ER OR SUPPLIER E SENIOR LIVING COMMUNITY			6/10/2022
E SENIOR LIVING COMMUNITY		ADDRESS, CITY, STATE, ZIP COD	
		JGAR LN IELD, IN 46168	
SUMMARY STATEMENT OF DEFICIENCIE EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
visit was for a Post Survey Revisit (PSR) to tigation of Complaint IN00375925 completed pril 1, 2022. plaint IN00375925 - Not Corrected lated deficiencies are cited at R0216, R0217, 6, and R0295. ey dates: June 10, 2022. ity number: 012394 lential Census: 134	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit.	
e State Residential Findings are cited in dance with 410 IAC 16.2-5.			
AC 16.2-5-1.2(k)(1-2)			
dents' Rights- Deficiency he facility must immediately consult the ent 's physician and the resident 's representative when the facility has ed: significant decline in the resident 's ical, mental, or psychosocial status; or need to alter treatment significantly, that need to discontinue an existing form of ment due to adverse consequences or to nence a new form of treatment.	R 0036	It is the intent of this facility to ensure that upon change of any	07/08/2022
nee men nen	d to discontinue an existing form of t due to adverse consequences or to ce a new form of treatment. record review and interview, the facility	d to discontinue an existing form oft due to adverse consequences or toce a new form of treatment.record review and interview, the facilitycollow their plan of correction (POC) to	d to discontinue an existing form of t due to adverse consequences or to ce a new form of treatment. record review and interview, the facility R 0036 It is the intent of this facility to

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

TITLE

(X6) DATE

PRINTED: 07/15/2022

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

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2022	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
SUGAR	GROVE SENIOR L	IVING COMMUNITY			UGAR LN FIELD, IN 46168		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nts. This deficient practice had					
		ect 134 of 134 residents who			Corrective Action:		
	resided in the facil	ity.			Residents and families are be	eing	
					notified of medical condition		
	Findings include:				change along with medical		
					condition change specifically		
		04 a.m., the Administrator (ADM)			related to blood glucose level		
		of correction (POC) binder.			Licensed staff in-service will I	be	
	-	-			completed by 7/5/2022 for		
	Upon review the binder did not contain any education, in-service documentation for staff members regarding notification of physician or			Physician\Family notification	on		
		g notification of physician or			condition changes.		
reside	resident's family				Identification of other Resider		
		· · · · · · · · · · · · · · · · · · ·			All residents have the potenti	al to	
	The facility's POC indic	uld include education for			be affected by the deficient	<u></u>	
		physician and all licensed staff			practice. An audit of the last		
		would receive education.			days of 100% of residents will conducted to determine if the		
	in the community	would receive education.			have been recent condition	le	
	On $6/10/22$ at 10.3	0 a.m., during an interview the			changes and if notification wa		
		e was hired in April and the			made to MD and family.	15	
		ce before she had arrived at the			Notifications as appropriate v	/ill he	
	-	tor of Nursing (DON) would			made in accordance with the		
		ation documentation in her			findings.	adan	
	office.				Measures:		
					Upon orientation with new sta	aff,	
	On 6/10/22 at 11:1	0 a.m., during an interview, the			training will be provided rega		
	DON indicated she	e had been employed by the			MD\family notification of cond		
	facility since April	l. She came to the facility right			change. All licensed nurses		
	after the ADM. Sh	e did not locate the education			community will educated on t	he	
		he had done one in-service			state regulation and Commur	nity	
		he had been at the facility, on			Policy entitled "Significant		
		ne provided a copy of the			Condition Change and		
	-	s for Levemir (a type of insulin)			Notification." All community		
		pe of insulin) from the			licensed Nursing Staff was		
		did not provide any			educated on 6/28/22. An auc		
		owing date, time of the			tool will be completed to mon		
	_	er or a list of attendees. The			blood glucose levels and to e	nsure	
		have been done, as indicated in			that MD\family notification is		
		vas not able to locate the			completed per "Significant	<i></i>	
	education docume	nts or sign off sheets.			Condition Change and Notific	ation"	

