STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00405762. Complaint IN00405762 - No deficiencies related to the allegations are cited. Survey dates: May 8, 9, 10, 11 and 12, 2023 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Census bed type: SNF/NF: 84 Total: 84 Census payor type: Medicare: 7 Medicaid: 60 Other: 17 Total: 84 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 15, 2023.	F 0000	Please find the enclosed plan of correction for the survey ending May 12, 2023. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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

Holly Thompson | Executive Director | 05/19/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure the development and implementation of person-centered interventions to prevent falls for 2 of 8 residents reviewed for accidents. (Residents 65 and 45) Findings include: 1. The clinical record for Resident 65 was reviewed on 5/9/23 at 1:58 p.m. The resident's diagnoses included, but were not limited to, fracture of part of the neck of the right femur, fracture of part of the neck of the left femur, unsteadiness on feet, weakness, abnormalities of gait and mobility, osteopenia, and dementia with behavioral disturbance. The care plan, dated 9/10/22 and last revised 5/8/23 at 11:53 a.m., indicated the resident was at risk for falls due to history of falls, age, urgency/frequency/incontinence, high risk medications, requiring assistance or supervision for mobility, transfer or ambulation, unsteady gait, visual impairment affecting mobility, altered awareness of immediate physical environment, impulsive, lack of understanding of one's physical and cognitive limitations, encephalopathy, anxiety, insomnia, Alzheimer's disease, benign neoplasm of cerebral meninges, dementia, hypertension, atherosclerosis, endocarditis, atrial fibrillation, major depressive disorder, urinary tract infection, pacemaker, vitamin deficiency, aftercare following right hip arthroplasty, and left hip fracture with prosthesis. The resident's goal was to have fall risk factors reduced in an attempt to avoid significant fall related injury. The	F 0689	1. Residents #45 and #65 care plans were reviewed and updated as needed to reflect the current interventions being used to prevent falls and to decrease the resident's risk of injury. A 3-day bowel and bladder assessments were completed to determine toileting plans and both have a new intervention to offer/assist to wheelchair when restless. Nurse Managers ensured fall interventions were in place. 2. All residents have the potential to be affected. All residents' fall care plans will be reviewed to ensure they reflect the current needs of the residents and that interventions are in place. 3. The Fall Management Program Policy and Procedures were reviewed with no changes made (See Attachment A). The Interdisciplinary Team and all nursing staff will be in-serviced on the above policies by the CEN or designee by 5-26-23. Customer Care Representatives will ensure fall interventions are in place during daily GEMBA rounds. 4. The DNS or designee will complete a Fall Management QA Tool (See Attachment B) weekly times 4 weeks, then monthly times 6 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's	05/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	interventions included, but were not limited to, staff to ensure resident has something to drink while sitting at the dining room table (dated 5/6/23), offer/assist to bed after lunch (dated 4/8/23), assist with toileting every 2 hours (dated 2/11/23), hipsters to be worn at all times (dated 1/26/23), neon tape to wheelchair brakes as a visual cue (dated 1/13/23), non-skid strips on floor next to open side of bed (dated 1/13/23), neon tape to call light as visual cue (dated 1/12/23), reminder sign, "Don't get up, call for assistance" (dated 1/12/23), staff to assist to dining room for meals (dated 12/27/23), assist resident with toileting prior to meals (dated 12/25/23), scoop mattress at all rimes (dated 11/9/22), anti-rollbacks to wheelchair (dated 11/7/22) offer/assist to lie down after supper (dated 11/6/22), bed against the wall to allow open floor plan (dated 