Crystal L Werner

PRINTED: 06/21/2023 FORM APPROVED OMB NO. 0938-039

06/16/2023

i '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/26/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
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.		R 00	000			
R 0042 Bldg. 00	Residents' Rights - Noncompliance		R 00		POC for R042 ¿ What corrective action(s) will accomplished for those reside found to have been affected be deficient practice: The most recent survey was added to the Survey Results binder and plain a prominent location while the survey was still underway. ¿ Header the survey was still underway.	nts y the e ced he	06/15/2023
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Administrator

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/26/2023	
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
TIMBER	CREEK VILLAGE			BYVILLE, IN 46176	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE
		Resident C, on 5/25/2023 at		the facility will identify other	
	· ·	ed she has been looking for the lways reads the surveys after		residents having the potentia be affected by the same defice	
	_	but they have moved the		practice and what corrective	
	-	ndicated it was kept in the		will be taken: All residents ha	
		ey moved the binder to be by		the potential to be affected by	/ the
	the fish tank then to	the nurses' station and now		deficient practice. Immediate	
	is back at the fish ta	ank. She stated the sign says it		upon receipt of the current su	-
	is in the library, but	it is not and that the most		results, a copy of those resul	ts
	recent visit from a s	surveyor is not in there.		was placed in the binder.	
				Additionally, an 8 X 11 sign w	/as
During an observation, on 5/25/23, at 3:00 p.m., a				posted in a prominent locatio	n
binder that contained the state surveys was				indicating the specific location	n of
		ounted holder, to the right of		the Survey Results binder. A	
		The binder included surveys		smaller directional sign was	
		d earlier, but did not contain		placed above the specific loc	ation
		vey, dated 3/23/23. A framed		to further ensure appropriate	
		e of the survey binder,		access and a note was adde	
		ys were in a desk drawer in the		the binder cover requesting the	
	-	ervation in the library, failed to		the binder be returned to that	
	locate a survey bind	der in any of the drawers.		location to ensure consistent	
	0 5/06/00 + 0.05	d 12 1 2d d		availability of the Survey Res	I
		p.m., the binder with the state		for all. ¿ What measures will	I
	• •	ved in the wall holder beside		put into place or what system	
	3/23/23 was not in	nd the latest survey, dated		changes the facility will make	
	3/23/23 was not in	the bilider.		ensure that the deficient practices does not recur: The administration	
	On 5/26/23 at 2.24	p.m., the Corporate Nurse		will provide a written notice to	
	,	d they have the survey form		residents regarding the locati	
		provided the survey with the		the Survey Results binder as	I
	-	She said she didn't know when		as a request that the Survey	WCII
	_	or why it wasn't in the binder,		Results binder consistently b	ے ا
	-	ould put it in the binder.		returned to that location. The	
				Administrator will conduct an	
	3.1-3(b)(1)			"All-Staff" training on Resider	nt
				Rights as well as the specific	
				location of the Survey Result	
				binder. ¿ How the corrective	
				action(s) will be monitored to	
				ensure the deficient practice	will
			1	1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			JILDING	00	COMPL 05/26/	ETED	
	PROVIDER OR SUPPLIER CREEK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					not recur, i.e., what quality assurance program will be put place: The administrator (or designee) will conduct an auditimes weekly for 2 weeks, then time weekly for 2 weeks, then monthly on an ongoing basis tonfirm the Survey Results Bir as well as the appropriate sign remains accessible for all.	t 4 n 2 n 1 n der,	
R 0090 Bldg. 00	(g) The administration overall management responsibilities of include, but are not (1) Informing the cocurrence that di welfare, safety, or of unusual occurretelephone, followe a written report on electronic mail to the twenty-four (24) ho occurrences include (A) epidemic outbin (B)poisonings; (C) fires; or (D) major accident If the division cannot be made to the enpublished by the division of monursing care or other contracts.	If Management - Deficiency tor is responsible for the ent of the facility. The the administrator shall of limited to, the following: livision within twenty-four ming aware of an unusual rectly threatens the health of a resident. Notice ence may be made by d by a written report, or by ly that is faxed or sent by he division within the our time period. Unusual de, but are not limited to: reaks;					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WI	NG		05/26	/2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8	990 PROGRESS PARKWAY				
TIMBER	CREEK VILLAGE		SHELBYVILLE, IN 46176				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	representative.	atan annua val muian ta tha					
		ctor approval prior to the					
	years of age to an	ndividual under eighteen (18)					
		acility maintains, on the					
		urate record of actual time					
	worked that indica						
	(A) employee's full name; and						
	1 ' ' ' '	rs worked during the past					
	twelve (12) month	o ,					
	(5) Posting the results of the most recent						
	annual survey of the facility conducted by						
	state surveyors, any plan of correction in						
	l	t to the facility, and any					
		ys. The results must be					
		nination in the facility in a					
	1 '	essible to residents and a					
	notice posted of the						
	. , ,	ports of surveys conducted					
	1 -	each facility for a period of					
	1 ' ' '	making the reports					
	I	ection to any member of the					
	public upon reque	:51	R 00	000	p paraid="1618038198"		06/15/2023
	Based on interview	and record review, the facility	1 1 00	,,,0	paraeid="{6cc15442-b163-477	77-he	00/13/2023
		inusual occurrence of a burn			30-3d62a9b24141}{179}" >PC		
		skin within 24 hour of			R090		
	· ·	residents reviewed for			-		
	unusual occurrence						
	Findings include:						
					What corrective action(s) will I		
		for Resident F was reviewed on			accomplished for those reside		
	5/24/2023 at 2:15 p.m. The medical diagnosis included diabetes.				found to have been affected b	-	
					deficient practice: DON asses		
		4-12/10/2022			Resident F's ankle to confirm	tne	
		ted 3/19/2023, indicated that			skin of the affected area was		
		spilling hot water on his			healed and fully intact, though	l	
		skin around this 1/2" x 1 1/2"			there is evidence of scarring.		
	the area had "dead skin around this 1/2" x 1 1/2"				Further, the resident stated no	J	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/26/2023				
	ROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE (X5) COMPLETION DATE			
	An interview with I Wellness on 5/25/2 Resident F had drog and sustained a bur surrounding it. She The burn was talke morning meeting, 3 An interview with t at 1:35 p.m. indicat this event was repohealth for Resident would be an unusual	R LSC IDENTIFYING INFORMATION 1/2 inch] area". Director of Nursing and 023 at 11:45 a.m., indicated that oped water on his ankle/foot n with some dead skin had applied first aid treatment. d about the next day in		cross-referenced to the APPRODEFICIENCY) current pain or discomfort area. ·How the facility will ider other residents having the potential to be affected by same deficient practice are corrective action will be ta residents had the potential affected by the deficient produced have additional recent incidents been overlooked for report unusual occurrences, as on by IDOH and Indiana Res Regulations. No incidents found that required an Uniforcurrence report. ·What measures will be place or what systemic chart the deficient practice arecur: The Administrator conduct an "All-Staff" train Unusual Occurrence reportequirements. ul class="BulletListStyle1" SCXW72436656 BCX8" restyle="margin: 0px; paddituser-select: text; -webkit-user-drag: none;	in the Intify Intify Intify Interport Interpo			
				-webkit-tap-highlight-color transparent; overflow: visil				

State Form Event ID: W65Z11 Facility ID: 014548 If continuation sheet Page 5 of 62