Event ID: WDOT12 Facility ID: 012394 If continuation sheet Page 2 of 20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/10/2022
	PROVIDER OR SUPPLIE	^R IVING COMMUNITY	5865	t address, city, state, zip cod SUGAR LN IFIELD, IN 46168	
(X4) ID PREFIX TAG	(EACH DEFICIE	TSTATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN (X5) BE COMPLETION PRIATE DATE
		as cited on 4/1/22. The facility at a systemic plan of correction ace.		Policy. DON \ Designee w monitor audit tool 5 days a for 1 month, 3 days a week month, then weekly for 1 m Monitored: Executive Director \ Design collaboration with Director Nursing\Designee will revie audits with QA Committee monthly x 3 months and wi continue to review audit res monthly for duration of extec timeframe as applicable. Completion Date: 7/8/2022	week a for 1 nonth. nee, in of ew Il sults ended
R 0216 Bldg. 00	shall be delineate manual, but at a assessment shall following: (1) The resident mental status. (2) The resident activities of daily (3) The resident admission and se (4) If applicable, self-administer m (d) The evaluatio writing and kept i Based on observat	compliance d content of the evaluation ed in the facility policy minimum the needs I include an evaluation of the s physical, cognitive, and s independence in the living. s weight taken on emiannually thereafter. the resident 's ability to redications. n shall be documented in n the facility. ions, interviews, and record	R 0216	It is the intent of this facility	r to 07/08/202:
	medications in the assessments to inc self-administer me	y failed to residents' with ir room had self-administration lude the residents' ability to dications for 4 of 10 residents 1 for medications (Residents H,		ensure that residents' with medications in their room h had self-administration assessments which include residents' ability to self -administer medications.	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
			A. BUILDING		COMPLETED
UND LAIN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	06/10/2022
					00/10/2022
NAME OF	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD	
SUGAR	GROVE SENIOR L	IVING COMMUNITY	PLAIN	FIELD, IN 46168	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	Findings include:			Corrective Action: Director o	f
				Nursing and Assistant Directed	or of
	1. On 6/10/22 at 9:	30 a.m., Resident H was		Nursing was in-serviced on	
	observed in her roo	m. There were two bottles of		6/27/2022 on Self-Administra	tion
	medication on top of her microwave in the			of Medication Assessment	
	kitchenette. She inc	licated she only took two		including Semi-Annual Evalu	ations
		so it was pretty easy. She did		& Service Plans.	
		s of the medications but knew		Identification of Other Reside	nts:
	they were for blood	l pressure. She had not been		All residents have the potenti	al to
	told where or how	her medication should be		be affected by the deficient	
	stored, they were ju	ist always on top of her		practice. An Audit of residen	ts
	microwave to make	e it easier to remember. Resident		was completed over the past 30	
	H indicated she usu	ally pulled her door closed		days to ensure that all reside	nts
	when she left the ro	oom but did not always lock the		that self medicate have up to	date
	door.			self medication administration	n l
				assessments and medication	s are
	On 6/10/22 at 1:15	p.m., Resident H's medical		stored appropriately. This au	dit
	record was reviewe	ed. She had current active		will be completed by 7/8/2022	2.
	diagnoses which in	cluded, but were not limited to,		Measures: An audit tool will	be
	Hypertension (HTN	I, high blood pressure).		completed to ensure that all	
				residents who self medicate	will
	Her current physici	an orders for Amlodipine and		have appropriate self	
	Atenolol (both med	lications treat high blood		administration assessment	
	pressure). She had	4 additional prescriptions for,		completed as well as semi-ar	nnual
	Caltrate (a calcium	supplement), Aspirin 81,		assessments and service pla	ns
	Alendronate (a med	lication used to help treat		per protocol. DON \ Design	ee
	osteoarthritis) and	docusate (a stool softener).		will monitor audit tool 5 days	a
				week for 1 month, 3 days a w	/eek
		on her physician order set		for 1 month, then weekly for	1
	indicated, "Self-Ad	minister."		month. All Community license	ed
				nursing staff was educated o	n
	The most recent Se	lf-Administration and Service		6/28/2022 and agency	
	Plan Assessment w	as dated 9/28/2020. The record		Monitored:	
		ion that regular assessments		Executive Director \ Designed	e, in
		d every 6 months as required		collaboration with Director of	
	and did not provide	e a more up to date assessment		Nursing\Designee will review	
	of the resident' abil	ity to self-administer her		audits with QA Committee	
	medication			monthly x 3 months and will	
				continue to review audit resu	lts
	2. On 6/10/22 at 9:	38 a.m., Resident K's door was		monthly for duration of exten	ded