10/27/22), bed in lowest position, call light in reach, keep pathways free of clutter, non-skid footwear, and therapy to screen (dated 9/10/22). The nurse's note, dated 9/10/22 at 3:26 p.m., indicated the resident arrived to the facility and required assistance of 2 staff members to stand and pivot from her wheelchair. The nurse's note, dated 10/6/22 at 2:45 p.m., indicated the resident was found lying on the floor in the dining room. Her right leg was rotated outward and had pain with movement. A STAT (immediate) x-ray was ordered. The nurse's note, dated 10/6/22 at 5:59 p.m., indicated the x-ray results showed an acute right femoral fracture. The resident was sent to the emergency room. The IDT (Interdisciplinary Team) note, dated 10/7/22 at 2:45 p.m., indicated the new intervention		QAPI meeting and issues will be addressed and the above plan will be altered accordingly if 100% is not achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	was to provide the resident with activities of interest when in the dining room. The nurse's note, dated 10/26/22 at 7:38 a.m., indicated the resident was found sitting on the bathroom floor with no injuries. The IDT note, dated 10/27/22 at 10:20 a.m., indicated the root cause of the resident's fall on 10/26/22 was the resident attempting to transfer herself to the restroom. The new interventions were to toilet the resident every 2 hours, bed in the lowest position, and bed against the wall to allow for an open floor plan. The nurse's note, dated 11/9/22 at 3:55 a.m., indicated staff heard a noise from the resident's room and found she had fallen from bed onto her left side, striking her left elbow on the bedside dresser. Her left leg was bent at knee, and the resident stated she could not straighten her leg. Orders were received for a STAT left hip/pelvic x-ray and the resident was placed on hourly checks for her safety. The nurse's note, dated 11/9/22 at 4:04 p.m., indicated the x-ray results showed a fracture of the resident's left hip. The resident was sent to the emergency room. The IDT note, dated 11/10/22 at 9:49 a.m., indicated the root cause of the resident's fall on 11/9/22 was the resident rolling out of her bed. The new interventions were to offer and assist the resident to the toilet every 1 hour and a scoop mattress to the bed at all times. The Quarterly MDS (Minimum Data Set) assessment, indicated the resident was severely cognitively impaired, required extensive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	assistance of 2 staff with toileting, bed mobility, and transfers, was always incontinent of bladder, and frequently incontinent of bowel. The nurse's note, dated 12/25/22 at 5:58 p.m., indicated the nurse was called to the resident's room. The resident was sitting on the floor in the bathroom. The resident was unable to voice what had happened. She had gotten herself up and walked to the bathroom. The IDT note, dated 12/27/22 at 11:01 a.m., indicated the root cause of the resident's fall on 12/25/22 was the resident ambulating unassisted to the restroom. A new intervention to toilet the resident prior to meals and assist the resident to the dining room for meals was implemented. The nurse's note, dated 1/12/23 at 11:45 p.m., indicated the resident was found lying on her back by her bed. The resident indicated she wet the bed and didn't want to be wet. A sign was placed in the room to remind the resident to call for assistance prior to attempting to get out of bed. The IDT note, dated 1/13/23 at 10:45 a.m., indicated the root cause of the resident's fall on 1/12/23 was the resident not using her call light and attempting to get out of bed without assistance. The new intervention was to place a reminder sign in the room. The nurse's note, dated 1/26/23 at 8:00 p.m., indicated the nurse heard the resident yell for help and found her sitting on her bottom in front of her recliner. She indicated she was trying to get up to use the bathroom and couldn't remember the rest. She was last checked at 6:30 p.m., and last seen at 7:00 p.m. lying in bed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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