PRINTED: 06/21/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00	COMPLETED 05/26/2023				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176					
HINDEK	CREEK VILLAGE		SHELD					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
R 0092 Bldg. 00	disaster preparedricontinuity of care of emergency as follows: (1) Fire exit drills in transmission of a fixed simulation of emergency that the more residents to safe at the building is not conducted quarter familiarize all faciliand emergency acconditions. At least held every year. We between 9 p.m. and announcement manualible alarms. (2) At least every sixed shall attempt to how in conjunction with	t maintain a written fire and ness plan to assure of residents in cases of ows: In facilities shall include the fire alarm signal and regency fire conditions, overment of nonambulatory reas or to the exterior of required. Drills shall be ly on each shift to ty personnel with signals etion required under varied t twelve (12) drills shall be left of the drills are conducted		cursor: text; font-family: verdar How the corrective action(s) we monitored to ensure the deficie practice will not recur, i.e., who quality assurance program will put into place: The Administrat (or designee) will review programites for 5 residents, all Morni Meeting notes and all Incident Reports weekly for , then mon for 6 months to ensure all Unu Occurrences have been appropriately identified and reported.	vill be ent at I be ator eess ing thly			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 05/26/2023			
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
	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:		R 0092	p paraid="1715713359" paraeid="{311799e2-27fa-43 0-1ad833243f79}{206}" >PO R092			
	During an interview Corporate Nurse Conot find any fire dri On 5/26/25, at 12:0 Consultant indicate fire drills that were provided fire drills	y, on 5/26/23, at 11:30 a.m., the onsultant indicated she could lls for the last 12 months. 8 p.m., the Corporate Nurse d she had found some of the conducted in the last year, and dated 6/8/22 at 2:30 p.m., 2/1/23 17/23 at noon, and said that is e.		What corrective action(s) will accomplished for those reside found to have been affected deficient practice: The Administrator planned a Fire in-service and posted a notice. How the facility will identife other residents having the potential to be affected by the same deficient practice and corrective action will be take residents had the potential to affected by the deficient practice and active action of fire drills. To calendar has a fire drill schedular to properly mathe execution of fire drills. To calendar has a fire drill schedular department invited attend 2 fire drills per calend year.	dents by the Drill be on and time y e what n: All be be ctice. ire nage he duled he to ar		
				place or what systemic chan the facility will make to ensur	ges		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED 05/26/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				that the deficient practice does recur: The Administrator will conduct an "All-Staff" training Fire Drill requirements.				
				ul class="BulletListStyle1 SCXW117111813 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: textwebkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verda How the corrective action(s) w monitored to ensure the defici- practice will not recur, i.e., whi quality assurance program wil put into place: The Administra (or designee) will conduct fire quarterly on each shift with the local fire department invited to attend 2 fire drills each calend year. A monthly audit will be conducted on the last Tuesday each month for one year to confirm the fire drill scheduled that month has been complete as planned. The audit will mo documentation of each month- fire drill, which will be placed in both the POC Audit Binder as as the Maintenance Binder.	na;" vill be ent at I be ator drills e o ar y of for ed, nitor s' n			
R 0120 Bldg. 00	education and train advance for all per							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 05/26/2023			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO THE APPROP	E COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE		
		esidents' rights, prevention					
		ection, fire prevention,					
		revention, the needs of ations served, medication					
		nd nursing care, when					
	appropriate, as fo	_					
		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.						
	1 ' '	he above required inservice					
	i i	nave contact with residents mum of six (6) hours of					
		training within six (6)					
	· ·	(3) hours annually					
		t the needs or preferences,					
		vely impaired residents					
	_	gain understanding of the					
	1	of care for residents with					
	dementia.						
	(3) Inservice reco	rds shall be maintained and					
	shall indicate the	•					
	(A) The time, date						
	(B) The name of the						
	(C) The title of the (D) The names of						
	` '	content of inservice.					
		l acknowledge attendance					
	by written signatu	_					
	, ,		R 0120	POC for R120	07/15/2023		
	Based on interview	and record review, the facility			57720.2020		
	failed to have requi	red dementia training for 3 of 5					
		eviewed. (QMA 6, Dietary		What corrective action(s) wi	ll be		
	Manager, and Mair	ntenance 7)		accomplished for those residual			
				found to have been affected	-		
	Findings include:			deficient practice: A video-b	ased		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> C			ETED	
			B. W	B. WING			05/26/2023	
				CTREET	ADDRESS SITE STATE SID COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP COD			
TIMBED	000000000000000000000000000000000000000				OGRESS PARKWAY			
HMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
					dementia education program v	was		
	Employee records were reviewed, on 5/26/23 at 11:00 a.m., and indicated:				purchased for staff training			
					purposes.			
					parpooo.			
	OMA 6 was hired of	on 8/22/22. Six hours of						
	dementia training was not completed on the				·How the facility will identify			
	employee record after hire.				other residents having the			
	improjet retera ur				potential to be affected by the			
	The Dietary Manager was hired on 3/28/20. No				same deficient practice and w			
	dementia training was indicated in the last 12				corrective action will be taken:			
	months on the employee record.				residents had the potential to			
	months on the employee record.				affected by the deficient practi			
	Maintenance 7 was hired on 3/26/22. No dementia				The administrator developed a			
		ted in the last 12 months on the			in-service calendar to appropr			
	employee record.	ted in the last 12 months on the			plan and track ongoing staff	iatery		
	employee record.				1 .			
	On 5/26/22 of 11.2	0 a.m., the Corporate Nurse			training. The calendar has a			
		d she could not find any			different training topic to be			
		or the employees reviewed on			presented at each monthly	J		
	the employee record				"all-staff" meeting. The calend	ıaı		
	the employee record	d Ioriii.			incorporates each in-service			
	A Daliary fam !!Omiam	tation/Tuoining/Hoalth			training topic specified in the	ali.a. a.		
	-	ntation/Training/Health s provided by the Corporate			Residential Regulations, included	uing		
	_				dementia training.			
		on 5/26/23 at 2:20 p.m. The						
		at was not limited to:						
		ion and training will be			·What measures will be put			
		rees before they are assisted			place or what systemic change			
		ssisting residentsEach new			the facility will make to ensure			
		nplete orientation prior to			that the deficient practice does	s not		
		ntlyAnnual Training:			recur: The Administrator will			
		must have 8 hours of			audit all employee files to ens			
	_	dar year. Non-Nursing			dementia training is completed			
	•	e contact with residents			all current employees and will			
		s of in-service per year. All			assign new employees the			
		hours of dementia specific			required 6 hours of dementia			
	_	6 months of hire and then 3			specific training within their fire			
	hours annually ther	eafter"			months of employment. How	the		
					corrective action(s) will be			
	5.1-4(e)(2)				monitored to ensure the defici-	ent		
					practice will not recur, i.e., who	at		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	A. BUILDING 00 B. WING		COMPLETED 05/26/2023		
NAME OF PROVI	DER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
					quality assurance program will put into place: The Administra or designee will conduct month "All-Staff" meetings to include a hours of dementia specific train throughout the year. A quarter audit will be conducted for one year to confirm all employees he completed all required dement training.	tor ally 3 ning rly	
Bldg. 00 Per (f) / em cor skir PP car rec dat adr folk (1) (1) (1) anr per tub mu wool had tesi mo sho firsi per	ployee of a facilitate. The screen test, using the D), unless a prender be documented orded in millime te given, date reministered. The owing: At the time of emonth prior to emouth prior terculosis. The first be read prior reference to a documented the tesult during the puld employ the testep is negative formed one (1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING 05/26/2023			/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			OGRESS PARKWAY		
TIMBER	CREEK VILLAGE		SHELBYVILLE, IN 46176				
	T						<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY		DATE
	tuberculosis.						
	(2) All employees who have a positive reaction to the skin test shall be required to						
		•					
		y and other physical and					
	_	ations in order to complete					
	a diagnosis.	all maintain a health record					
		all maintain a health record that includes reports of all					
	employment-related health screenings. (4) An employee with symptoms or signs of						
	active disease, (symptoms suggestive of						
	active disease, (symptoms suggestive of active tuberculosis, including, but not limited						
	to, cough, fever, night sweats, and weight						
	-	permitted to work until					
	tuberculosis is rule	•					
			R 0	121	p="" paraid="259049428"		07/15/2023
	Based on interview	and record review, the facility		paraeid="{6104bafc-5340-		1-85f	
		ff had an annual Tuberculin			8-4e142decb528}{197}">POC		
	(TB) skin test and/o	or tuberculosis risk assessment			R121 What corrective action(
	for 5 of 5 employee	e records reviewed. (QMA 6,			will be accomplished for those	•	
	QMA 3, Dietary M	anager, QMA 8, and			residents found to have been		
	Maintenance 7)				affected by the deficient practi	ce:	
					An audit of all employee files v	was	
	Findings include:				conducted to identify which		
					employees were missing		
	Employee records v	were reviewed on 5/26/23 at			appropriate health screenings	,	
	11:00 a.m., and ind	icated:			specifically the Two-Step TB		
					screening and/or an annual ris		
	•	on 8/22/22. No first step TB skin			assessment How the facility w		
	_	TB skin test was found in the			identify other residents having		
	employee record.				potential to be affected by the		
		1/15/00 31			same deficient practice and w		
		on 1/17/23. No second step TB			corrective action will be taken:		
	skin test was found	in the employee record.			residents had the potential to		
	The Died 34				affected by the deficient practi	ce.	
		ger was hired on 3/28/20. No			A TB screening session for	45	
		nent was found in the			all-staff was planned for June		
	employee record.				2023. What measures will be	put	
	OMA 9 1::- 1	on 2/14/22 No finat			into place or what systemic	4_	
	QMA 8 was hired on 2/14/23. No first or second				changes the facility will make	(O	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/26/2023	
NAME OF PROVIDER OF			990 PF	ADDRESS, CITY, STATE, ZIP COD ROGRESS PARKWAY BYVILLE, IN 46176	
TAG REGU	CH DEFICIEN JLATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION as found in the employee	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) ensure that the deficient pract	DATE
risk asserecord. On 5/26 Consultate document	/23, at 11:3 ant indicated ntation of T	hired on 3/26/22. No annual found in the employee 0 a.m., the Corporate Nurse d she could not find any B skin tests or annual risk		does not recur: The DON will conduct 1 step TB skin tests at the time of hire, to be read prithe new employee beginning work. The 2 step TB skin test be scheduled by the DON dur the first 3 weeks of employment An annual TB risk assessment be scheduled on the employment.	et or to will ing ent. t will
A Policy Screenin Nurse C policy ir "Employ provided responsi Screenin evaluation must incomphysical	of for "Orien ngs/TB" was onsultant of ondicated, but yee orientath to employ bilities in angs: All staff on prior to relude immunexamination	tation/Training/Health s provided by the Corporate n 5/26/23 at 2:20 p.m. The t was not limited to: ion and training will be ees before they are assisted ssisting residentsHealth if must undergo a health resident contact. Evaluation inization status and include a ion. TB Testing: Each employee		anniversary date for each employee. ul="" role="list" How the corrective action(s) v monitored to ensure the defici practice will not recur, i.e., wh quality assurance program wi put into place: The Administrator designee will conduct montaudits on 25% of all employee files to confirm employees has completed all required TB screenings.	ent at Il be ator hly
with the must be no more first TB starting not had during the step TB should be stepAr	Control of completed than 1 more test must be work. For he documented the preceding test. If first the performenually all of the complete test of the performenually all of the complete test.	lin skin test in accordance Tuberculosis Code. This test at the time of employment or th prior to employment. The e read prior to employee ealthcare workers who have I negative TB test result g 12 months, they need a 2 TB is negative, the 2nd test d 1-3 weeks after the first employees and non-paid creened for TB."			
	C 16.2-5-1.	4(h)(1-10) onformance			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			JILDING	onstruction 00	(X3) DATE COMPL 05/26 /	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE	
Bldg. 00	accurate personnel recinclude the followi (1) The name and (2) Social Security (3) Date of beginn (4) Past employment education, if applie (5) Professional liconumber or dining a of completion, if a (6) Position in the (7) Documentation facility, including respecific job skills. (8) Signed acknownesidents' rights. (9) Performance with facility policy. (10) Date and read Based on record reversided to ensure new orientation checklist employees reviewed Findings include: Employee records with 1:00 a.m., and indicated to the control of the con	address of the employee. In number. Ing employment. Ing employment. In ent, experience, and cable. It cansure or registration In assistant certificate or letter In pplicable. In a facility and job description. In of orientation to the In esidents' rights, and to the Invelopment of orientation to Invelopment of orientation to In evaluations in accordance In experience, and In experience, and In experience or letter In pplicable. In a cordance In evaluations in accordance In experience, and In experien	R 0	123	p paraid="408167940" paraeid="{5d6dbb2f-cefd-4dff-646cdb70458f}{197}" >POC for R123 What corrective action(s) will be accomplished for those reside found to have been affected be 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	oe ents y the	07/15/2023	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	ING		05/26/	2023
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
TIMPED					OGRESS PARKWAY		
HIMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	y, on 5/26/23, at 11:30 a.m., the			same deficient practice and w	hat	
	Corporate Nurse Co	onsultant indicated she could			corrective action will be taken:	All	
	not find any specifi	c job orientations for the			residents had the potential to I	be	
	employees listed on	the employee record form.			affected by the deficient practi		
					All current QMAs were provide		
	A Policy for "Orien	tation/Training/Health			with job specific training and a		
	Screenings/TB" was provided by the Corporate				checklist was utilized to indica		
	_	n 5/26/23 at 2:20 p.m. The			completion of the training.		
	policy indicated, but was not limited to:]		
	"Employee orientation and training will be provided to employees before they are assisted responsibilities in assisting residentsEach new						
					·What measures will be put i	into	
					place or what systemic change		
	-	plete orientation prior to			the facility will make to ensure		
	working independen	ntly6. Documentation of the			that the deficient practice does	s not	
	orientation in the er	nployee's personnel record by			recur: The Administrator will		
	the person supervisa	ion (sic) the orientation"			audit all QMA employee files t	0	
					ensure job-specific training is		
	5.1-4(h)(7)				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: verda	na;"	
					How the corrective action(s) w		
					monitored to ensure the deficie	ent	
					practice will not recur, i.e., who	at	
					quality assurance program wil	l be	
					put into place: The DON or		
					designee will provide job spec	ific	
					QMA training to all newly hired		
					QMAs prior to the new employ	/ee	
					working independently.		
R 0148	410 IAC 16.2-5-1.	5(e)(1-4)					
	Sanitation and Sa	fety Standards - Deficiency					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> C		COMPL	COMPLETED 05/26/2023	
	PROVIDER OR SUPPLIER CREEK VILLAGE			990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
Bldg. 00	(e) The facility sha grounds, and equi in good repair, and adversely affect the residents or the put (1) Each facility sha implement a writte to ensure the cont (2) The electrical sappliances, cords, sources, fire alarm shall be maintaine functioning and concept electrical codes. (3) All plumbing shad comply with state (4) At least yearly, systems shall be in Based on interview failed to ensure the system was inspected the potential to affect facility. Findings include: Annual inspection mand ventilation was 5/25/2023. An interview with the Maintenance on 5/2 that the facility had system repaired over have a full inspection.	Ill maintain buildings, pment in a clean condition, if free of hazards that may e health and welfare of the ablic as follows: all establish and in program for maintenance inued upkeep of the facility. Eystem, including switches, alternate power and detection systems, if to guarantee safe impliance with state in all function properly and columbing codes. The heating and ventilating inspected. In and record review, the facility heating and ventilation and at least annually. This had cot 44 residents residing in the interest and fe/2023 at 2:05 p.m. indicated the heating and ventilation in the last year, but did not in in the last 12 months. The	R 0		p paraid="23251769" paraeid="{5926b9cc-171f-4cb8d-e8767d3c24f2}{206}" >POC R148 What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice: A licensed HVAC vendor/service provider contacted to request a comple inspection of the building heating and ventilation system.	for ne nts y the was te	07/15/2023
		naware of this needing to be ut he would work on getting			·How the facility will identify other residents having the potential to be affected by the same deficient practice and wh	nat	