WDOT12 Facility ID: 012394

If continuation sheet Page 4 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 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 06/10/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5865 SUGAR LN SUGAR GROVE SENIOR LIVING COMMUNITY PLAINFIELD, IN 46168 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE observed opened. She was asleep in her bed but timeframe as applicable. woke easily to a knock. Upon entrance into her a Completion Date: 7/8/2022 room, a prescription bottle was noted to be left on a table beside her recliner chair. Inside the bottle, there was a glass vile of Cyanocobalamin (an injectable B-12 supplement). Resident K indicated the nurse must have forgotten it. On 6/10/22 at 1:20 p.m., Resident K's medical record was reviewed. She had current active diagnoses which included, but were not limited to, edema, asthma, incomplete paraplegia at the 1st/4th/5th cervical vertebra, and diabetes mellitus. Her current physician order list, dated 6/30/22, indicated in hand-written script, "Self-Administers." The record lacked documentation of a current service plan. The record lacked documentation of a current medication self-administration assessment of the resident's ability to self-administer her medications. 3. On 6/10/22 at 9:56 a.m., Resident J was observed in his room. His room was cluttered with personal items which included but were not limited to various prescription and over the counter medications/vitamins. On 6/10/22 at 1:30 p.m., Resident J's medical record was reviewed. He had current diagnoses which included but were not limited to, depression, COPD (chronic obstructive pulmonary disease) and chronic back pain. His current physician order list, dated 6/30/22, did WDOT12 Facility ID: 012394 Event ID: Page 5 of 20 State Form If continuation sheet

07/15/2022

PRINTED:

PRINTED: 07/15/2022 FORM APPROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 06/10/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5865 SUGAR LN SUGAR GROVE SENIOR LIVING COMMUNITY PLAINFIELD, IN 46168 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE not indicate his ability to self-administer his medications. The record lacked documentation of a current service plan. The record lacked documentation of a current medication self-administration assessment of the president's ability to self-administer her medications. 4. On 6/10/22 at 10:35 a.m., Resident L's apartment door was open, and she was not there. A moment later she was observed as she returned from the laundry room with a basket of clothes on her walker. Resident L indicated she always left her door open because there was nothing to steal. A bottle of Tums (an OTC anti-acid) was observed on an end-table beside her couch. She indicated she took those whenever she needed to for heart burn. On 6/10/22 at 1:25 p.m., Resident L's medical record was reviewed. She had active diagnoses which included, but were not limited to dementia, diabetes mellitus and HTN. Her current physician order set did not include an order for Tums. The record lacked documentation of current service plan. The record lacked documentation of a current medication self-administration assessment of the president's ability to self-administer her medications. During an interview on 6/10/22 at 1:38 p.m., the Director of Nursing (DON) indicated, she had WDOT12 Facility ID: 012394 Event ID: Page 6 of 20 State Form If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES									
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCT						
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00						
		B. WING							
		-							

PRINTED: 07/15/2022 FORM APPROVED

AND PLAN	B. WING			COMPLETED 06/10/2022		
	PROVIDER OR SUPPLIE	^R IVING COMMUNITY	5865	et address, city, state, zip (SUGAR LN NFIELD, IN 46168	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
R 0217	completed new ad new hire date in A not had the time to ensure assessment regular basis and a semiannual basis. On 6/10/22 at 2:38 indicated there wa assessments and/o evaluations, but it facility followed th evaluations at leas should include the self-administer me On 6/10/22 at 2:00 provided a copy of "Self Administrati 5/20/20. The polic offered the opport her medication dur the facilities interor resident desires to assessment is conor team of the resider visual ability to ca during the care pla demonstrates the a medications, a fur	mission assessments since her pril of 2022, however, she had a audit other resident charts to s were being completed on a s needed, at least on a s needed, at least on a s needed, at least on a s no facility policy on r regularly scheduled was her expectation that the ne state regulations to complete t on a semi-annual basis, which resident's ability dications or not. 9 p.m., the Administrator (ADM) c current facility policy titled, on of Medications," revised y indicated, " each resident is unity to self-administer his or ring the routine assessments of disciplinary team if the self-administer medications, an lucted by the interdisciplinary nts cognitive, physical, and rry out this responsibility, nning process if the resident bility to safely self-administer her assessment of the safety of as storage is conducted"				
Bldg. 00	Evaluation - Definition (e) Following confacility, using approximation members, shall in services to be pro- follows:					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIDUE	CONSTRUCTION	(X3) DATE SURVEY
			. ,		(-)
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		06/10/2022
NAME OF	PROVIDER OR SUPPLIE	R	STREE	T ADDRESS, CITY, STATE, ZIP COD	
				SUGAR LN	
SUGAR	GROVE SENIOR L	IVING COMMUNITY	PLAI	NFIELD, IN 46168	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	resident shall be	appropriate to the:			
	(A) scope;				
	(B) frequency;				
	(C) need; and				
	(D) preference;				
	of the resident.				
	(2) The services	offered shall be reviewed and			
		priate and discussed by the			
		ity as needs or desires			
		e facility or the resident may			
	request a service				
		pon service plan shall be			
		by the resident, and a copy			
	-	n shall be given to the			
	resident upon rec	-			
		on and documentation of			
		l is needed if evaluations			
		e initial evaluation indicate			
	no need for a cha				
		on of medications or the			
		ential nursing services, or			
		a licensed nurse shall be			
		fication and documentation of			
	the services to be	e provided.			
		•	R 0217	It is the intent of this facility to	o 07/08/20
	Based on interview	vs and record reviews, the		ensure that regular assessm	
		sure regular assessments and		and evaluations of the reside	
		resident's needs and services		needs and services be comp	leted
	were completed at	a minimum on a semiannual		at a minimum on a semiannu	
	-	sidents randomly reviewed for		basis.	
		lents B, C, D, E, F, and G).			
	Ì			Corrective Action:	
	Findings include:			Director of Nursing and Assis	stant
	_			Director of Nursing was in-se	
	On 6/10/22 at 1:30	p.m., the Administrator (ADM)		on 6/27/2022 on	
		l most current service plan		Self-Administration of Medica	ation
		Residents B, C, D, E, F, and G		Assessment including	
		ed during a random medication		Semi-Annual Evaluations &	
	administration obs			Service Plans.	
		,		Identification of Other Reside	ents:
			1		•• •