The IDT note, dated 1/27/23 at 11:33 a.m., indicated the root cause of the resident's fall was the resident attempting to toilet herself. The new intervention was for hipsters to be worn at all times.

The nurse's note, dated 2/11/23 at 4:06 p.m., indicated the resident was found sitting on her bathroom floor with no injury. She was unable to verbalize how or why she got there. The resident was in her wheelchair, coming out of the main dining area just minutes prior to finding her on her bathroom floor.

The IDT note, dated 2/13/23 at 2:47 p.m., indicated the root cause of the resident's fall on 2/11/23 was the resident attempting to toilet herself. The intervention put into place was to assist the resident with toileting every 2 hours.

During an interview, on 5/11/23 at 1:23 p.m., CNA (Certified Nurse Aide) 2 indicated the resident had several interventions. She had hipsters on, her bed was low to the ground, and she had the papers that said to put the call light on. She was checked and changed every 2 hours. She didn't think they had any residents who were more frequent, every resident was on an every 2 hours check and change. The resident tried to get up and walk on her own and go to the bathroom on her own. She did try to use the restroom frequently. She was incontinent at times. Usually whenever they first came in she would be wet. So she would be incontinent at night. The resident's care profile sheet indicated to check her every 2 hours.

During an interview, on 5/11/23 at 1:57 p.m., LPN (Licensed Practical Nurse) 3 indicated the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	was very impulsive. They toileted her every 2 hours, before and after meals. During an interview, on 5/11/23 at 2:56 p.m., the DON (Director of Nursing) indicated on 10/26/22 they had implemented every 2 hour toileting on the resident as a new fall intervention because she had been trying to go to the restroom. On 11/9/22 they did the every 1 hour because she was trying to go to the restroom again. Then on 1/27/23, they looked at her interventions and discontinued the every hour intervention because she had a decline and was a 2 person assist with transfers and she was a check and change. The intervention to toilet her every 2 hours was not put back into place on her care plan until 2/11/23. She wrote a note saying she should have been on every 2 hours check and change, but did not add the intervention to the care plan. 2. The clinical record for Resident 45 was reviewed on 5/10/23 at 9:04 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia, Parkinson's disease, cognitive communication deficit, lack of coordination, abnormalities of gait and mobility, muscle weakness, age-related physical debility, unsteadiness on feet, hemiplegia and hemiparesis following cerebrovascular event affecting right dominant side, and repeated falls. The care plan, dated 12/21/17 and last revised on 5/1/23, indicated the resident was at risk for falls related to benign prostatic hyperplasia with urgency, incontinence, dementia, right sided hemiplegia, age, two or more high risk medications, history of falls, decreased mobility, Parkinson's, weakness, unsteady gait, requiring assistance with ambulation/transfers/ambulation, altered awareness of immediate physical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	environment, impulsive, and lack of understanding of one's physical and cognitive limitation. The interventions included, but were not limited to, urinal in reach while in bed (dated 5/3/23), ensure bedside table within reach while up in chair (dated 4/17/23), high back wheelchair with lateral supports while out of bed (dated 4/9/23), bed in lowest position (dated 4/3/23), hospice notified to exchange bedframe for a low bed (dated 4/3/22), mat on floor next to the open side of the bed (dated 3/21/23), wheelchair to be parked and locked at bedside at all times when not in use (dated 1/19/23), bed against the wall to allow an open floor plan (dated 3/3/22), offer to assist to bed after all meals (dated 12/28/20), dycem to wheelchair at all times (9/22/20), remind resident to carry phone in pocket while up to wheelchair (dated 12/11/19), neon tape to wheelchair brakes as visual cue (dated 11/1/19), neon tape to call light as visual cue (dated 5/20/19), scoop mattress to bed (dated 1/16/19), encourage resident to wear non-skid footwear (dated 3/27/18), and call light in reach (dated 12/21/17). The fall event, dated 10/24/22, indicated the resident had a witnessed fall. He was sitting on the edge of the bed and before staff could intervene, he slid to the floor. The IDT note, dated 10/25/22 at 11:26 a.m., indicated the resident had a fall on 10/24/22. The resident was sitting on the edge of his bed in preparation of transfer and before staff could intervene he slid from the bedside into floor. The root cause of fall was the resident sliding from the bed. The IDT reviewed previous fall interventions, and found the fall mat to no longer be appropriate. The fall mat was removed and non-skid strips were placed to open side of bed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	The nurse's note, dated 1/19/23 at 3:45 a.m., indicated the nurse heard a noise from the resident room and found him lying on his side on the fall mat. He indicated he was trying to get his shoes on and get ready for work and slipped out of bed. He had ripped his brief off and urinated