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/26/2023	
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD		
TIMBER (CREEK VILLAGE			BYVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE	N
				corrective action will be tak residents had the potential affected by the deficient properties. An inspection of the facility heating and ventilation sys was scheduled.	to be actice.	
				·What measures will be place or what systemic chat the facility will make to ensith that the deficient practice of recur: The Administrator was chedule an annual followheating and ventilation systems inspection and inform the vendor/service provider that inspection must be schedule conducted consistently on annual basis. This annual expectation will be added to communities' preventative maintenance calendar.	inges ure oes not vill up tem ut this led and	
				ul class="BulletListStyle1 SCXW9924165 BCX8" role style="margin: 0px; paddin user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visib cursor: text; font-family: ver How the corrective action(s monitored to ensure the de practice will not recur, i.e., quality assurance program put into place: The Admini or designee will set an elec calendar alert for 11 month	g: 0px; le; rdana;" s) will be ficient what will be strator stronic	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING			COMPLETED 05/26/2023		
	ROVIDER OR SUPPLIER CREEK VILLAGE			990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
					the most recent heating and ventilation system inspection to ensure the next annual inspection is scheduled with the vendor/service provider in a tirmanner.	tion	
R 0154	410 IAC 16.2-5-1.	• •					
Bldg. 00	(k) The facility sha kitchen areas, con equipment, and ut and rubbish, and r accordance with 4 Based on observation review, the facility of temperatures high en dishes, failed to mai dishwasher, walk in freezer, and failed to	ensils clean, free from litter naintained in good repair in	R 0	154	p paraid="1932736529" paraeid="{caeeb550-9248-40d 10-83d24fefb845}{206}" >POC R154		07/15/2023
	kitchen observations	s. This deficient practice had et all 44 residents who resided			What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice: Administratic confirmed that disposable tableware was utilized for 100	nts y the or	
	Assistant 5. The war registered 150 degree temperature didn't re the gauge did not m was interviewed at the did not have any off temperatures of the gauge has not been better Wanager us	egister due to the needle on ove. The Dietary Manager hat time and indicated they her way to check the dish machine. She said the working off and on. The ed a hand held food			all meal services while the dish machine rinse temperature wa 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	n s	
		ed a hand held food sted the water temperature,			potential to be affected by the same deficient practice and wh	nat	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
			B. W	ING		05/26/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L.			OGRESS PARKWAY		
TIMPED	CREEK VILLAGE						
HIVIDER	CREEK VILLAGE			SHELD	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	after the rinse cycle	, from a cup that was turned			corrective action will be taken:	: All	
		ent through the dishwasher			residents had the potential to	be	
	I -	es. The water tested 145.5			affected by the deficient practi	ce.	
	_	y Manager attempted to find			The dish machine was repaire	ed	
		s for the dishwasher but the			and returned to service after		
	_	ve temperatures written on			confirming the rinse cycle		
	1	. The Dietary Manager			consistently reached the		
	1	d use styrofoam plates and			appropriate sanitizing		
	1 ~	nch and indicated she would			temperatures.		
	use would not use the						
	dishwasher. The sanitizing part of the 3 compartment sink was in use, and tested by the						
					·What measures will be put	into	
	Dietary Manager between 200 to 400 parts per				place or what systemic chang		
	million (PPMs). The Dietary Manager said they				the facility will make to ensure	!	
	could use the sanitizing compartment of the 3				that the deficient practice does	s not	
	compartment sink to	o sanitize some dishes.			recur: The Dining Services		
					manager has implemented a		
		2 a.m., observed the walk in			kitchen cleaning schedule to b		
	_	e Dietary Manager. On the right			used by all dining services tea		
		om metal wire shelves were 2			members and is monitoring th		
		on the floor. One area was			dish machine temperature log	S	
		thes by 4 inches, and the other			daily.		
		naller. The Dietary Manager					
		was from hamburger that was					
	_	namburger, in large rolls, was			ul class="BulletListStyle1		
		l wire shelf. On the left side,			SCXW263911438 BCX8"		
		etal wire shelf, were scattered			role="list" style="margin: 0px;		
		stance and the Dietary			padding: 0px; user-select: text	t;	
	_	it looked like mold but she			-webkit-user-drag: none;		
		the black substance was a			-webkit-tap-highlight-color:		
		substance, and scattered			transparent; overflow: visible;		
	onion skins on the f	loor.			cursor: text; font-family: verda		
	0 5/04/02 110.0	0 1 1 1			How the corrective action(s) w		
		0 p.m., lunch was observed			monitored to ensure the defici		
	_	room, and residents were			practice will not recur, i.e., who		
		plates and cups, and plastic			quality assurance program wil		
		were also using porcelain			put into place: The Administra		
	coffee cups, glass c	ups, and square glass bowls.			or designee will conduct an au		
	0 5/04/00 11/15	D' 41 51 1 4 1			of dish machine temperature I	-	
	On 5/24/23, at 1:15	p.m., Dietary Aide 5 indicated			3 times weekly for 3 weeks an	ıa 1	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/26/2023	
	PROVIDER OR SUPPLIER CREEK VILLAGE	990 PR	ADDRESS, CITY, STATE, ZIP COD ROGRESS PARKWAY BYVILLE, IN 46176		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
TAG	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 and pans used to cook the meal had been sanitized in the 3 compartment sink prior to be but he didn't know if the dishes in the dining related been sanitized. Observation of the glass dishes used from lunch that were beside the 3 compartment sink inclusives a small porcelain bowls, 5 larger porcelain be 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 refriger floor was observed. On the right side, under the metal shelves, the 2 blood spills remained on 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 in 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 the dish machine, freezer or fridge temperature having been taken. A policy for "Kitchen Equipment maintenance was provided by the Corporate Nurse Consult on 5/26/23 at 2:20 p.m. The Policy included, not limited to: "Maintain all major kitchen equipment in good working condition by ensured.	e pots unch, room ch ided: bowls, rator he the ck al the for res e" tant was	time weekly for 3 months. The Administrator or designee will conduct a kitchen inspection 3 times weekly for 3 weeks and time weekly for 3 months to ensure cleanliness is maintain in all kitchen areas, to include walk-in refrigerator. The Administrator or designee will audit the Kitchen Sanitation bi to confirm appropriate utilization the kitchen cleaning schedule.	ed the nder on of	
	regularly scheduled and as-needed servicing Perform regularly scheduled maintenance and	.1.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 05/26/2023
		990 PR	OGRESS PARKWAY	
SUMMARY S		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REGULATORY OR	LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
coolers, etc.) on a retemperature (dish) va minimum of 180 direquired temperature. Services Director wimmediately to ensua timely manner. B. utensils can be used service OR c. All diutilizing a 3-Compa QUAT sanitizer as fiprocess." A policy for "Dietar by the Corporate Nu 12:08 p.m. The policito: "Refrigeration be recorded dailyI temperatures must be temperatures are abordered.	regular basis4. Ensure high ware washing machine reaches legree F during rinse cycle. a. If e is not reached, the Food ill notify the Administrator are repairs can be scheduled in Disposable plates, bowls, and until machine is returned to shes may be sanitized by rtment Sink with appropriate final step in the ware washing The Staff Policies was provided are Consultant on 5/26/23 at cy included, but was not limited and Freezer temperatures must Dishwasher and kitchen water we recorded daily. If the over the blow Health mes, then adjustments must be			
,	•			
(a) An evaluation of each resident shall admission and sha semiannually and change in the resident often at the resident A licensed nurse is needs of the resident Based on interview failed to ensure each evaluation of the resident to ensure each evaluation evaluation expectation to ensure each evaluation expectation expect	of the individual needs of I be initiated prior to all be updated at least upon a known substantial dent's condition, or more int's or facility's request. shall evaluate the nursing ent. and record review, the facility in resident had an an aident's condition updated at anonths and with any known in the resident's status, with a	R 0214	p paraid="670629941" paraeid="{20866d29-87b4-49; 04-4afd774866b7}{206}" >PO R214	
	ROVIDER OR SUPPLIER CREEK VILLAGE SUMMARY S (EACH DEFICIENCE REGULATORY OR cleaning on kitchen coolers, etc.) on a re temperature (dish) v a minimum of 180 d required temperature Services Director w immediately to ensu a timely manner. B. utensils can be used service OR c. All di utilizing a 3-Compa QUAT sanitizer as f process." A policy for "Dietar by the Corporate Nu 12:08 p.m. The polic to: "Refrigeration be recorded dailyI temperatures must b temperatures are abo Department guidelir made to units to cor 410 IAC 16.2-5-2(a Evaluation - Defici (a) An evaluation of each resident shal admission and sha semiannually and change in the reside A licensed nurse s needs of the reside A licensed nurse s needs of the reside Based on interview failed to ensure each evaluation of the reside least every six (6) m substantial change in	OF CORRECTION IDENTIFICATION NUMBER ROVIDER OR SUPPLIER CREEK VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION cleaning on kitchen equipment (freezers, stoves, coolers, etc.) on a regular basis4. 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	ROVIDER OR SUPPLIER CREEK VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION cleaning on kitchen equipment (freezers, stoves, coolers, etc.) on a regular basis4. 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 dailyDishwasher and kitchen water temperatures must be recorded dailyIf temperatures are above or below Health Department guidelines, then adjustments must be made to units to correct" 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. Based on interview and record review, the facility failed to ensure each resident had an an evaluation 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	PROVIDER OR SUPPLIER CREEK VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR IS CUBENTEYMON FOR MATON cleaning on kitchen equipment (freezers, stoves, coolers, etc.) on a regular basis4. Ensure high temperature (fish) 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 uttensils 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: "Refigeration and Freezer temperatures must be recorded dailyDishwasher and kitchen water temperatures are above or below Health Department guidelines, then adjustments must be made to units to correct" 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 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 and an an evaluation of the residen

State Form Event ID: W65Z11 Facility ID: 014548 If continuation sheet Page 21 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
			B. W	ING		05/26/2	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
TIMEE	ODEEK VIII A OE				OGRESS PARKWAY		
HIMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	resident, for 2 of 7 residents reviewed for						
	evaluations and service plans. (Residents B and						
	D)				What corrective action(s) will be	ре	
	Findings include:				accomplished for those reside	nts	
					found to have been affected b	y the	
					deficient practice: An audit wa	s	
	The clinical reco	ord of Resident B was reviewed			conducted to identify additiona	al	
	on 5-24-23 at 11:35	a.m. His diagnoses included,			residents who may need upda	ted	
	but were not limited	d to, COPD (chronic			semi-annual assessments		
	obstructive pulmonary disease), legally blind,				completed.		
	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				·How the facility will identify		
	cognition. His 12-7-22, "Level of Care				other residents having the		
	Assessment," indicated he had minimal cognitive				potential to be affected by the		
		ng occasional remainders and			same deficient practice and w	hat	
	_	-23, "Service Plan," indicated			corrective action will be taken:		
		" judgement. A "Mini Mental			residents had the potential to l		
		(MMSE)", dated 2-20-23,			affected by the deficient practi		
		score of 22 out of 30, which			All residents identified as need	ding	
	could indicate poss	ible cognitive impairment.			updated assessments were		
					evaluated by the DON or		
	_	unknown, Resident B, elected			designee.		
		begin to administer his					
		interview with Resident B on					
	_	n., he indicated he previously			·What measures will be put i		
		vn medications and prefers for			place or what systemic change		
		ter his medications as he			the facility will make to ensure		
		ough to safely administer his			that the deficient practice does		
	medications.				recur: The DON has develope	d	
	A	-1 4 20 22 indicated 1.1 BOA			and implemented a		
	_	ed 4-28-23, indicated the POA			calendar/schedule to track		
	(power of attorney) wished "to take ove	for Resident B indicated she			resident assessments, ensurir	-	
					evaluations are completed on	а	
		n updated self-administration			semi-annual basis.		
	assessment was not located in the clinical record, prior to the resident resuming self-administering						
	_				المالية		
	his medications for	1 to 2 days.			ul class="BulletListStyle1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	To an interior	5 25 22			SCXW86319677 BCX8" role=		
	in an interview with	h the Administrator on 5-25-23			style="margin: 0px; padding: 0	ıpx;	

State Form Event ID: W65Z11 Facility ID: 014548 If continuation sheet Page 22 of 62

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	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	00	COMPL 05/26/	ETED
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
TIMBER	CREEK VILLAGE				YVILLE, IN 46176		
	SUMMARY S (EACH DEFICIEN REGULATORY OR at 9:50 a.m., she ind approached the staff self-administer his r care providers provi She indicated the fa could safely admini being legally blind, he did not wish to d enough to administe An updated self-adm not located in the cl resident self-admini 2 days for on/aroun plan was not located reflect Resident B h administration for o 2. The clinical recor on 5/24/2023 at 11: included chronic ob and emphysema. The most recent sen for Resident D was Per an interview wit Wellness on 5/25/20 the last semi-annual Resident D was doc She stated she woul	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION dicated when the POA f with wanting Resident B to medications, one of his medical ided an order for him to do so. cility staff did not feel he ster his medications due to as well as the resident saying to this as he cannot see well er his medications. ministration assessment was inical record, prior to the stering his medications for 1 to d 4-28-23. An updated service d in the clinical record to ad resumed self-medication n/around 4-28-23. d for Resident D was reviewed do a.m. The medical diagnoses structive pulmonary disease mi-annual nursing assessment dated for September 2022. the Director of Nursing and do 23 at 1:55 p.m. indicated that nursing assessment for umented in September 2022.		990 PR	OGRESS PARKWAY	na;" ill be ent at be tor dit % of	(X5) COMPLETION DATE
	the Corporate Nurse policy indicated, "	/Care Plan", was provided by e on 5/26/2023 at 2:20 p.m. The The service plan must be MI ANNUALLY or when a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/26/2023		
	PROVIDER OR SUPPLIER			990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0216	2-5-2(a) 410 IAC 16.2-5-2(Evaluation - Nonc						
Bldg. 00	(c) The scope and shall be delineated manual, but at a nassessment shall following: (1) The resident 's mental status. (2) The resident 's activities of daily li (3) The resident 's admission and set (4) If applicable, the self-administer medication writing and kept in Based on interview failed to ensure and the resident's ability medications, if the accurately documer any significant char	I content of the evaluation I in the facility policy I inimum the needs I include an evaluation of the I include an evaluation of the I independence in th	R 0.	216	p paraid="1129071297" paraeid="{a13a3f62-01c7-476 8-1d66d80c4e84}{206}" >POOR216	C for	07/30/2023
	on 5-24-23 at 11:35 but were not limited obstructive pulmon	ord of Resident B was reviewed a.m. His diagnoses included, Ito, COPD (chronic ary disease), legally blind, cripheral vascular disease and ture.			What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice: An audit was conducted of all residents currently self-administering the medications.	nts y the s	
	self-medicate r/t [re	tion of Medication 2-22-22, indicated, "Can lated to] VA [Veteran's rse sets all meds up in daily			·How the facility will identify other residents having the potential to be affected by the same deficient practice and w		