PRINTED:	07/15/2022
FORM API	PROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 06/10/2022
	PROVIDER OR SUPPLIE	^R IVING COMMUNITY	5865 \$	i address, city, state, zip cod SUGAR LN IFIELD, IN 46168	
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY 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)	ATE DATE
		hission date 1/5/21, had no		All residents have the potentia	
	service plan provid	led.		be affected by the deficient practice. An Audit of resident	
	b. Resident C, adm	thission date $3/31/20$, the most		was completed over the past	
	current service pla	n, 6 month (180 day) was dated		days to ensure that all resider	
	6/15/20.			assessments (including	
				semi-annual evaluations and	
		hitted $9/25/18$, the most current		service plans). This audit will	
	service plan, 6 mor 9/28/20.	nth (180 day), was dated		completed and all residents whave current assessment by	vill
	d Desident E. adm	itted 12/5/14, the most current		7/8/2022.	ha
	,	nth (180 day), was dated $3/5/20$.		Measures: An audit tool will completed to ensure that all	be
	service plan, o mos	(100 day), was dated 5/5/20.		residents will have assessme	nts
	e. Resident F. adm	itted on 8/6/21, had 25 care		completed and timely per	
)/22 and 4/11/22, signed off by		protocol. DON \ Designee w	vill
	-	r Assistant Director of Nursing.		monitor audit tool 5 days a we	
	There was no servi	ice plan provided.		for 1 month, 3 days a week for month, then weekly for 1 mor	or 1
	f. Resident G, adm	itted on $11/1/16$, the most		Monitored:	
	current service pla as 6/16/20.	n, 6 month (180 day), was dated		Executive Director \ Designee collaboration with Director of	e, in
	0 (110/00 + 0.20	1		Nursing\Designee will review	
		p.m., during an interview, the cated, she did not know why		audits with QA Committee	
		had created care plans for		monthly x 3 months and will continue to review audit resul	te
		of a service plan. She was no		monthly for duration of extend	
		t the facility. There was no		timeframe as applicable.	
		nual assessments, they were		Completion Date: 7/8/2022	
	working on them (to make current).			
R 0241	410 IAC 16.2-5-4				
Bldg. 00	Health Services -	oπense ation of medications and the			
Diag. 00		ential nursing care shall be			
		e resident 's physician and			
	-	ed by a licensed nurse on			
	the premises or c	-			
		all be administered by			
		personnel or qualified			
				1	