on the bed. He was assisted onto the bed and changed into clean clothes. Staff informed the resident of the time and that it was too early to get up per his preference. The resident indicated he thought it was later in the morning. The IDT note, dated 1/19/23 at 3:45 a.m., indicated the root cause of the resident's fall was the resident attempting to transfer himself from bed to his wheelchair to go to work. The new intervention was for his wheelchair to be parked and locked at bedside at all times when not in use and fall mat to open side of the bed. The IDT note, dated 1/19/23 at 10:48 a.m., indicated the resident now had a fall mat to his bedside and his non-skid strips were removed. The nurse's note, dated 2/24/23 at 3:32 p.m., indicated the resident was in the floor on his bottom with his back against his bed. The IDT note, dated 2/27/23 at 12:46 p.m., indicated the root cause of the fall was the resident sliding from bed. The new intervention was to remove the fall mat and place down nonskid strips to the resident's bedside. The fall event, dated 3/14/23 at 9:08 p.m., indicated the resident had an unwitnessed fall where he slid from the bed trying to transfer himself. He indicated " ... I was going to go get that tractor with [Name of family member] ..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	The IDT note, dated 3/15/23 at 11:!4 a.m., indicated the root cause of the resident's fall was the resident's confusion and attempt to transfer himself from his bed to the wheelchair. The new intervention was to obtain a complete blood count to rule out infection. The nurse's note, dated 3/21/23 at 12:10 a.m., indicated the resident was sitting on his bottom on the floor. He indicated he had to go to town to get the tractor. He was assisted back to bed with call light and fluids in place. The IDT note, dated 3/21/23 at 10:10 a.m., indicated the root cause of the fall was the resident's attempt to self transfer without staff assistance. The new intervention was to place a mat to the floor next to the open side of the bed. The nurse's note, dated 4/3/23 at 9:49 p.m., indicated the resident was on the fall mat. He was found lying on his left side with gripper socks and hipsters on and stated he had to go to town as there was too much work to do. The IDT note, dated 4/4/23 at 3:21 p.m., indicated the root cause of the resident's fall was the resident being confused, having dementia, and attempting to transfer himself. His hospice provider was notified and requested to exchange his bed for one with a low bed frame. The Quarterly MDS assessment, dated 4/4/23, indicated the resident was severely cognitively impaired, required extensive assistance of 2 staff with toileting, bed mobility, and transfers, was always incontinent of bladder, and always incontinent of bowel. The nurse's note, dated 5/2/23 at 9:40 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	indicated the resident was found in the floor on his fall mat. He indicated he needed to "go very badly ..." Staff checked and changed the resident every 2 hours. The IDT note, dated 5/3/23 at 10:59 a.m., indicated the root cause of the resident's fall was the resident attempting to get out of bed for the bathroom. The new intervention was to place a urinal within reach while in bed. During an observation, on 5/11/23 at 10:30 a.m., Resident 45 was resting in bed. His fall mat was in place and the bed was in the low position, however there was no urinal within reach. During an observation, on 5/11/23 at 2:08 p.m., Resident 45 was resting in bed. His fall mat was in place and the bed was in the low position. There was no urinal observed in the room. During an interview, on 5/11/23 at 1:26 p.m., CNA 2 indicated the resident was to have a floor mat in place. Having the urinal in reach was one of his interventions, but he was not able to use it by himself. He was usually wet when they got to him. He used to be able to use it but could not any longer. They helped him use a urinal when he told them he needed to pee, and they put him on the toilet throughout the day. They assisted him to toilet every 2 hours. During an interview on 5/11/23 at 1:44 p.m., LPN 3 indicated his falls were mainly in the evenings. He was having delusions that prompted him to get up. He was trying to get a tractor. They tried to redirect him with the delusions. He had the strips, then he was still having falls so they went to the mat. He did not transfer himself, but he thought he could. When there was a fall, she would assess			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	the situation to see what was going on as to why they were getting up. She would investigate what happened and then that would be the intervention she put into place. She would go by her investigation of what's happened, to keep that particular incident from happening again. During an interview on 5/11/23 at 3:21 p.m., the DON indicated on 10/25/22 they discontinued the fall mat and did non-skid strips. Then on 1/19/23 he had another fall and they were using a fall mat that night so the IDT met and added it to the care plan. Then on 2/27/23 he slid from his bed, so they removed the floor mat and did non skid strips again because they thought he may have slid from the floor mat. Then on 3/21/23 they added the mat back to the floor because she didn't want a fracture. Non-skid strips were not going to help with that, so she put the fall mat back down. She was aware they had an issue with falls as they were her weakness. The resident's urinal was not in his room. During an interview on 5/12/23 at 9:20 a.m., the DON indicated the resident now had a urinal in his room and they were doing a 3 day bowel and bladder assessment. The resident kept falling at night. She needed to see if they were putting him to bed too early. She had not thought of interventions to address the hallucinations the resident was having at night. The Fall Management Policy, last revised 8/22, provided on 5/11/23 at 2:23 p.m., by the Executive Director, included, but was not limited to, " ... Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls ... Procedure ... Post fall ... 5. A fall event will be initiated as soon as the resident has been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	assessed and cared for ... The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions ... 6. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls ... The care plan will be reviewed and updated as necessary ..." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure proper indwelling urinary catheter care, and handling of the catheter was provided during care for 2 of 4 residents catheter care reviewed. (Residents 79 and 52) Findings include: 1. The clinical record for Resident 79 was reviewed on 5/9/23 at 10:24 a.m. The diagnoses included, but were not limited to, acute infarction of spinal cord, hematuria, anemia, proteus mirabilis morganii UTIs (urinary tract infections), personal history of urinary tract infections, chronic retention of the urine, neuromuscular dysfunction of bladder. The nurse's note, dated 10/4/22 at 3:52 p.m., indicated a new order was received to place the catheter related to the resident's wounds. The care plan, dated 10/5/22 and last revised on 2/26/23, indicated the resident required an indwelling urinary catheter due to the neuromuscular dysfunction of his bladder, extensive wounds, paraplegia. The interventions, dated 11/3/22, indicated the resident was at risk for infection related to indwelling catheter; dated 10/5/22, keep the position of the bag below the level of the bladder, and to provide assistance for catheter care.	F 0690	1. Residents #52 and #79 were not harmed. Catheter/Pericare was completed again per policy. Nurse Aide #4, LPN #5, C.N.A. #6, C.N.A. #7 were in-serviced on the deficiencies, MD Orders, and Skills Validations. 2. All residents with catheters have the potential to be affected. Catheter care performed per policy and MD orders. Nurse Aide #4, LPN #5, C.N.A. #6, C.N.A. #7 were in-serviced on the deficiencies, MD Orders, and Skills Validations. 3. The Indwelling Urinary Catheter Skills Validations and Perineal Care Skills Validations were reviewed with no changes made (See Attachment C and D). The above Skills validations will be completed with all Nurses and C.N.A.s by the CEN or designee by 5-26-23. The CEN or Designee will complete Indwelling Urinary Catheter/Perineal Care Skills Validations (See Attachment C and D) with all residents with a catheter. 4. The DNS or designee will complete a Catheter QA Tool (See	05/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	The physician's order, dated 10/5/22, indicated to provide catheter care three times daily and the nurse was to record the output every shift. The order was discontinued on 11/14/22. The Admission MDS (Minimum Data Set) assessment, dated 10/6/22, indicated the resident was cognitively intact. The nurse's note, dated 10/6/22 at 6:45 p.m., indicated a CNA (Certified Nurse Aide) notified this nurse to come assess the resident's catheter related to the resident indicating there had not been any urine in the catheter bag since Thursday morning, but his brief was noticeably wet. The catheter was assessed by the nurse, who tried to deflate the balloon to reposition the catheter. The balloon had no fluid in it. Supplies were collected to change the catheter. The old catheter was removed without issue, and the resident urinated. Using sterile technique, the nurse cleaned the head of the penis with 3 iodine swabs. Lubricant was applied to the 16 French catheter. The catheter was inserted with ease with slight resistance met. The catheter tubing was pushed through without incident. Pink urine came out of the catheter. 20 mL (milliliters) of sterile water was applied to balloon. The nurse was unable to push the other 10 mL of fluid in. The catheter was secure at this time and the catheter bag was applied. 800 mL of pink, yellow urine was present. The ADL (Activities of Daily Living) note, dated 10/11/22 at 1:14 p.m., indicated the resident required maximum assistance for ADLs and bed mobility. He required maximum assistance of 2 staff with a lift for transfers. The resident was incontinent of bowel.		