State Form Event ID: W65Z11 Facility ID: 014548 If continuation sheet Page 24 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONS			ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		05/26/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2					
TIMEED					OGRESS PARKWAY		
HIMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE .	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	container. Nursing	staff to monitor Res [resident]			corrective action will be taken:	All	
	r/t res legally blind	& may drop meds. If does res			residents who self-administer	heir	
	cannot see to find d	ropped meds. Needs assist			medications had the potential	to	
	[sign for with] eye				be affected by the deficient		
					practice. Any residents currer	ıtlv	
	At some point, date unknown, Resident B, elected				self-administering their	,	
	to have the facility begin to administer his				medications were evaluated by	v the	
	medications. In an interview with Resident B on				DON or designee to ensure th		
		n., he indicated he previously			are able to safely continue	-)	
	administered his own medications and prefers for				self-administration.		
		ter his medications as he					
		ough to safely administer his					
	medications.	5			·What measures will be put i	nto	
					place or what systemic change		
	A nursing note, date	ed 4-28-23, indicated the POA			the facility will make to ensure		
	_	for Resident B indicated she			that the deficient practice does		
	wished "to take ove				recur: The DON or designee		
		n updated self-administration			conduct self-administration	******	
		located in the clinical record,			assessments with all residents	:	
		t resuming self-administering			who wish to self-administer the		
	his medications for	_			medications.	211	
	ins incarcations for	1 to 2 days.			medications.		
	In an interview with	h the Administrator on 5-25-23					
		dicated when the POA			ul class="BulletListStyle1		
		f with wanting Resident B to			SCXW255534332 BCX8"		
		medications, one of his medical			role="list" style="margin: 0px;		
		ided an order for him to do so.			padding: 0px; user-select: text		
		acility staff did not feel he			-webkit-user-drag: none;	,	
		ister his medications due to			-webkit-tap-highlight-color:		
		as well as the resident saying			transparent; overflow: visible;		
	1	lo this as he cannot see well			cursor: text; font-family: verdar	na."	
	enough to administ				How the corrective action(s) w		
	chough to udminist	er ms medications.			monitored to ensure the deficie		
	An undated self-adi	ministration assessment was			practice will not recur, i.e., what		
	_	linical record, prior to the			quality assurance program will		
		istering his medications for 1 to			put into place: The Administra		
		d 4-28-23. An updated service			or designee will audit 25% of	itOl	
		d in the clinical record to			residents who self-administer	hoir	
		a in the clinical record to nad resumed self-medication					
	administration for o				medications monthly for 3 mor and 10% of residents who	III 15	
	aummistration for C	on around 4-20-23.			and 10% of residents who		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 05/26/	ETED
	ROVIDER OR SUPPLIER			990 PR	NDDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	2. The clinical record on 5/25/2023 at 3:40 included chronic fat Syndrome. An individualized so indicated that Residite total assistance with administered only so administration assess record to identify we safely self administration. An interview with February 10:45 a.m. indicated medications for her room, but they will pill and early mornical administer. She assistance with administer. She assistance with administer and she utilized an amedication times for the Corporate Nurse policy indicated, "In the Corporate Nurse policy indicated, "In updated at least SEM significant change of medications or the provided in identity of the services to be involved in identity of the services to be serviced.	rd for Resident C was reviewed 0 p.m. The medical diagnoses tigue and Elher's-Danlos ervice plan, dated 12/22/2022, dent C needed moderate to a medications and that she self ome medications. No self ssment was in the clinical shich medications she could er. Resident C on 5/25/2023 at d that staff prepare all her and will deliver them to her leave her night time sleeping ng thyroid pill for her to self alarm on her phone for exact or those two medications. Resident by Care Plan'', was provided by the on 5/26/2023 at 2:20 p.m. The construction of the service plan must be mus		TAG	self-administer their medicatio for 3 months to ensure self-medication administration assessments are completed a present in the residents' chart.	ns	DATE
R 0217	2-5-2(c)(4) 410 IAC 16.2-5-2(Evaluation - Defici	, ,					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		JILDING	<u>00</u>		3) DATE SURVEY COMPLETED 05/26/2023	
	ROVIDER OR SUPPLIEF	8		990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
Bldg. 00	(e) Following comfacility, using appropriate appropriate (a) The services of the resident shall be a (b) preference; (c) need; and (d) preference; (e) the resident (f) preference; (f) the services of the resident. (g) The services of the resident. (g) The services of the resident and facility change. Either the request a service (g) The agreed upsigned and dated of the service plar resident upon request (g) The agreed upsigned and dated of the services provided subsequent to the no need for a chain (s) If administration provision of reside both, is needed, a involved in identifity the services to be a plan for 3 of 7 residence. Service Plans. (Resident G's reconstitution of the services to be the service of the services of the services to be the services of the services o	pletion of an evaluation, the ropriately trained staff entify and document the vided by the facility, as offered to the individual appropriate to the: offered shall be reviewed and oriate and discussed by the try as needs or desires a facility or the resident may plan review. It is not	R 0.		p paraid="262834459" paraeid="{c5f5682e-4897-438; b-5576c1e96d18}{251}" >POOR217	c for	07/30/2023	
	2:00 p.m. and indic	ated Resident G was admitted			accomplished for those reside	nts		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING _		05/26/	/2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ROGRESS PARKWAY		
TIMRER	CREEK VILLAGE				YVILLE, IN 46176		
	TOTALLIN VILLAGE				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	on 2/24/23, with a c	diagnosis of fluid on the brain.			found to have been affected b	•	
	. t.				deficient practice: An audit wa		
		idualized service plan in the			conducted to identify additional		
		Resident G. 2. The clinical B was reviewed on 5-24-23 at			residents who may need upda	itea	
		gnoses included, but were not			service plans completed.		
		chronic obstructive pulmonary					
	·	nd, atrial fibrillation, peripheral			·How the facility will identify		
	vascular disease and history of a hip fracture.				other residents having the		
	vascular disease and history of a hip fracture.				potential to be affected by the		
In an interview with the Administrator on 5-25-23					same deficient practice and w	hat	
at 9:50 a.m., she indicated when the POA					corrective action will be taken:		
approached the staff with wanting Resident B to					residents had the potential to		
	self-administer his medications, one of his medical				affected by the deficient practi		
		rided an order for him to do so.			The DON or designee updated		
		acility staff did not feel he			service plans for all residents	-	
		ister his medications due to			whose service plan had not be	een	
	_	as well as the resident saying			updated within the past 6 mon		
	he did not wish to d	lo this as he cannot see well					
	enough to administ	er his medications.					
					·What measures will be put	into	
		e plan was not located in the			place or what systemic change	es	
		eflect Resident B had resumed			the facility will make to ensure		
		ministration for on/around			that the deficient practice does		
	4-28-23.				recur: The DON has develope	d	
		rd for Resident D was reviewed			and implemented a		
	.	40 a.m. The medical diagnoses			calendar/schedule to track		
		ostructive pulmonary disease			resident service plans, ensurir	ng	
	and emphysema.				updates are completed on a		
	A	Con Desident D. detail			semi-annual basis or at chang	e ot	
		or Resident D, dated			condition.		
	·	red that the facility and outside					
	_	e responsibility for managing adin monitoring and labs.			ul algon="Bullett intStyle 4		
		ing was not reflected on the			ul class="BulletListStyle1 SCXW250115030 BCX8"		
		lualized Service Plan for			role="list" style="margin: 0px;		
	Resident D, dated 5				padding: 0px; user-select: text	·-	
	Resident D, dated 3	11 12 12 12 12 12 12 12 12 12 12 12 12 1			-webkit-user-drag: none;	٠,	
	A nursing progress	note, dated 4/6/2023,			-webkit-tap-highlight-color:		
		ent D to use non-invasive			transparent; overflow: visible;		
l	I		ı		I danaparent, evernow, visible,		I

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		05/26/2023
			CTREE	TADDRESS CITY STATE ZID COD	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	L		T ADDRESS, CITY, STATE, ZIP COD	
TIMPED				PROGRESS PARKWAY	
HIMBER	CREEK VILLAGE		SHEL	BYVILLE, IN 46176	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DDOVIDED'S DI AN OF CODDECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	ventilation.			cursor: text; font-family: verda	na:"
				How the corrective action(s) v	
	The most recent ind	lividualized service plan for		monitored to ensure the defici	
		ed for 5/12/2022. The service		practice will not recur, i.e., wh	
		coumadin monitoring, testing,		quality assurance program wi	
	_	he use of non-invasive		put into place: The Administra	
	ventilation. This service plan indicated under			or designee will conduct an au	
oxygen as "2 LPM [liter per minute] @ rest 4				of 25% of all resident charts	aut
	LPM"			monthly for 3 months, then 10	1% of
	LPM"			all resident charts monthly for	
	A policy entitled, "I	Resident		months to ensure service plar	
		c/Care Plan", was provided by		are updated semi-annually an	
		e on 5/26/2023 at 2:20 p.m. The		present in the resident chart.	ч
	_	The service plan must be		present in the resident chart.	
		MI ANNUALLY or when a			
	•	occursA copy of all services			
		sident will be kept in the			
	facility office"	sident will be kept in the			
	racinty office				
	This Desidential too	moletes to Commisint			
	IN00407499.	relates to Complaint			
	1110040/499.				
	2.5.2(2)				
	2-5-2(2)				
	2-5-2(3)				
R 0241	410 IAC 16.2-5-4(a)(1)			
11.0271	Health Services -	, , ,			
Bldg. 00					
Blug. 00	, ,	ation of medications and the			
		ential nursing care shall be			
		resident 's physician and			
		d by a licensed nurse on			
	the premises or or				
	, ,	all be administered by			
	•	ersonnel or qualified			
	medication aides.		D 02 11		00/04/2055
		on, interview and record	R 0241	p paraid="719604552"	08/01/2023
	-	failed to ensure medications		paraeid="{0a2f20a5-0a9f-46a	
		as ordered for 2 of 12 residents		6802bc802bcc}{206}" >POC f	or
	reviewed for medic	ations. (Residents B and M)		R241	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	JILDING	onstruction 00	(X3) DATE COMPL 05/26 /	ETED
	PROVIDER OR SUPPLIER CREEK VILLAGE			990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	1. The clinical reco on 5-24-23 at 11:35 but were not limited obstructive pulmon atrial fibrillation, polistory of a hip frac In an interview on a Administrator, she provider for Reside (Veteran's Administance are view of the medication administered as documedication administered as documedication administered and documedication was documedication was documedication was documedication was documedication was documedication to make 2 tabs po every prior to bedtime." documented as adm 5-25-23 of two tables and the sum of the medication was documedication was documented as adm 5-25-23 of two tables. The MAR in minerals, Gummies medication was documedication was documented as adm 5-2-23 through 5-2-23 through 5-2-2-23 through 5-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2	5-26-23 at 11:00 a.m., with the indicated the preferred medical nt B was identified as the VA tration) home care services. In lication orders for Resident B, cations were prescribed, by the ices, as of 5-20-23, and how cumented on the May, 2023, stration record (MAR) as Strength 25/500 mg (milligrams) (bedtime) for sleep was ented as "Tylenol PM Extra to [by mouth] at HS." The cumented as administered from 5-23 of one tablet each evening. Take 1 tablet every day po at a contract of the co			What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice: Clarification physician orders was obtained residents affected and MAR we 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 we corrective action will be takent residents on the communities' medication administration prophad the potential to be affected the deficient practice. An audication administration prophad the potential to be affected the deficient practice. An audication administration prophad the potential to be affected the deficient practice. An audication administration prophad the potential to be affected the deficient practice. An audication administration prophad the deficient practice of the made to ensure orders were accurately reflected on the MAC. What measures will be put place or what systemic change the facility will make to ensure that the deficient practice does recur: A new protocol is being established to have all physici orders electronically sent to on new LTC pharmacy directly for their inclusion on the printed for the printed fo	nts y the of I for as hat All gram d by it ders ere AR. into es s not an ur r MAR,	
	•	e 1 ampule via nebulizer every 6					

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/26/2023
	PROVIDER OR SUPPLIER		990 PF	ADDRESS, CITY, STATE, ZIP COD ROGRESS PARKWAY BYVILLE, IN 46176	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAG	hours as needed." documented as adm without times indic. 5-2-23 through 5-2: -"Guaifenestin [sic] hours as needed for the MAR and admin 5-2-23 through 5-2: corresponding orde 5-20-23 order list"Finasteride 5 mg, documented as adm 5-25-23 of one table a corresponding ord 5-20-23 order listCholecalciferol (vi (micrograms) (5,00 every day po for 30 "Cholecalcif 50 mc oral daily." This m administered from stablet once dailyAspirin 81 mg che daily po for 30 days "Aspirin 81 mg EC oral daily." This m administered from stablet once dailyAtorvastatin 40 mg This order was not -Dicyclomine 10 m This order was not -Furosemide 20 mg This order was not -Loratadine 10 mg, This order was not -Senna with docusa	This medication was inistered over 30 times, ated of administration, from 5-23. 400 mg, one tablet po every 8 cough," was documented on inistered over 10 times from 5-23. There was not a r from the VA listed on the take 1 tablet oral daily," was inistered from 5-2-23 through et each evening. There was not ler from the VA listed on the tamin D3) 125 mcg 0 units) capsule, take 1 capsule days. The MAR indicated, g (D3 2,000 units), take 1 table edication was documented as 5-2-23 through 5-25-23 of one wable tablet, chew one tablet is. The MAR indicated, [enteric coated] tab, take 1 table edication was documented as 5-2-23 through 5-25-23 of one system of the MAR indicated, g, take 1 tablet po for 30 days. found on the MAR. g, take 1 tablet po every day. found on the MAR. take 1 tablet po every day. found on the MAR. take 1 tablet po every day.	IAG	ul class="BulletListStyle1 SCXW78665898 BCX8" roles style="margin: 0px; padding: user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible cursor: text; font-family: verda How the corrective action(s) monitored to ensure the defic practice will not recur, i.e., wh quality assurance program w put into place: The DON or designee is a full review of al residents' medication orders the transition process as we to our new LTC pharmacy provider.	="list" Opx; ; ana;" will be sient at ill be I within