STATEME	R MEDICARE & MEDIO NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DATE SUF COMPLETE 06/10/202	
	PROVIDER OR SUPPLIE	R IVING COMMUNITY		5865 S	address, city, state, zip cod SUGAR LN FIELD, IN 46168		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	 medication aides Based on observatively review, the facility glucose tests (accurate national endines of the most accurate nation administer insuling to ensure resident's documented prior of for 5 of 5 residents medication adminiation adminiation adminiation adminiation adminiation adminiation adminiation pass of Medication Aide (or preparing to check the hallway by the removed the accuracia alcohol wipe. He to finger with a lance on the test strip. The 266. Licensed Prace QMA 4 obtained to blood and did not of from the finger. LPN 3 then checked insulin orders on the resident's arm or administered 6 unit by pen injection to the strip. The strip endice of the strip and the finger. 	ion, interview, and record failed to administer blood checks) in a manner to provide reading, failed to properly using an insulin pen, and failed a pain was assessed and to administration of medications a observed during a random stration observation (Residents 0:54 a.m., during a random stration observed Resident B's blood sugar, in medication cart. QMA 4 heck machine from a black aned resident B's finger with an hen punctured the resident's t and obtained a drop of blood ne blood sugar reading was strical Nurse (LPN) 3 watched as he sample from the first drop of wipe away any alcohol residue ed Resident B's sliding scale he medication administration pped the injection pen by shot" of 2 units (to clear the n dialing the dose, she cleaned with an alcohol swab and ts of Lispro (fast acting insulin) the resident's arm, in the idents were in the hall and	R 02		It is the intent of this facility ensure that blood glucose (accuchecks) are done in a manner to provide the most accurate reading, administ insulin using an insulin per assess and document resi- pain prior to administration medication. Corrective Action: All community Licensed st in-service was completed 6/28/2022 on proper admin of blood glucose tests (accuchecks) including disinfection, insulin admini completion of pain assess PRN pain medication and notification. Identification of Other Res All residents have the pote be affected by the deficient practice that have medicat administered by facility lice staff. An Audit of resident medication over the last 30 will be completed to ensur medication administration insulin injection was comp These audits will be comp 7/8/2022. Measures: Upon orientation with new training will be provided re proper administration of bl glucose tests (accuchecks including disinfection, insu administration, completion assessments, PRN pain	tests a st ter n, and dent of aff on nistration stration, ments, nurse idents: ential to t ions ensed 0 days e proper and\or leted. leted by staff, garding ood) lin	07/08/2022

State Form

Event ID: WDOT12 Facility ID: 012394 If continuation sheet Page 10 of 20

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/10/2022
	PROVIDER OR SUPPLIE	^R IVING COMMUNITY	5865 S	address, city, state, zip cod SUGAR LN FIELD, IN 46168	
(X4) ID PREFIX	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) COMPLETIO
TAG	 2. On 6/10/22 at 11 as he prepared meet tablets of Acetamin (mg) were remove placed in a plastic seated in the hallw cart. LPN 3 was president C's blood accucheck machimeleaned resident C. He then punctured lancet and obtained strip. The blood sudid not wipe away finger before obtain strip. LPN 3 checked the indicated Resident scheduled humalog additional units perblood sugar of 267 the insulin pen. She cleaned a spot on H attempted to inject plunger did not more Resident C, she has before injecting he the pen and discard needle on the syrir of 2 units to clear the dose. LPN 3 the resident C's abdom her with the insulin as he prepared Resident C's abdom her with the insulin for the syrin of 2 units to clear the dose. LPN 3 the resident C's abdom her with the insulin for the insulin for	R LSC IDENTIFYING INFORMATION 1:05 a.m., QMA 4 was observed dications for Resident C. Two nophen (Tylenol) 500 milligrams d from the blister package and medication cup. Resident C was ay adjacent to the medication resent as QMA 4 checked 1 sugar. QMA 4 removed the e from a black zipper bag and 's finger with an alcohol wipe. the resident's finger with a d a drop of blood on the test gar reading was 267. QMA 4 any alcohol residue from the ning the sample on the test e orders on the MAR and C was to receive 18 units of g (fast acting insulin) and 3 r sliding scale orders for a '. The nurse placed a needle on e lifted Resident C's shirt, ner abdomen with alcohol and her with the insulin pen. The ove. LPN 3 indicated, to d forgot to dial up the dose r. She removed the needle from ded it. She then placed a new gge and performed an "air shot" the syringe needle and dialed up en recleaned an area on nen with alcohol and injected n. 1:14 a.m., QMA 4 was observed ident D's medications, at the e removed a scheduled dose of tic pain medication) from the	TAG	medication and nurse notific All community licensed staff educated on 6/28/2022 and agency licensed staff will be educated prior to their scheo shift. An audit tool will be completed to monitor medica administration\insulin injectio DON \ Designee will monitor tool 5 days a week for 1 mort days a week for 1 month, the weekly for 1 month. Monitored: Executive Director \ Designe collaboration with Director of Nursing\Designee will review audits with QA Committee monthly x 3 months and will continue to review audit resu- monthly for duration of exter timeframe as applicable. Completion Date: 7/8/2022	e, in e, in was luled ation audit on. audit on