Attachment E) weekly times 4 weeks, then monthly times 6 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's QAPI meeting and issues will be addressed and the above plan will be altered accordingly if 100% is not achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	The physician's order, dated 11/21/22, indicated to provide catheter care three times a day with the nurse to record the output every shift. The order was discontinued on 1/23/23. The nurse's note, dated 11/26/22 at 8:39 p.m., indicated the catheter was changed per sterile procedure, related to urine leakage. The nurse's note, dated 11/27/22 at 10:46 p.m., indicated the catheter was changed once again related to leaking. The nurse's note, dated 11/29/22 at 1:39 p.m., indicated sediment and dark amber colored urine were present. The NP (Nurse Practitioner) was notified, and an order was received to send a specimen over to a local hospital for a urinalysis. The urinalysis report, dated 11/29/22, indicated large occult blood, 100 mg/dL (milligrams per deciliter) of protein, nitrite positive, small leukocytes, 21-50 per HPF (high powered field) of white blood cells, slight bacteria, and 4-10 per HPF of red blood cells. The nurse's note, dated 11/29/22 at 9:27 p.m., indicated a culture was pending on the urinalysis results. The NP was made aware with a new order for Bactrim DS (double strength) twice daily for 7 days. The urine culture and sensitivity results, dated 12/2/22, indicated greater than 100,000 CFU/mL (colony forming units per milliliters) ESBL (Extended Spectrum Beta-Lactamase) E-coli (Escherichia coli). The results were sent to the NP and no new orders were obtained. The nurse's note, dated 12/3/22 at 9:00 a.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	indicated the NP called with new orders for Ciprofloxacin 500 mg (milligrams) twice daily for 14 Days. The nurse's note, dated 12/19/22 at 1:39 a.m., indicated the catheter was leaking. The catheter was irrigated, however, continued to leak. The catheter was removed and an 18 French catheter was placed with no resistance. There was no urine output upon insertion, however, urine was observed a few minutes after insertion. The nurse's note, dated 12/22/22 at 12:44 a.m., indicated the catheter had clear yellow urine with an odor. The resident was incontinent of bowel with peri-care given as needed. The nurse's note, dated 12/23/22 at 1:38 p.m., indicated the catheter was draining dark yellow urine. The nurse's note, dated 12/29/22 at 3:01 p.m., indicated the resident had decreased urine output, which was amber in color. The catheter was irrigated without difficulty. The urine culture results, dated 1/3/23 at 11:33 a.m., indicated the presence of rare streptococci, beta hemolytic group B beta hemolytic streptococci, which were predictably susceptible to penicillin and other beta lactams. The nurse's note, dated 1/18/23 at 5:49 a.m., indicated the catheter was changed related to it leaking urine with green and red discharge. After removing the catheter, a moderate amount of blood was observed coming out of the penis opening. The re-insertion of a new catheter produced a moderate amount of blood into the catheter tubing and bag. The NP was notified and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	indicated she would look at resident when she entered the facility. The nurse's note, dated 1/18/23 at 10:11 p.m., indicated the resident had been shaky this shift. The catheter had an output of 400 mL of dark tinted bloody urine. The nurse's note, dated 1/18/23 at 12:57 p.m., indicated an appointment was made per the request of the NP with a urologist. An appointment was made for 1/31/23 at 11:20 a.m. The nurse's note, dated 1/21/23 at 10:29 p.m., indicated the resident had a large amount of dark red bloody urine. The NP was called and an order to get a CBC (complete blood cell count) with differential was given. The nurse's note, dated 1/22/23 at 3:21 a.m., indicated the resident continued to have a large amount of dark red blood in the urine. The nurse's note, dated 1/22/23 at 3:53 a.m., indicated the resident was passing a large amount of dark red blood clots. The NP was called and gave an order to send the resident to the ER (emergency room) to evaluate and treat. The hospital records, dated 1/22/23, indicated the discharge diagnosis was gross hematuria due to traumatic catheter pull, morganella morganii UTI, and acute blood anemia due to hematuria. The resident received bladder irrigation. The nurse's note, dated 1/26/23 at 12:55 p.m., indicated the resident returned from the hospital. The physician's order, dated 1/26/23, indicated to provide catheter care three times a day with the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	nurse to record the output every shift. The physician's order, dated 1/26/23, indicated to administer cefdinir 300 mg every 12 hours for a urinary tract infection. The discontinuation date was 2/2/23. The nurse's note, dated 1/30/23 at 10:53 p.m., indicated the resident continued to receive an antibiotic related to the UTI. The catheter was draining clear yellow urine. The nurse's note, dated 2/2/23 at 11:28 a.m. indicated the resident continued to receive an antibiotic related to the UTI. The catheter was patent and draining dark amber urine. The nurse's note, dated 2/3/23 at 10:30 a.m., indicated a new order to irrigate the catheter with 100 mL of NS (normal saline) as needed was received. The nurse's note, dated 3/10/23 at 12:53 a.m., indicated the catheter was changed related to it leaking. The nurse's note, dated 4/17/23 at 1:26 a.m., indicated the catheter was leaking and had only a 50 mL output. The catheter was changed using a sterile procedure. There was good urine return which was yellow in color. During an interview on 5/9/23 at 8:47 a.m., the resident indicated the staff just emptied the catheter bag, they didn't do catheter care. During an observation of incontinence and catheter care for Resident 79 on 5/9/23 at 1:03 p.m., NA (Nurse Aide) 4 and LPN (Licensed Practical Nurse) 5, entered the room and applied gloves.