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY TPLETED 26/2023
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO	OD	
TIMBER	CREEK VILLAGE			OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE PPROPRIATE	COMPLETION
TAG		te NA 50 mg/Sennosides 8.6	TAG	DEI CHEICETT		DATE
		as needed for constipation."				
	This medication wa	s documented as not				
	administered from 5	5-1-23 through 5-25-23.				
	-Acetaminophen 32	5 mg tablet, take 2 tablets three				
		0 days. The MAR indicated,				
	-	25 mg tab, take 2 tablets three				
	-	ed, not to exceed 3,000 mg per				
	-	ophen products." This				
		rumented as not administered				
	from 5-2-23 through	h 5-25-23.				
	2. The clinical reco	ord of Resident M was reviewed				
	on 5-25-23 at 2:30	p.m. Her diagnoses included,				
	but were not limited	d to type 2 diabetes. During 1				
	of 3 medication pas	s observations with 1 of 1 staff				
	members for 5 of 5	residents on 5-25-23 at 9:15				
		as observed to prepare a				
	-	dial the pen to 48 units of				
		3 observe the dial for accurate				
	-	f-administer her insulin.				
		ed to document on the May,				
	· ·	ation administration record),				
		wn up 48 units of Novolin				
		ninistered the insulin. During				
		MA 3 at this time, she the resident has an order that				
	= =	n or Novolin insulin because				
		nger covers the Novolin."				
	ner maranee no for	iger covers the rovoini.				
		5-25-23 at 2:45 p.m., with the				
	_	(DON), she indicated the				
		hysician's order via fax on				
	_	e insulin from Novolin to				
		he provided a copy of the faxed				
		which indicated, "Humulin N				
		, KwikPen 100 unit/ml				
		ons: 48 units (0.48 ml)				
		times a day for 30 days."				
	inis order did not c	larify if this order was in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING	<u> </u>	05/26/2023
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>
NAME OF P	ROVIDER OR SUPPLIER	t .		ROGRESS PARKWAY	
TIMBER	CREEK VILLAGE			BYVILLE, IN 46176	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	•	ious Novolin order or if the			
		to be discontinued. The DON			
		l seek further clarification from			
		ian. The MAR indicated the			
		er had been documented as			
		daily from 5-1-23 through			
	5-25-23. However,				
		lumulin insulin administration			
	from 5-9-23 through	n 5-25-23.			
	TTI: D :1 4:14	1			
	IN00407499.	relates to Complaint			
	INUU40/499.				
	2.5-4(e)(1)				
R 0242	410 IAC 16.2-5-4(e)(2)			
	Health Services -	, , ,			
Bldg. 00		hall be observed for effects			
	` '	ocumentation of any			
		s shall be contained in the			
		e physician shall be notified			
	immediately if und	lesirable effects occur, and			
	such notification s	hall be documented in the			
	clinical record.				
	Based on interview	and record review, the facility	R 0242	p paraid="1003639583"	08/01/2023
	failed to ensure resi	dents were monitored for the		paraeid="{f0069bb6-f1fa-47e2	⊵-bf5c-
	,	needed) medications received		8fd46044cd87}{206}" >POC fo	or
	from facility staff for	or 4 of 12 residents reviewed for		R242	
	medications. (Resid	dents B, C, D and N)			
	Findings include:				
	1. The clinical reco	ord of Resident B was reviewed		What corrective action(s) will l	ne.
		a.m. His diagnoses included,		accomplished for those reside	
		to, COPD (chronic		found to have been affected b	
		ary disease), legally blind,		deficient practice: The DON	,
	_	eripheral vascular disease and		implemented the use of a PRI	v
	history of a hip frac	-		Log Binder and provided train	
				staff regarding the appropriate	-
	A review of Resider	nt B's PRN medications for		protocols related to PRN	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	JILDING	onstruction 00	(X3) DATE : COMPL 05/26 /	ETED
NAME OF PROVIDER OR SUPPLIE TIMBER CREEK VILLAGE	ER	990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
-Albuterol Nebuli or ml) in nebulize medication admin	ted he received the following: zer 0.083%, 1 ampule (3 milliliter every 6 hours PRN. The istration record (MAR) indicated on was administered over 30		medications, specifically the documentation of potential adverfects of PRN medications.	/erse	
times during the motes failed to ack been discussed with being administered the MAR for this appecific reason for administered, such wheezing. There documentation on for monitoring for resident's health stath this medication. "Fiber gummies (The MAR indicate administered 2 times and nursing notes medication had be nurse prior to bein The order on the Mark indicated and the modern of the Mark indicated and	the MAR or the nursing notes improvement or decline in the atus, related to the receipt of 2) po [by mouth] as needed. 2d this PRN medication was needed the during the month. The MAR failed to acknowledge this en discussed with the licensed g administered by the QMA. MAR for this medication did not		·How the facility will identify other residents having the potential to be affected by the same deficient practice and who corrective action will be taken: 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 who reviewed for documentation potentially indicating an adverse effect. •What measures will be put it place or what systemic change the facility will make to ensure that the deficient practice does	e s ere se nto	
medication was to constipation. The documentation on for monitoring for resident's health st this medication. A review of the M PRN medications following: -Albuterol SO4 0. ampule via nebuli The MAR indicate documented as ad	the reason for why the be administered, such as the was an absence of the MAR or the nursing notes improvement or decline in the atus, related to the receipt of any, 2023 MAR of Resident B's indicated he received the as with a management of the same and the same an		that the deficient practice does recur: The Administrator and E conducted an in-service with a staff who administer medicatio to re-educate them on the processes related to the appropriate administration of F medications, including the expectation to call the DON or designee prior to administration appropriate documentation of time the PRN medication was administered, the reason PRN medication was requested as a stocumenting the effects of PRN medication, any potential	s not DON III Inns PRN Inn, the	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/26/2023
	PROVIDER OR SUPPLIER		990 PF	ADDRESS, CITY, STATE, ZIP COD ROGRESS PARKWAY BYVILLE, IN 46176	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
IAU	acknowledge this m with the licensed m administered by the MAR for this medical specific reason for administered, such wheezing. There we documentation on the for monitoring for it resident's health state this medication. -Guaifenesin 400 m needed for cough. Medication was doen 10 times during the notes failed to acknowledge discussed with being administered absence of documentursing notes for modecline in the resident the receipt of this multiple. The MAR in documented as administered by the of documentation of notes for monitoring the resident's health of this medication. 2. The clinical receipt of this medication.	edication had been discussed arse prior to being QMA. The order on the cation did not indicate the why the medication was to be as shortness of breath or as an absence of the MAR or the nursing notes are mprovement or decline in the trus, related to the receipt of the MAR indicated this are mented as administered over month. The MAR and nursing owledge this medication had at the licensed nurse prior to by the QMA. There was an antation on the MAR or the conitoring for improvement or ent's health status, related to needication. The trust diarrhea and 1 tab or with a maximum of 4 tablets dicated this medication was an antation on the MAR or the conitoring for improvement or ent's health status, related to needication.	IAG	adverse effects and DON for up for sign off on the administration of the PRN medication. ul class="BulletListStyle1" SCXW51805295 BCX8" role style="margin: 0px; padding user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible cursor: text; font-family: vero How the corrective action(s) monitored to ensure the defi practice will not recur, i.e., w quality assurance program v put into place: The DON wil 25% of resident charts for the receiving PRN medication administration monthly for 3 months and 10% monthly for months.	e="list" : 0px; lana;" will be cient that will be I audit ose

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AND PLAN OF C		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ILDING	00	COMPL 05/26/	ETED
NAME OF PROV	VIDER OR SUPPLIER				DODESS, CITY, STATE, ZIP COD		
TIMBER CR	REEK VILLAGE				OGRESS PARKWAY /VILLE, IN 46176		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	nedications, indicat or May, 2023:	ed he received the following					
	• •	nilligram) tablet, take 1 to 2					
		s as needed, not to exceed 8					
		nspecified pain. The					
		ration record (MAR) and					
		ed he had received 2 tablets					
fe	our times daily. Th	e MAR and nursing notes					
fa	ailed to acknowledg	ge this medication had been					
		censed nurse prior to being					
	-	QMA. There was an absence					
		the MAR or the nursing					
		g for improvement or decline in					
		status, related to the receipt					
	f this medication.						
		acetaminophen 5/325 mg, give ars as need for pain, not to					
	-	y, for a maximum of 8 tablets					
		on administration record					
	-	log indicated he had received					
		daily. The MAR and nursing					
		owledge this medication had					
		the licensed nurse prior to					
		by the QMA. There was an					
at	bsence of documen	tation on the MAR or the					
nı	ursing notes for mo	onitoring for improvement or					
de	ecline in the resider	nt's health status, related to					
th	ne receipt of this mo	edication.					
l In	ı an interview with	the Director of Nursing on					
		, she indicated she did not					
		documentation to indicated if					
		s were beneficial for the					
		notes or on the MAR.					
	•	d for Resident C was reviewed					
OI	n 5/25/2023 at 3:40	p.m. The medical diagnoses					
in	ncluded chronic fati	igue and Elher's-Danlos					
Sy	yndrome.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/26/2023		
	OF PROVIDER OR SUPPLIE ER CREEK VILLAGE	₹	990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Resident C indicated she had	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	received her as nee medication two tim The administration of complaint of pai The administration indication nor resul	ded (PRN) narcotic pain les (5/5/2023 and 5/26/2023). on 5/5/2023 had an indication in with no results documented. 5/26/2023 did not have an its documented.				
	order for Tylenol to This medication wa	also indicated an as needed be given for pain or fever. as administered 20 times nor results documented.				
	on 5/24/2023 at 11:	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.				
	for Resident D, date	mi-annual nursing assessment ed for September of 2022, dent D needed total assistance				
	order for narcotic p to three times a day medication was sig times on this MAR listed it was given these administration	R for Resident D indicated an ain medications to be given up as needed for pain. This need off as administered 45, 18 of these administrations for complaints of pain, 27 of and did not include an and all 45 did not list a result of attion.				
	provided by the Co 11:00 a.m. The pol- and administered, s	Medication Program", was rporate Nurse on 5/26/2023 at icy indicated, "For each PRN taff will documented the date, and the effectiveness of the				

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD B. WING	ING	00	COMPL 05/26		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	<u>, I</u>	, · · · · · · · · · · · · · · · · · · ·		(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
	This Residential tag IN00407499. 3.1-50(a)(1)	relates to Complaint						
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency		R 0243		p paraid="1003639583" paraeid="{f0069bb6-f1fa-47e2 8fd46044cd87}{206}" >POC fo R243		08/01/2023	
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				What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice: The DON implemented the use of a PRN Log Binder and provided training 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 will corrective action will be taken:	nts y the I ng to			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		05/26/	
				_	_		
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
					OGRESS PARKWAY		
TIMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	medication was adr	ninistered to the resident.			residents who are on the		
	-"Fiber gummies (2	2) po [by mouth] as needed.			community medication		
	The MAR indicated	d this PRN medication was			administration program had th	е	
	administered 2 times during the month. The MAR				potential to be affected by the		
	and nursing notes failed to acknowledge the				deficient practice. All resident	s	
	specific time the medication was administered to				with PRN medication orders w		
	the resident.				reviewed for documentation of	the	
					time of administration.		
	A review of the May, 2023 MAR of Resident B's						
	PRN medications indicated he received the						
	following:				·What measures will be put i	into	
	-Albuterol SO4 0.83% inhalation 3 ml Use 1				place or what systemic change	es	
	ampule via nebulizer every 6 hours as needed.				the facility will make to ensure		
	The MAR indicated this medication was				that the deficient practice does		
	documented as adn	ninistered over 30 times during			recur: The Administrator and [
	the month. The Ma	AR and nursing notes failed to			conducted an in-service with a	ıll	
	acknowledge the sp	pecific time the medication was			staff who administer medication	ns	
	administered to the	resident.			to re-educate them on the		
	-Immodium A-D 2	tabs at first diarrhea and 1 tab			processes related to the		
	after each loose sto	ol with a maximum of 4 tablets			appropriate administration of F	PRN	
	daily. The MAR in	ndicated this medication was			medications, including the		
	documented as adn	ninistered 8 times during the			expectation to call the DON or		
	month, with 3 of 8	times having the time			designee prior to administration	n,	
	administered being	omitted from the MAR or			appropriate documentation of	the	
	nursing notes.				time the PRN medication was		
	2. The clinical reco	rd for Resident D was reviewed			administered, the reason PRN		
	on 5/24/2023 at 11:	40 a.m. The medical diagnoses			medication was requested as	well	
	included chronic of	ostructive pulmonary disease			as documenting the effects of	the	
	and emphysema.				PRN medication and DON		
					following up for sign off on the		
	The most recent ser	mi-annual nursing assessment			administration of the PRN		
	for Resident D, dat	ed for September of 2022,			medication.		
	indicated that Resid	lent D needed total assistance					
	with medications.						
					ul class="BulletListStyle1		
		nistration record (MAR) for			SCXW109114314 BCX8"		
	April of 2023 indicated an order for coumadin 2				role="list" style="margin: 0px;		
	milligrams (mg) by mouth daily Sunday, Monday,				padding: 0px; user-select: text	.,	
	Tuesday, Wednesd	ay, and Thursday. This			-webkit-user-drag: none;		
	medication was init	tialed as given on 4/30/2023			-webkit-tap-highlight-color:		

