5/26/23 at 11:57 a.m., the Administrator indicated they have no second step TB skin test for Resident G. 3. The clinical record for Resident F was reviewed on 5/24/2023 at 2:15 p.m. The medical diagnosis included diabetes. Resident F was admitted on 7/22/2022. Review of the clinical record indicated no Mantoux test for admission or completed since admission. An interview with the Director of Nursing and Wellness on 5/26/2023 at 10:25 a.m. indicated that she had started doing the annual Mantoux test and/or Risk Assessments, but had not completed them for Resident B or F yet. She was unable to locate any Mantoux test or risk assessment for Resident B or F in the last 12 months. 4. The clinical record for Resident C was reviewed on 5/25/2023 at 3:40 p.m. The medical diagnoses included chronic fatigue and asthma. Review of the clinical record indicated no Mantoux test or annual risk assessment for tuberculosis for Resident B in the last 12 months. An interview with the Administrator on 5/26/2023 at 2:15 p.m. indicated it is the expectation that unless a resident has a documented allergy, that a two step Mantoux test would be completed at admission then yearly the residents should received a risk assessment and/or a Mantoux test. 2-5-12(f) 2-5-12(h)		The 2 step TB skin test, as indicated, will be scheduled by the DON during the first 3 weeks of residency. An annual TB risk assessment will be scheduled on the resident move-in anniversary date for each resident. ul class="BulletListStyle1 SCXW245484802 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will conduct monthly audits on 25% of all resident charts to confirm residents have been provided all required TB screenings.	