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	The resident indicated the catheter bag was just emptied. The NA obtained wipes and the brief was pulled down. The brief was wet with urine. The tubing was cleaned first, with the NA holding the tubing at the junction, but not at the tip of the penis. She removed her gloves and applied hand sanitizer. Clean gloves were applied. She obtained a wipe, and the right crease was cleaned in an upward direction. She obtained a fresh wipe for each swipe, cleaning from the tip down the shaft of the penis. The right and left creases were cleaned downward. She removed her gloves and applied hand sanitizer. Clean gloves were applied. The resident was rolled onto his right side. The NA indicated catheter care was provided daily, but it depended on the day. Depending on the day, different things were done. One time daily or twice. She lifted the catheter bag above the bladder to check it and held it in place ten seconds. She asked the resident if the staff said anything about the odor or color. She lowered the catheter bag onto the bed. She lifted the catheter bag up above the bladder again. The LPN requested for her to lower the catheter bag below the bladder. During an interview on 5/9/23 at 1:24 p.m., LPN 5 indicated the catheter bag should not be lifted above the bladder, so that it wouldn't drain urine back into the bladder. During an interview on 5/9/23 at 1:26 p.m., NA 4 indicated she should hold the catheter tubing at the end and at the penis itself to clean the tubing. The tubing should be held to prevent from being pulled out or it could cause leakage. The catheter tubing had been leaking. During a second observation of catheter care for Resident 79 on 5/11/23 at 8:53 a.m., CNA 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	performed hand hygiene and applied gloves. The urine in tubing was amber to bloody colored. The catheter tubing was cleaned, holding four inches away from the penis. She obtained a wipe and with the same area of the wipe, she swiped 2 times from the tip of the penis down the shaft. She did not dry the penis or the creases. The resident was helped to roll onto his right side. The resident had stool on his bottom. The stool had a dry ring around the edges. The CNA obtained a wipe and with 5 swipes of the same area of the wipe, she cleaned anal area, front to back. She obtained a wipe and with one swipe in a back to front direction, she cleaned the anal area. She obtained a wipe and with 2 swipes of the same area of the wipe, in a back to front direction, the stool was wipes off. She obtained another wipe and with 2 swipes with the same area of the wipe cleaned the anal area, front to back. She obtained another wipe and with 4 swipes with the same area of the wipe, folding and with 2 swipes with the same area of the wipe, cleaned the anal area. She did not pat the anal area dry. The resident was rolled onto his back. She obtained a wipe and in a back to front direction, she cleaned the scrotum. She did not pat the area dry. She removed her gloves and performed hand hygiene. She wasn't sure when the catheter bag was emptied last. The catheter bag was half full of urine. The urine in the catheter bag was emptied and it was amber to bloody colored. During an interview on 5/11/23 at 9:05 a.m., CNA 6 indicated the catheter bag was emptied at the beginning, middle and again at the end of the shift. For catheter perineal care, she would clean the tubing first, cleaning the tube a little way down, and pat it dry after cleaning. She should hold the tubing at the penis because it could pull out, and his tended to pull out easily. She patted			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	the area dry with the wipe. His catheter tended to leak. She checked the resident every 2 hours for stool. He could tell them when he needed changed. His stool was usually dry around the edges of the stool. She should clean his bottom from the top downward and she should not repeat the same area of the wipe to clean. 2. The clinical record for Resident 52 was reviewed on 5/11/23 at 10:37 a.m. The diagnoses included, but was not limited to, Parkinson's disease, dementia, Alzheimer's disease, neuromuscular dysfunction of the bladder, neurogenic bladder, hydronephrosis with a right ureteral stent, and cystitis without hematuria pyocystis. The care plan, dated 1/31/19, indicated the resident required an indwelling catheter related to a neurogenic bladder and obstructive uropathy. The interventions, dated 1/31/19, indicated to manipulate the tubing as little as possible during care, position the bag below the level of the bladder, and provide assistance for catheter care. The nurse's note, dated 5/31/22 at 10:58 p.m., indicated the catheter was draining at the bedside and had milky yellow urine with a foul smell. The physician's order, dated 6/7/22 indicated to provide catheter care three times daily at 5:00 a.m., 1:00 p.m., and 9:00 p.m. The nurse was to record the output every shift. The nurse's note, dated 6/14/22 at 1:38 a.m., indicated the catheter was draining cloudy yellow urine. The nurse's note, dated 6/16/22 at 11:35 p.m., indicated the catheter was draining cloudy yellow urine.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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