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/10/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5865 SUGAR LN SUGAR GROVE SENIOR LIVING COMMUNITY PLAINFIELD, IN 46168 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE locked narcotic drawer and pushed out the pill from the medication blister packet into a plastic medication cup. He then removed a medication blister pack from the file drawer of resident medications and placed 2 tablets of 4 mg Zocor (for nausea) into the medication cup. He took the medication to the resident's apartment and handed the medication cup with the 3 pills to Resident D. Resident D asked if her nausea medication was in the cup. QMA 4 indicated the cup contained her pain and nausea medication. Resident D swallowed the pills and the QMA exited the apartment. QMA 4 did not ask Resident D about her nausea or pain level when administering the medications. Pain level was not documented on the medication administration record (MAR), or vital sign record. QMA 4 did not notify a licensed nurse before administering a PRN (as needed) medication to the resident. A nurse assessment was not completed. 4. On 6/10/22 at 11:18 a.m., QMA 4 was observed as he prepared Resident E's medications, at the medication cart. He removed a scheduled dose of Oxycodone-Acetaminophen 10/325 (narcotic pain medication) from the medication cart and placed it into the plastic medication cup, from a blister pack. QMA 4 took the medication to Resident E's apartment and administered it. QMA 4 did not inquire about the resident's pain level or document a pain level in the vital sign record or on the MAR. 5. On 6/10/22 at 11:26 a.m., QMA 4 prepared Resident G's medications from the orders on the MAR. He removed a vision shield vitamin from a bottle and placed it in a plastic medication cup. He then took a scheduled tramadol 50 mg tablet from a blister pack (in narcotic drawer) and placed it in Event ID: WDOT12 Facility ID: 012394 Page 12 of 20 State Form If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

07/15/2022

PRINTED:

FORM APPROVED

OMB	NO.	0938-039	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2022		
	PROVIDER OR SUPPLIE	R IVING COMMUNITY		5865 SU	ddress, city, state, zii GAR LN ELD, IN 46168	P COD	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	CORRECTION N SHOULD BE	(X5) COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	DATE
	Resident G in the d	ion cup. QMA 4 located lining room, having lunch. He					
		edication to Resident G without					
		in level. A pain level was not					
	documented on the MAR.	vital sign record or on the					
	On 6/10/22 at 12:5	0 p.m., the Administrator (ADM)					
		ty had no policy related to					
		ng PRN medications. They					
		ules. There was no glucometer					
		ved a skills check off (copy not					
	provided) for prope	er procedure.					
		p.m., during an interview, the					
		g (DON) indicated when an formed, the first drop of blood					
	-	viped off before the sample					
		As were required to contact the					
		g any PRN medication. The					
		sess the resident. A pain level					
	should have been a	ssessed and followed up when					
	-	was given. She did not believe					
	-	n the MAR for it to have been					
	recorded. These we	ere standards of practice.					
		0 p.m., the ADM provided a					
		bared 5/21/18 and reviewed					
		lliams Bros Long Term Care blicy indicated "In the event					
		state regulations are updated					
		e strict/current regulations					
		and thus, supercede the less					
		Indications can not be					
	-	olic areas such dining rooms,					
		allwaysDocumentationPRN					
		stration: Date, time, and route of					
		ason or symptoms for					
		low-up results of prn inistration. Initials or electronic					
	()						

PRINTED: 07/15/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/10/2022	
	PROVIDER OR SUPPLI	^{ER} LIVING COMMUNITY	5865 \$	address, city, state, zip cod SUGAR LN FIELD, IN 46168		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COME	(X5) PLETION ATE
	signature of licens medication"	sed personal that administered				
R 0246 Bldg. 00	indicated there was assessments and/c evaluations, but it facility followed to evaluations at lease should include the self-administer m This deficiency w failed to implement to prevent recurrer 410 IAC 16.2-5 Health Services (6) PRN medication physician. The C authorization for PRN medication physician not on authorization to documented in t the time and dat Based on observa review, the facilit authorization and nurse before administer and the time and the service administer and the time and the time and the time and the service administer authorization and nurse before administer authorization and nurse before administer authorization and authorization authorization and authorization authorization and authorization authorization authori	edications or not. as cited on 4/1/22. The facility nt a systemic plan of correction nce. 4(e)(6) - Deficiency tions may be administered by cation aide (QMA) only upon a licensed nurse or QMA must receive appropriate each administration of a . All contacts with a nurse or the premises for administer PRNs shall be he nursing notes indicating e of the contact. tion, interview and record y failed to obtain licensed an assessment from a licensed inistering a PRN (as needed)	R 0246	It is the intent of this facility to ensure that prior to administratic of a PRN medication, authorization\notification of a licensed nurse and assessment	on	8/202
	reviewed for med D). Findings include:			completed. Corrective Action: All community Licensed staff in-service was completed on 6/28/2022 on PRN Medication a proper notification and		
	On 6/10/22 at 11:	10 a.m., during a medication		assessment by a licensed nurse	e. 🔰	