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STATEMENT OF DEFICIENCIES X1) PH		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	NG _		05/26/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	Ľ			OGRESS PARKWAY		
TIMBER	CREEK VILLAGE			SHELBYVILLE, IN 46176			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	without a medication time listed.				transparent; overflow: visible;		
					cursor: text; font-family: verda		
A policy entitled, "Medication Program", was			How the corrective action				
		rporate Nurse on 5/26/2023 at			monitored to ensure the deficie		
	_	cy indicated, "The licensed			practice will not recur, i.e., wha		
	-	document the medication			quality assurance program will		
		e MAR, indicated time, name			put into place: The DON will a		
	of the medications, dose and the person administering the medications"				25% of resident charts for thos	se	
					receiving PRN medication		
					administration monthly for 3		
	_	g relates to Complaint			months and 10% monthly for 3		
	IN00407499.				months.		
	2-5-4(e)(3)(A)						
R 0244	410 IAC 16.2-5-4(e)(4)					
	Health Services - Noncompliance						
Bldg. 00	(4) Preparation of doses for more than one (1)						
· ·	scheduled administration is not permitted.				p paraid="111383756"		
	μ		R 0	244			08/01/2023
	Based on interview	and record review, the facility			paraeid="{fb2245a7-6bef-4add-836		
	failed to prepare on	ly a single dose of a controlled			8-ac8c0f59b0d8}{206}" >POC	for	
	substance at a time	for 1 of 7 residents reviewed			244		
	for narcotic medicat	tion compliance. (Resident C)					
	Findings include:						
	The clinical record	for Resident C was reviewed			What corrective action(s) will b	ne.	
		0 p.m. The medical diagnoses			accomplished for those reside		
		tigue and Elher's-Danlos			found to have been affected by		
	Syndrome.	and the Biller & Buller			deficient practice: The DON	y uio	
	= 1				implemented new protocols fo	r	
	An individualized s	ervice plan, dated 12/22/2022,			managing narcotic medication		
	indicated that Resident C needed moderate to				administration to ensure only a		
		n medications and that she self			single dose of a controlled		
	administered only some medications. An interview with Resident C on 5/25/2023 at				substance is prepared at a tim	e.	
		d that staff prepare all her			·How the facility will identify		
		and will deliver them to her			other residents having the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 05/26/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
TIMBER	CREEK VILLAGE			SYVILLE, IN 46176	
PREFIX TAG (EACH DEFICIENCY MUST REGULATORY OR LSC IDER room, but they will leave her pill and early morning thyror administer. She assures her of and she utilized an alarm on medication times for those to A physician's order, dated 11 for Resident C to receive pro (milligrams) by mouth one to and one tablet at noon. A narcotic count sheet for he received date of 4/19/2023, if that two 100 mg doses were An interview with the Direct Wellness on 5/26/2023 at 10 the staff signed out two dose		ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION leave her night time sleeping ing thyroid pill for her to self ares her door is always locked alarm on her phone for exact in those two medications. dated 11/17/2022, indicated deeive provigil 100 mg inth one tablet in the morning on. deet for her provigil with a 9/2023, indicated on 5/22/2023 des were signed out at 7:30 a.m. die Director of Nursing and 23 at 10:45 a.m. indicated that	990 PF	ROGRESS PARKWAY	hat All ation on ave es d by ation rm ed
	administer (noon). T	pocket until it was time to The staff did this to keep from e narcotic box a second time.		that the deficient practice does recur: The Administrator and I conducted an in-service with a staff who administer medication to re-educate them on the processes related to the appropriate administration of controlled substances, specific the expectation that only a sin dose is to be prepared at a tin Medication carts with double locked narcotic medication storage boxes have been order as a part of the new LTC pharmacy agreement and transition to improve the efficient of medication administration overall and specifically of controlled medications.	cally gle ne.

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/26/2023
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY	
TIMBER	CREEK VILLAGE			YVILLE, IN 46176	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0246 Bldg. 00	410 IAC 16.2-5-4(Health Services - (6) PRN medication a qualified medica authorization by a physician. The QN authorization for e PRN medication. A physician not on the authorization to ac documented in the the time and date Based on interview	e)(6) Deficiency ons may be administered by tion aide (QMA) only upon licensed nurse or MA must receive appropriate ach administration of a All contacts with a nurse or ne premises for dminister PRNs shall be e nursing notes indicating	R 0246	ul class="BulletListStyle1" SCXW79100942 BCX8" role= style="margin: 0px; padding: 0 user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verda How the corrective action(s) w monitored to ensure the defici practice will not recur, i.e., wh quality assurance program wil put into place: The DON will a the narcotic logbook 4 times weekly for 1 month, 2 times weekly for 2 months and 1 tim weekly for 2 months to ensure only a single dose of any narc medication is prepared at a tir	"list" Opx; na;" vill be ent at I be audit e e e otic ne. 08/01/2023
	PRN (as needed) me licensed nurse prior medication and the document the prior- medication in the re	edication notified a facility to the administration of the licensed nurse failed to		accomplished for those reside found to have been affected b deficient practice: The DON implemented the use of a PRI Log Binder and provided train staff regarding the appropriate	nts y the N ing to

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		05/26/	
					_		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					OGRESS PARKWAY		
TIMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	WANTED DE DRECEDED DAY FILL DEFEND (FACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	B, C, D, N)				protocols related to PRN		
					medications.		
	Findings include:						
	The clinical reco	ord of Resident B was reviewed			·How the facility will identify		
	on 5-24-23 at 11:35 a.m. His diagnoses included,				other residents having the		
	but were not limited to, COPD (chronic				potential to be affected by the		
	obstructive pulmonary disease), legally blind,				same deficient practice and w	hat	
	atrial fibrillation, peripheral vascular disease and				corrective action will be taken:		
	history of a hip fracture.				residents who are on the		
	motory of a mp fraction				community medication		
	A review of Resident B's PRN medications for				administration program had th	е	
	April, 2023 indicated he received the following:				potential to be affected by the		
	-Albuterol Nebulizer 0.083%, 1 ampule (3 milliliter				deficient practice. All resident	s	
	or ml) in nebulizer every 6 hours PRN. The				with PRN medication		
	medication adminis	stration record (MAR) indicated			administrations are being revie	ewed	
	this PRN medication	on was administered over 30			by the DON for appropriate		
	times during the mo	onth. The MAR and nursing			authorization and documentati	ion	
	notes failed to ackn	nowledge this medication had			of the prior authorizations,		
	been discussed with	h the licensed nurse prior to			including time and date of		
	being administered	by the QMA. The order on			contact.		
	the MAR for this m	nedication did not indicate the					
	specific reason for	why the medication was to be					
	administered, such	as shortness of breath or			·What measures will be put i	into	
	wheezing.				place or what systemic change	es	
	-"Fiber gummies (2	2) po [by mouth] as needed.			the facility will make to ensure		
	The MAR indicated	d this PRN medication was			that the deficient practice does	s not	
	administered 2 time	es during the month. The MAR			recur: The Administrator and [OON	
	and nursing notes f	ailed to acknowledge this			conducted an in-service with a	ıll	
		en discussed with the licensed			staff who administer medication	ns	
	nurse prior to being	g administered by the QMA.			to re-educate them on the		
		AR for this medication did not			processes related to the		
	indicate the specific	c reason for why the			appropriate administration of F	PRN	
		be administered, such as			medications, including the		
	constipation.				expectation to call the DON or		
					designee prior to administration	n,	
		ay, 2023 MAR of Resident B's			appropriate documentation of	the	
		ndicated he received the			reason PRN medication was		
	following:				requested as well as documer	nting	
	-Albuterol SO4 0.8	3% inhalation 3 ml Use 1			the effects of the PRN medica	tion	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/26/2023	
	PROVIDER OR SUPPLIER		990 PR	ADDRESS, CITY, STATE, ZIP COD ROGRESS PARKWAY BYVILLE, IN 46176	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	The MAR indicated documented as adm the month. The MA	er every 6 hours as needed. I this medication was inistered over 30 times during AR and nursing notes failed to redication had been discussed		and DON following up for sign on the administration of the P medication.	
	with the licensed nu administered by the MAR for this medic specific reason for vadministered, such a wheezing. -Guaifenesin 400 m needed for cough. medication was doc 10 times during the notes failed to acknobeen discussed with being administered -Immodium A-D 2 after each loose stoodaily. The MAR in documented as administered as administered as administered as administered as administered.	QMA. The order on the cation did not indicate the why the medication was to be as shortness of breath or g, take 1 tablet every 8 hours as The MAR indicated this umented as administered over month. The MAR and nursing owledge this medication had a the licensed nurse prior to by the QMA. tabs at first diarrhea and 1 tab ol with a maximum of 4 tablets dicated this medication was inistered 8 times during the nd nursing notes failed to redication had been discussed arse prior to being		How the corrective action(s be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place The DON will audit 25% of resident charts for those rece PRN medication administration monthly for 3 months and 109 monthly for 3 months.	r, : iving on
	2. The clinical reco on 5-25-23 at 3:15 p but were not limited. A review of Resider medications, indicat for May, 2023: -Tramadol 50 mg (r tablets every 4 hour tablets per day for u medication adminis narcotic log indicate	ord of Resident N was reviewed o.m. His diagnoses, included, I to, unspecified pain. Int N's PRN (as needed) pain ted he received the following milligram) tablet, take 1 to 2 as as needed, not to exceed 8 unspecified pain. The tration record (MAR) and ted he had received 2 tablets are MAR and nursing notes			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00	COMP	LETED 5/2023	
	PROVIDER OR SUPPLIER CREEK VILLAGE		990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	failed to acknowled discussed with the I administered by the -Hydrocodone and a 2 tablets every 4 ho exceed 8 tablets dai daily. The medicati (MAR) and narcotic 2 tablets four times notes failed to acknobeen discussed with being administered. In an interview with 5-25-23 at 3:20 p.m. notify me before the try to document in twas given. I haven' Resident N]. Unfor document the QMA The clinical record on 5/25/2023 at 3:40 included chronic fat Syndrome. An individualized so indicated that Resident total assistance with administered only so administration assess record to identify we safely self administered medications for her room, but they will pill and early mornic administer. She assistance is she assistance.	ge this medication had been icensed nurse prior to being QMA. acetaminophen 5/325 mg, give urs as need for pain, not to lay, for a maximum of 8 tablets on administration record e log indicated he had received daily. The MAR and nursing owledge this medication had the licensed nurse prior to by the QMA. A the Director of Nursing on, she indicated, "The QMA's ey give a PRN to a resident. I he nursing notes that a PRN to done that yet for [name of tunately, I don't always 's told me about the PRN."3. for Resident C was reviewed to p.m. The medical diagnoses igue and Elher's-Danlos ervice plan, dated 12/22/2022, the content of the content o				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 05/26 /	ETED	
	PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION OF those two medications.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Resident C's medice (MAR) for May of order (PRN) for Ty fever. This medicate by QMA's without authorization given 4. The clinical reco on 5/24/2023 at 11 included chronic of and emphysema. The most recent ser for Resident D, dat indicated that Residuit had indicated that Residuith medications. A medication admit May of 2023 indicated pain medications to day as needed for put MAR indicated QN times with no docute a licensed nurse. An interview with the Wellness on 5/25/2 gives verbal author	rd for Resident D was reviewed 440 a.m. The medical diagnoses ostructive pulmonary disease mi-annual nursing assessment ed for September of 2022, dent D needed total assistance mistration record (MAR) for ated an order for an narcotic be given up to three times a pain (PRN). Review of this MA giving this medications 31 mented prior authorization from the Director of Nursing and 023 at 11:35 a.m. indicated she ization when the QMA call her dimedications, but she is not					
	A policy entitled, "provided by the Co 11:00 a.m. The pol medications admin authorized by a lice administration. The	Medication Program", was rporate Nurse on 5/26/2023 at icy indicated, "PRN istered by a QMA will be					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/26/2023	
	PROVIDER OR SUPPLIER CREEK VILLAGE	R	STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
R 0247	IN00407499.	g relates to Complaint					
Bldg. 00	Health Services - Deficiency		R 0247		p paraid="846305689" paraeid="{4d1c4852-8ffd-45dd-b22 7-90257f96ff98}{206}" >POC for R247		08/01/2023
	on 5/26/2023 at 11: included weakness An interview with I p.m. indicated that medications and the	Resident N on 5/26/2023 at 1:25			What corrective action(s) will I accomplished for those reside found to have been affected by deficient practice: An audit of resident charts was conducted identify medication errors that not have been appropriately addressed.	ents by the all d to	
	located in Resident A Medication Error was found in QMA indicated that Resid	r medication error report was N's chart. Report, dated for 2/20/2023, 8's personnel file. This form lent N did not receive his the medications ordered by the			·How the facility will identify other residents having the potential to be affected by the same deficient practice and w corrective action will be taken residents on the communities'	hat : All	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		05/26/	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
TIMEED	CREEK VILLAGE				OGRESS PARKWAY YVILLE, IN 46176		
HIVIDER	CREEK VILLAGE			SHELD	YVILLE, IN 40176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	physician.				medication administration prog	gram	
					had the potential to be affected	d by	
	2. The clinical reco	ord for Resident Q was reviewed			the deficient practice. The		
	on 5/26/2023 at 11	:30 a.m. The medical diagnoses			medication error policy was		
	included Parkinson	's disease and atria fibrillation.			reviewed and updated to align	with	
					residential regulations.		
		Resident Q on 5/26/2023 at 2:05					
	p.m. indicated that						
		February this year, there was a			·What measures will be put i		
		s medications late, over an hour			place or what systemic change		
	when he is supposed to get them. He reported this				the facility will make to ensure		
	to the staff and his medication times are improved				that the deficient practice does	s not	
	since then.				recur: The DON and		
					Administrator will present an		
	No progress note or medication error report was				in-service training session for	all	
	located in Resident	Q's chart.			staff who administer medication	n to	
					re-educate on the medication		
		ion Form, dated for 2/21/2023,			policy and procedures including	-	
		dent N and Q had medications			expectations for documentatio		
	errors related to tin	neliness of medications.			(progress notes) and notification		
					all parties as well as completion	on of	
		"Indiana Residential Care			a medication error report.		
		ided by the Corporate Nurse on					
		o.m. The policy indicated, "All					
		hat occur for residents			ul class="BulletListStyle1		
		ons supervision from our			SCXW263504663 BCX8"		
		ed to be reported. A medication			role="list" style="margin: 0px;		
		ong Medication, Wrong			padding: 0px; user-select: text	;	
		me (within 1 hour before or 1			-webkit-user-drag: none;		
	-	eribed time is acceptable),			-webkit-tap-highlight-color:		
		ng MedicationIf a medication			transparent; overflow: visible;		
		pany Medication Error form			cursor: text; font-family: verda		
		tA copy needs to go into the			How the corrective action(s) w		
		wellA note in the resident's			monitored to ensure the deficience		
	record muse also be	e made regarding the error"			practice will not recur, i.e., who		
					quality assurance program will		
	3 1 25(a)(0)				put into place: The Administra		
	3.1-25(e)(9)				or designee will conduct montl audits on 25% of all resident	ıııy	
			1		charts to confirm medication		