CENTERS FOR MEDICARE & MEDICAID SERVICES

NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/10/2022	
ddress, city, state, zip cod IGAR LN ELD, IN 46168		
PROVIDER'S PLAN OF CORRECTION	(X5)	
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
	DATE	
Identification of Other Resident		
All residents have the potential	l to	
be affected by the deficient		
practice that have PRN		
medications administered by		
facility licensed staff. An Audit	of	
resident medication over the la	ist	
30 days will be completed to		
ensure proper PRN medication	ו ו	
administration and\or		
documentation\notification was	6	
completed. These audits will b	be	
completed by 7/8/2022.		
Measures:		
Upon orientation with new staff	f,	
training will be provided regard		
PRN Medication and proper	5	
notification and assessment by	/a	
licensed nurse. All community		
licensed staff was educated on		
6/28/2022 and agency licensed		
staff will be educated prior to the		
scheduled shift. An audit tool v		
be completed to monitor PRN		
Medication\assessment\notifica	atio	
n. DON \ Designee will monito		
audit tool 5 days a week for 1	//	
month, 3 days a week for 1		
month, then weekly for 1 month	h	
Monitored:		
Executive Director \ Designee,	in	
collaboration with Director of		
Nursing\Designee will review		
audits with QA Committee		
monthly x 3 months and will		
-		
continue to review audit results		
monthly for duration of extended	ea	
timeframe as applicable.		
Completion Date: 7/8/2022		
Con	npletion Date: 7/8/2022	

Event ID: WDOT12 Facility ID: 012394

If continuation sheet Page 15 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 06/10/2022	
	PROVIDER OR SUPPLIE	R IVING COMMUNITY	5865	t address, city, state, zip cod SUGAR LN NFIELD, IN 46168	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY 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	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
R 0295 Bldg. 00	 indicated the facilit QMAs administerit followed the state On 6/10/22 at 12:5 current policy, pre 5/20/20, titled, "W Pharmacy." This p current federal and or found to be more should be followed strict guidelinesI medication adminit administration. Re administration. For medication(s) adminitization. 410 IAC 16.2-5-6 Pharmaceutical S (a) Residents wh and use prescription medications in the them secured from Based on observation review, the facility medications were prooms to keep there for 4 of 4 randoministoriage (Residents Findings include: 1. On 6/10/22 at 92 observed in her row 	 0 p.m., the ADM provided a pared 5/21/18 and reviewed illiams Bros Long Term Care olicy indicated "In the event a state regulations are updated e strict/current regulations and thus, supercede the less DocumentationPRN stration: Date, time, and route of ason or symptoms for 10w-up results of prn inistration. Initials or electronic ed personal that administered 6(a) Services - Noncompliance o self-medicate may keep tion and nonprescription eir unit as long as they keep m other residents. ion, interview, and record failed to ensure that properly stored in resident's n secure from other residents y observed for medication H, K, J, and L). 30 a.m., Resident H was om. There were two bottles of of her microwave in the 	R 0295	It is the intent of this facility to ensure that medications are properly stored in residents' roo to keep them secure from other residents. Corrective Action: All community Licensed staff in-service will be completed by 7/5/2022 on properly storing medications. A special Residen Meeting is being held on 7/6/20 to educate on properly storing	t

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		СОМР 06/10	(X3) DATE SURVEY COMPLETED 06/10/2022	
	PROVIDER OR SUPPLIEF	R VING COMMUNITY	586	EET ADDRESS, CITY, STATE, ZIP 5 SUGAR LN INFIELD, IN 46168	COD	
X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO THE	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION
TAG	medications daily, s not recall the names they were for blood told where or how I stored, they were ju microwave to make H indicated she usu when she left the ro door. On 6/10/22 at 1:15 record was reviewe diagnoses which im Hypertension (HTN Her current physici Atenolol (both med pressure). She had 4 Caltrate (a calcium Alendronate (a med osteoarthritis) and c 2. On 6/10/22 at 9:3 observed opened. S woke easily to a kn room, a prescription a table beside her ro there was a glass vi injectable B-12 sup the nurse must have On 6/10/22 at 1:20 record was reviewe diagnoses which im edema, asthma, ince 1st/4th/5th cervical mellitus. 3. On 6/10/22 at 9:3	R LSC IDENTIFYING INFORMATION so it was pretty easy. She did pressure. She had not been ner medication should be sist always on top of her sit easier to remember. Resident ally pulled her door closed oom but did not always lock the p.m., Resident H's medical d. She had current active cluded, but were not limited to, J, high blood pressure). an orders for Amlodipine and ications treat high blood 4 additional prescriptions for, supplement), Aspirin 81, lication used to help treat docusate (a stool softener). 38 a.m., Resident K's door was he was asleep in her bed but ock. Upon entrance into her a n bottle was noted to be left on scliner chair. Inside the bottle, le of Cyanocobalamin (an	TAG		Residents: potential to ficient inister it of resident er the last 30 d to ensure orage. These red by new staff s, training will g proper uside resident y licensed by 7/5/2022 staff will be r scheduled II be proper DON \ audit tool 5 onth, 3 days a en weekly for Designee, in ector of I review hittee ind will dit results of extended ole.	DATE