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	N OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COM		COMPLETED 05/26/2023				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				errors have been thoroughly a appropriately documented and associated notifications were made (and documented).	I		
R 0275 Bldg. 00	(h) Diet orders sha by the physician as requires.	1(h) nal Services - Deficiency all be reviewed and revised s the resident 's condition and record review, the facility	R 0275	p paraid="669087723"	07/30/2023		
	failed to ensure 5 of dietary orders had p	7 residents reviewed for hysician orders in place for . (Residents B, C, D, G and H)	160273	paraeid="{74f6948e-b7bd-491 2-ce44c6db765d}{206}" >POC R275	0-a1a		
	on 5-24-23 at 11:35 but were not limited obstructive pulmona atrial fibrillation, pe history of a hip fract	ary disease), legally blind, ripheral vascular disease and ture. A review of the clinical te any physician's orders for		What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice: An audit was conducted to identify additional residents who may need diet orders.	nts y the s		
	on 5-24-23 at 1:45 p but were not limited atrial fibrillaltion an anti-coagulation me clinical record failed orders for Resident G's record was revie and indicated Reside on the brain.	rd of Resident H was reviewed o.m. His diagnoses included, to, congestive heart failure, d long-term use of dications. A review of the d to locate any physician's H's dietary needs.3. Resident tweed on 5/24/23 at 2:00 p.m. ent G had a diagnosis of fluid		·How the facility will identify other residents having the potential to be affected by the same deficient practice and wl corrective action will be taken: residents had the potential to be affected by the deficient practice. Requests for diet orders were to the PCP for all residents identified as needing diet order.	All pe ce. sent		
	had a physician's or			·What measures will be put i	nto		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
			B. W	B. WING 05/26/2023			2023
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
TIMEE	005514.7/11.1.4.05				OGRESS PARKWAY		
HMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	On 5/25/23 at 11:57	7 a.m., the Administrator			place or what systemic change	es	
		not have diet orders for			the facility will make to ensure		
	Resident G. 4. The clinical record for Resident C was reviewed				that the deficient practice does		
					recur: The Administrator has	,	
		0 p.m. The medical diagnoses			revised the Physican Certifica	tion	
		tigue and Elher's-Danlos			(plan of care) to include a sect		
	Syndrome.	ague una Emer s Bumos			for the residents' PCP to include		
	Syndrome.				diet orders for all new resident		
	No physician order for diet was on the medical				prior to admission.	د.	
	record for Resident				prior to admission.		
	An interview with the Director of Nursing and						
					ul class="BulletListStyle1		
		023 at 10:45 a.m., indicated she			SCXW71533082 BCX8" role=	"liet"	
	could not locate a physician order for Resident C's diet.						
					style="margin: 0px; padding: 0 user-select: text;	γpx,	
	diet.				*		
	5 The district				-webkit-user-drag: none;		
		rd for Resident D was reviewed			-webkit-tap-highlight-color:		
		40 a.m. The medical diagnoses			transparent; overflow: visible;		
		ostructive pulmonary disease			cursor: text; font-family: verda		
	and emphysema.				How the corrective action(s) w		
	NT 1 '' 1	C 1' 4 4 1' 1			monitored to ensure the defici		
		for diet was on the medical			practice will not recur, i.e., who		
	record for Resident	D.			quality assurance program wil		
		1 D: (C) : .			put into place: The Administra		
		the Director of Nursing and			or designee will conduct an au	idit	
		023 at 1:55 p.m. indicated that			of 25% of all resident charts		
		e a physician order for			monthly for 3 months, then 10		
		Her expectation is that each			all resident charts monthly for		
	resident will have a	n updated diet order.			months to ensure diet orders a	are	
					present in the resident chart.		
	5-5.1(h)						
D 0000	440404005	() (0)					
R 0298	410 IAC 16.2-5-6(
DI-I 00		ervices - Deficiency					
Bldg. 00		harmacist shall be					
		er contract, and shall:					
	1 ' '	e for the duties as specified					
	in 856 IAC 1-7;						
	1 ' '	g handling and storage					
	practices in the fa	cility;					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					ETED
			B. W	ING		05/26	/2023
NAME OF I	PROVIDER OR SUPPLIEI	D.	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	ROVIDER OR SUPPLIER	K		990 PR	OGRESS PARKWAY		
TIMBER	TIMBER CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	` ' '	ultation on methods and					
	procedures of ord	-					
	_	d disposing of drugs as well					
	as medication red	· -					
	, , .	ng, to the administrator or se any irregularities in					
	_	ninistration of drugs; and					
		ig regimen of each resident					
	, ,	ervices at least once every					
	sixty (60) days.	s. These at loads office every					
		and record review, the facility	R 0	298	p="" paraid="1003639583"		08/01/2023
		consultant pharmacist	100	270	paraeid="{f0069bb6-f1fa-47e2	-bf5c-	00/01/2025
		regimen for each resident for 2			8fd46044cd87}{206}" >POC fc		
		wed for medications.			R298 What corrective action(s		
	(Residents B and H	I)			be accomplished for those	,	
					residents found to have been		
	Findings include:				affected by the deficient		
					practice: The Administrator se	t up	
		ord of Resident B was reviewed			a meeting with a LTC pharma	cy to	
		5 a.m. His diagnoses included,			begin transition plans.How the		
		d to, COPD (chronic			facility will identify other reside		
	-	nary disease), legally blind,			having the potential to be affect		
	-	eripheral vascular disease and			by the same deficient practice	and	
		cture. Documentation within			what corrective action will be		
		failed to identify any pharmacy			taken: All residents who are of	n	
		ication regimen had been st year in the facility.			the community medication	•	
	conducted in the las	si year iii iiic raciiity.			administration program had the potential to be affected by the	C	
	2. The clinical reco	ord of Resident H was reviewed			deficient practice. All resident	9	
		p.m. His diagnoses included,			missing a consultant pharmac		
		d to, congestive heart failure,			review will be reviewed by the		
		nd long-term use of			pharmacist and all		
		edications. Documentation			recommendations will be pron	nptly	
	_	record failed to identify any			followed up on.What measure		
		of his medication regimen had			be put into place or what syste		
		the last year in the facility.			changes the facility will make		
					ensure that the deficient pract		
	In an interview with	h the facility's consultant			does not recur: The Administra		
	pharmacist on 5-25	i-23 at 10:15 a.m., she indicated			has provided a contract for rev	/iew	
	she has only been r	reviewing the clinical records			and execution from the new L	TC	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 05/26/2023		
	ROVIDER OR SUPPLIER CREEK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	medications from the by. She indicated she with residential care her statement to indiconducting every 60	cility whom receive their e pharmacy she is employed ne was not well-experienced and regulations. She clarified icate she has not been day drug regimens for the their medications from other		pharmacy for the home office. ul="" role="list" How the corrective action(s) was be monitored to ensure the deficient practice will not recursive, what quality assurance program will be put into place: The new LTC pharmacy will begin their comprehensive services on August 1. Transit meeting #2 is scheduled for Ju 22. Synchrony Pharmacy has confirmed the expectation that their consultant pharmacist with complete a full review of all residents on the community's medication administration progressive for days, not only the residents that utilize their pharmacy for dispensing of the medication.	rill f, ey e ion une t II		
R 0300 Bldg. 00	(4) Over-the-count drugs, and biologic must be labeled in accepted profession the appropriate account instructions and the Based on observation review, the facility of over-the-counter (O labeled with the labeled with the labeled uring 1 of 3 medical of 1 facility staff medical control of 1 facility staff medical con	ervices - Deficiency er medications, prescription cals used in the facility accordance with currently onal principles and include cessory and cautionary e expiration date. n, interview and record	R 0300	p paraid="1988597429" paraeid="{a77a313b-54f3-4b8 e-efdbd5cb103f}{206}" >POC R300 What corrective action(s) will be	for		

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	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 05/26/2023
	ROVIDER OR SUPPLIER CREEK VILLAGE		990 PR	ADDRESS, CITY, STATE, ZIP COD ROGRESS PARKWAY SYVILLE, IN 46176	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: During a medication at 8:52 a.m., with Q prepare the morning The medication of "Plus Minerals" was medication. The bo not labeled with the The directions listed medication was to b with or without food physician. The physician. The physician. The physician medication for conce daily with a medication for concentration for	m pass observation on 5-25-23 MA 3, she was observed to genedications for Resident K. Caltrate 600 mg [milligrams] D3 observed to be an OTC ttle for this medication was correct directions for use. I on the label indicated this te taken up to two times daily or as directed by your sician's order indicated for one tablet to be taken orally		accomplished for those resider found to have been affected by deficient practice: An audit was conducted to identify additional residents whose OTC medical labeling may not include direct 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 was corrective action will be taken: residents who are on the communities' medication administration program and ta OTC medications had the potential to be affected by the deficient practice. All OTC medication labels missing instructions for appropriate use were updated the appropriate accessory and cautionary instructions as well expiration dates. What measures will be put place or what systemic change the facility will make to ensure that the deficient practice does recur: The DON or designee was review all OTC labels to ensure appropriate accessory and cautionary instructions as well expiration dates are included of the labels prior to those OTC medications being administered the resident.	nts y the s al cion tions hat All ke ential with l as into es s not vill e as on
			I	1	ı