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/10/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5865 SUGAR LN SUGAR GROVE SENIOR LIVING COMMUNITY PLAINFIELD, IN 46168 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE items which included but were not limited to various prescription and over the counter medications/vitamins: a. spiriva Respimat (a bronchodilator medication used to help treat symptoms of Chronic Obstructive Pulmonary Disease [COPD]) b. fluticasone propionate nasal spray 50 mg (milligrams) (a steroid used to treat nasal allergy symptoms can be used to help prevent asthma attacks) c. wixela propionatea propionate (a prescription medicine used to treat the symptoms of Asthma and COPD). d. salmeterol inhalation powder (a slow-acting bronchodilator that comes as a dry powder to inhale by mouth using a specially designed inhaler. When salmeterol is used to treat asthma or COPD) e. qunol ultra coq10 (FDA [Food and Drug Administration] unapproved an over-the-counter [OTC] dietary supplement used to help replenish the supply of CoQ10 in patients who are deficient) f. vitamin D3 (an OTC supplement) g. equate allergy relief (a generic antihistamine used to treat seasonal allergies) h. pramipexole dihydrochloride (a prescription drug used to treat Parkinson's disease) At this time, Resident J indicated he rarely closed his door because a lot of residents came and went to help themselves to the snacks, he purchased for them. He used to own a restaurant and was "in the business of customer service," so he was happy to share anything he had with his friends. On 6/10/22 at 1:30 p.m., Resident J's medical record was reviewed. He had current diagnoses which included but were not limited to, depression, COPD (chronic obstructive pulmonary disease) and chronic back pain. WDOT12 Facility ID: 012394 Event ID: Page 18 of 20 If continuation sheet State Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES

07/15/2022

PRINTED:

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/10/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5865 SUGAR LN SUGAR GROVE SENIOR LIVING COMMUNITY PLAINFIELD, IN 46168 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE His physician order set did not include or indicated the use of the following items which were observed in his room: a. salmeterol inhalation powder (a slow-acting bronchodilator that comes as a dry powder to inhale by mouth using a specially designed inhaler. When salmeterol is used to treat asthma or COPD) b. qunol ultra coq10 (FDA [Food and Drug Administration] unapproved an over-the-counter [OTC] dietary supplement used to help replenish the supply of CoQ10 in patients who are deficient) c. vitamin D3 (an OTC supplement) d. equate allergy relief (a generic antihistamine used to treat seasonal allergies) e. pramipexole dihydrochloride (a prescription drug used to treat Parkinson's disease) 4. On 6/10/22 at 10:35 a.m., Resident L's apartment door was open, and she was not there. A moment later she was observed as she returned from the laundry room with a basket of clothes on her walker. Resident L indicated she always left her door open because there was nothing to steal. A bottle of Tums (an OTC anti-acid) was observed on an end-table beside her couch. She indicated she took those whenever she needed to for heart burn. On 6/10/22 at 1:25 p.m., Resident L's medical record was reviewed. She had active diagnoses which included, but were not limited to dementia, diabetes mellitus and HTN. Her current physician order set did not include an order for Tums. During an interview on 6/10/22 at 1:38 p.m., the Director of Nursing (DON) indicated residents that could self-administer their medications Event ID: WDOT12 Facility ID: 012394 Page 19 of 20 If continuation sheet State Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES

07/15/2022

PRINTED:

FORM APPROVED

X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

		FORM APPROVED
		OMB NO. 0938-039
(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
A. BU	JILDING <u>00</u>	COMPLETED
B. W	ING	06/10/2022
	STREET ADDRESS, CITY, STATE, ZII	P COD

	PROVIDER OR SUPPLIER GROVE SENIOR LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 5865 SUGAR LN PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
IAU	 should keep their medications in an organized and central location, as well as have orders or at least let nursing staff know what was being kept in their rooms. On 6/10/22 at 2:00 p.m., the Administrator (ADM) provided a copy of current facility policy titled, "Self Administration of Medications," revised 5/20/20. The policy indicated, " each resident is offered the opportunity to self-administer his or 	140		DAIL	
	her medication during the routine assessments of the facilities interdisciplinary team a further assessment of the safety of bedside medications storage is conducted the following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if unlockable storage is deemed				
	inappropriate. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the pharmacy Medications stored at the decide are reordered in the same manner- as other medications. The nursing staff is responsible for proper rotation of bedside stock and removal of expired, discontinued or recalled medications"				