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	X3) DATE SURVEY COMPLETED 05/26/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE		
				ul class="BulletListStyle1 SCXW34911333 BCX8" role="Istyle="margin: 0px; padding: 0puser-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdan How the corrective action(s) will monitored to ensure the deficie practice will not recur, i.e., wha quality assurance program will put into place: The DON or designee will conduct an audit a 25% of all residents on the communities' medication administration program to ensure appropriate accessory and cautionary instructions as well a expiration dates are included of OTC labels monthly for 3 month then 10% of all residents on the communities' medication administration program monthly 3 months.	a;" I be nt t be of re as n ns,		
R 0302		ervices - Deficiency					
Bldg. 00	identified with the (A) Resident name (B) Physician name (C) Expiration date (D) Name of drug. (E) Strength. Based on observation review, the facility is	e. ee. e. on, interview and record	R 0302	p paraid="827556748" paraeid="{1f2dbbe0-f98c-40b9- d-2ec9606735d4}{206}" >POC	l l		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING 05/26/2023			/2023	
		<u>.</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			OGRESS PARKWAY		
TIMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	labeled during 1 of	-			R302		
		of 1 facility staff members for					
	1 of 5 residents reviewed during medication pass observation. (Resident K)						
	ooservation. (Resi	dent K)					
	Findings include: What corrective action(s) wi		What corrective action(s) will I	эе			
					accomplished for those reside	nts	
	_	n pass observation on 5-25-23			found to have been affected b	-	
		at 8:52 a.m., with QMA 3, she was observed to			deficient practice: An audit wa		
		prepare the morning medications for Resident K. The medication of "Caltrate 600 mg [milligrams] D3			conducted to identify additiona		
				residents whose OTC medica			
	Plus Minerals" was observed to be an OTC medication. The bottle for this medication was				labeling may not include resid	ent	
		e resident's name, the			name, physician name and		
		r the correct directions for use.			directions for use.		
	physician's name of	the correct directions for use.					
	In an interview wit	h QMA 3 on 5-25-23 at 9:10			How the facility will identify		
		she was not aware of any			other residents having the		
		nts for OTC medications. In an			potential to be affected by the		
		23 at 9:20 a.m., with the Director			same deficient practice and w		
	of Nursing, she ind	icated she was not familiar with			corrective action will be taken		
	labeling requirement	nts for OTC medications.			residents who are on the		
					communities' medication		
	2.5-6(c)(6)(A)				administration program and ta	ke	
	2.5-6(c)(6)(B)				OTC medications had the potential		
					to be affected by the deficient		
					practice. All OTC medication		
					labels missing resident name,		
					physician name and directions	s for	
					use were updated with the		
					appropriate information.		
					·What measures will be put	into	
					place or what systemic change		
					the facility will make to ensure		
					that the deficient practice does		
					recur: The DON or designee v		
					review all OTC labels to ensu		
					resident name, physician nam	e	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMPLETED 05/26/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	5.112		
				and directions for use are inc on the labels prior to those C medications being administe the resident.	OTC		
				ul class="BulletListStyle1 SCXW36109163 BCX8" role style="margin: 0px; padding: user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible cursor: text; font-family: verd How the corrective action(s) monitored to ensure the defic practice will not recur, i.e., wi quality assurance program w put into place: The DON or designee will conduct an auc 25% of all residents on the communities' medication administration program to en resident name, physician nar and directions for use are inc on OTC labels monthly for 3 months, then 10% of all resid on the communities' medicat administration program mont 3 months.	opx; ; ana;" will be cient hat rill be lit of sure me cluded dents ion		
R 0349	410 IAC 16.2-5-8. Clinical Records -	. , . ,					
Bldg. 00	(a) The facility mu on each resident. maintained under employee of the fa	st maintain clinical records These records must be the supervision of an acility designated with that e records must be as					

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPI	LETED
			B. W	B. WING 05/26/2023			/2023
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R					
TIMRER	CREEK VILLAGE			990 PROGRESS PARKWAY SHELBYVILLE, IN 46176			
INIDEN	ONLLIN VILLAGE			OI ILLD	,, ville, iiv 70170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(2) Accurately dod						
	(3) Readily acces						
	(4) Systematically	organized.		2.40			00/01/2022
			R 0	349	p paraid="1863034072"		08/01/2023
	Danidan i ()				paraeid="{5d18635b-a8bd-4fb		
		and record review, the facility			a-c9b0a6f65d04}{206}" >POC	TOr	
		the reason medications were			R349		
		ation Administration Record					
		ocument anticoagulant labs in a l, and failed to document when					
		tified of Resident F's burn.					
		residents reviewed for			What corrective action(s) will l		
		nical records. (Residents D, E,			accomplished for those reside		
	and F)	mear records. (Residents D, E,			found to have been affected b		1
					deficient practice: The DON,	y u ie	
	Findings include:				Corporate Nurse Consultant a	ınd	1
	i mamgo morado.				Administrator reviewed all res		
	1. Resident E's reco	ord was reviewed on 5/24/23 at			charts for clinical record		
		ord indicated Resident E had			compliance for completeness,		
		ided, but were not limited to,			accuracy, accessibility and		
	-	pulmonary disorder, high			organization.		
		h blood fats, insulin			~		
		mellitus, congestive heart					
	-	ney disease, and congestive			·How the facility will identify		
	heart failure.				other residents having the		
					potential to be affected by the		
		orders indicated an order for			same deficient practice and w	hat	1
		l powder 3350, mix 17 grams in			corrective action will be taken	: All	1
		juice, soda, coffee, or tea and			residents had the potential to	be	
	drink daily, with a	start date of 10/24/22.			affected by the deficient practi		
					All resident clinical records we	ere	
		ion Administration Records			audited.		
		y 2023, indicated the					
		l was scheduled to be					
	administered every	_			·What measures will be put		
		the MARs from May 1 through			place or what systemic chang		
	-	he nurse or QMA who had			the facility will make to ensure		
		s given, had circled the initials,			that the deficient practice does		
	-	5/9, 5/18 and 5/21, and on those			recur: The Administrator and I		1
	days the initials of	the nurse or QMA were not			conducted an in-service with a	all	I

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 05/26/2023		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY				
TIMBER	CREEK VILLAGE			YVILLE, IN 46176			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE		
	circled.			staff who have access to resid			
				clinical records to re-educate	all		
		nation on the back of the als had been circled.		potential contributors to the clinical record on clinical			
	MAKS WIIY IIIC IIIII	ars had been cheled.		documentation expectations,			
	On 5/26/23, at 11:30	a.m., the Corporate Nurse		including appropriate			
		d there was no documentation		documentation for PT/INR			
		dent E's MARs that explained		coumadin lab values, MAR			
	-	s were circled and that is		documentation, medication re-	fusal		
	•	on should have been		documentation and the			
		clinical record for Resident D 24/2023 at 11:40 a.m. The		documentation of physician notifications.			
		ncluded chronic obstructive		Houncations.			
	pulmonary disease a						
	A physician note, dathe facility and an omanage the coumad Resident D. Per an interview with Wellness on 5/25/20 that Resident D's dath and obtain his PT/I machine in his room provider's 1-800 nur	ated 12/20/2022, indicated that utside provider were to in dosing and PT/INR level for the the Director of Nursing and 023 at 1:30 p.m., she indicated ughter will usually come in NR level via a coagucheck in and then call it into the mber. She stated if the to come in, she calls the		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: verda How the corrective action(s) w monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place: The DON will a 25% of resident charts to revie all clinical record documentati	t; na;" vill be jent at ll be audit		
	Director and she wi level. Usually the da down on a post-it no stack in her office. S document these in the provider then will fa the pharmacy direct	Il go down and obtain the aughter will write the PT/INR ote that Director then puts in She indicated she does not he clinical record. The outside ax the new coumadin order into ly.		monthly for 3 months and 10% monthly for 3 months.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		JILDING	00	COMPL 05/26/	ETED	
	ROVIDER OR SUPPLIER	t	990 PR	DDRESS, CITY, STATE, ZIP COD DGRESS PARKWAY /VILLE, 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 APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		note, dated 3/27/2023, D checked his own PT/INR 21.5.				
		note, dated 5/5/2023, lent D's PT/INR was 1.5/16.8				
	A physician order, or Resident D's INR w	dated 5/5/2023, indicated that vas 1.5.				
	A physician order, or Resident D's PT/IN	dated 5/9/2023, indicated R was 1.7/18.6.				
	A lab reported, date Resident D's INR w	ed for 5/23/2023, indicated vas 4.4.				
	No additional PT/IN Resident D's record	NR's were documented in				
	a.m. indicated she d INR before giving h not know where it w be in his progress n	QMA 3 on 5/25/2023 at 11:25 lid not check the Resident's nis coumadin because she did was located. She stated it will otes "sometimes". She ot know what his target goal				
		ord for Resident F was reviewed 5 p.m. The medical diagnosis				
	Resident F reported foot/ankle three day	ted 3/19/2023, indicated that spilling hot water on his spilling not water on his skin around this 1/2" x 1 1/2" 1/2 inch] area".				
	Wellness on 5/25/20	Director of Nursing and 023 at 11:45 a.m., indicated she nurse practitioner from his				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING 00 B. WING		COMPLETED 05/26/2023		
	ROVIDER OR SUPPLIER			990 PR	DDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION
R 0410 Bldg. 00	home health compand on 3/20/2023, but shootification. She indidented home health until the A policy entitled, "For provided by the Core 2:20 p.m. The policy will occur when an atthat is not usual for of care occurs" This Residential tag IN00407499. 5-8.1(a)(1) 5-8.1(a)(4) 410 IAC 16.2-5-12 Infection Control (e) In addition, a tucompleted within the admission or upon forty-eight (48) to see result shall be reconstructed induration with the by whom administing (f) For residents we documented negative result during the promoths, the baseli should employ the first step is negative performed within the after the first test. It testing will depend with tuberculosis. (g) All residents will to the tuberculin should entitle the first test.	Noncompliance uberculin skin test shall be hree (3) months prior to admission and read at seventy-two (72) hours. The orded in millimeters of date given, date read, and ered and read.		TAG			DATE

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			05/26/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			OGRESS PARKWAY		
TIMBER CREEK VILLAGE				SHELBYVILLE, IN 46176			
HIVIDLIN ONEEN VILLAGE				OFFICED			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		_	TAG	DEFICIENCY)		DATE
	laboratory examinations in order to complete a diagnosis.						
				44.0			00/04/000
	D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		R 04	410	p paraid="853755971"	- 0	08/01/2023
		view, and interview, the facility			paraeid="{25fe42f3-05c9-441		
	_	a second step Tuberculin (TB)			9-3944034abc5d}{251}" >POC		
	Skin test for Resident G, failed to complete a first				R410		
	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.				What corrective action(s) will be	e action(s) will be	
	to 1D skin tests.				accomplished for those residents		
	Findings include:				found to have been affected by the		
					deficient practice: An audit of	•	
	1. Resident E's record was reviewed, on 5/24/23 at				resident charts was conducted to		
		ord indicated Resident E had			identify which residents were		
	diagnoses that inclu	ided, but were not limited to,			missing the Two-Step TB		
	chronic obstructive pulmonary disorder, high				screening and/or an annual risk assessment		
	blood pressure, high blood fats, insulin						
	dependent diabetes	mellitus, congestive heart					
	failure, chronic kid	ney disease, and congestive					
	heart failure.				·How the facility will identify		
					other residents having the		
		failed to indicate Resident E			potential to be affected by the		
		kin test on or prior to			same deficient practice and w	hat	
		ed to indicate Resident E had a			corrective action will be taken: All		
	second step TB skir	n test.			residents had the potential to	be	
					affected by the deficient practi	ice.	
		p.m., the Director of Nurses			A TB screening clinic for all		
	indicated she didn't have a first or second step				residents was planned for June 20,		
	skin test for Resident E.				2023.		
	2 Davident Cla 1	2 P. 11 (Cl. 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	2. Resident G's clinical record was reviewed on				What magazines will be said	into	
	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.				·What measures will be put into place or what systemic changes the facility will make to ensure		
	ale orani.	utani.					
	The record indicate	ed Resident G had a first step			that the deficient practice does not recur: The DON will conduct 1		
		dmission, but failed to indicate			step TB skin tests at the time	-	
	Resident G had a second step TB skin test.				admission, to be read within 48		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/26/2023		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY				
TIMBER CREEK VILLAGE				SHELBYVILLE, IN 46176				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG	On 5/26/23 at 11:57 indicated they have for Resident G. 3. T F was reviewed on medical diagnosis in was admitted on 7/2 Review of the clinic Mantoux test for adadmission. An interview with t Wellness on 5/26/20 she had started doin and/or Risk Assess them for Resident E locate any Mantoux Resident B or F in t 4. The clinical record on 5/25/2023 at 3:4 included chronic fat Review of the clinic Mantoux test or am tuberculosis for Resident ha two step Mantoux te admission then year	7 a.m., the Administrator no second step TB skin test The clinical record for Resident 5/24/2023 at 2:15 p.m. The ncluded diabetes. Resident F 22/2022. cal record indicated no mission or completed since the Director of Nursing and 023 at 10:25 a.m. indicated that ng the annual Mantoux test ments, but had not completed 3 or F yet. She was unable to a test or risk assessment for the last 12 months. rd for Resident C was reviewed 0 p.m. The medical diagnoses		TAG	The 2 step TB skin test, as indicated, will be scheduled by DON during the first 3 weeks or residency. An annual TB risk assessment will be scheduled the resident move-in anniversidate 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: verda How the corrective action(s) with monitored to ensure the deficition practice will not recur, i.e., which quality assurance program will put into place: The Administration or designee will conduct monta audits on 25% of all resident charts to confirm residents has been provided all required TB screenings.	of on ary i; na;" vill be ent at I be ator hly ve	DATE	
			1				1	

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