The nurse's note, dated 6/25/22 at 3:55 a.m., indicated the urine was obtained for the urinalysis per the MD (medical doctor's) order and taken to the local hospital.

The Urinalysis report, completed on 6/25/22, indicated the resident's urine was yellow and turbid, had moderate occult blood, 100 mg/dL, was positive for nitrites, had a large number of leukocytes, greater than 100 per hpf white blood cells, and marked red blood cells. No culture was indicated.

The nurse's note, dated 7/7/22 at 10:09 a.m., indicated new orders were received to flush the catheter with 100 ml of normal saline every 8 hours as needed for blockage or a change in urine, color, or clarity.

The physician's order, dated 7/8/22, indicated to flush the catheter with 100 ml of normal saline every 8 hours as needed for blockage or a change in urine color or clarity.

The nurse's note, dated 8/7/22 at 2:51 a.m., indicated a CNA reported to the nurse that the catheter was leaking. The catheter bag was assessed and was leaking from the bag, but also at the insertion site. The catheter was removed. An 18 French catheter was inserted using sterile technique. A small flash of yellow urine was observed.

The Quarterly MDS assessment, dated 8/24/22, indicated the resident was severely cognitively impaired. She required substantial assistance from staff for toileting hygiene.

The nurse's note, dated 12/8/22 at 12:03 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	indicated the catheter was changed per order. A 18 French 10 mL catheter was anchored via sterile technique. The catheter was patent, draining yellow colored urine. The nurse's note, dated 12/25/22 at 2:17 a.m., indicated the catheter was changed related to leaking. The nurse's note, dated 1/8/23 at 1:53 a.m., indicated a new catheter was anchored via sterile technique. A 16 French 20 mL balloon with immediate urine return was provided. The nurse's note, dated 3/10/23 at 11:54 p.m., indicated the resident required assistance of one staff for ADL's. The catheter was anchored and patent with cloudy yellow urine flowing in line. She was incontinent of bowel and did not make wants and needs known to staff most often. Staff were to anticipate all of the resident's wants and needs. The nurse's note, dated 4/7/23 at 10:50 p.m., indicated the catheter was anchored and patent with amber yellow and somewhat cloudy urine. During an observation of catheter care for Resident 52 on 5/11/23 at 8:38 a.m., by CNA 7 with LPN 5, present, the CNA applied hand sanitizer and gloves. She obtained a wipe and with 3 swipes of the same area of the wipe, she cleaned the crease to the left of the labia. The catheter tubing was not cleaned. As the CNA swiped down the labial area toward the catheter tubing, stool could be seen on the wipe, with each swipe. The CNA removed her gloves and applied hand sanitizer. She applied clean gloves. The resident was rolled onto her left side. The CNA obtained a wipe and with 2 swipes of the same area of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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

wipe she cleaned the anal area. She folded the wipe and with 2 swipes of the same area of the wipe, cleaned the anal area. She obtained a wipe and with 2 swipes of the same area of the wipe she cleaned the anal area. She folded the wipe and with 2 swipes of the same area of the wipe, cleaned the anal area. She did not dry the anal area. The clean brief was applied. The catheter tubing was still not cleaned. She removed her gloves and applied hand sanitizer.

During an interview on 5/11/23 at 8:50 a.m., CNA 7, indicated she had cleaned the tubing before the perineal care, and it was just not in view. She indicated if stool was present, it could have brought the stool back onto the tubing while cleaning. She indicated she cleaned the tubing every 2 hours. The catheter bag was emptied at the end of her shift. The resident was good at drinking fluids. The CNA indicated she pat the resident's perineal area dry after she cleaned with the wipes. She then admitted she didn't do that during the care.

During an interview on 5/11/23 at 12:41 p.m., the DON (Director of Nursing) indicated the nurse was supposed to let the CNA know the orders for catheter care. They should clean the resident from front to back, folding the cloth or changing to a new one with each swipe. They should dry the area from front to back when doing perineal care. They should not lift the catheter bag above the bladder and should hold the catheter tubing at the entry site while cleaning. She later indicated she found the area on the policy for drying the resident after cleaning the perineal area.

The Perineal Care Skills Competency procedure steps, last reviewed on March 2023, was provided by the DON on 5/11/23 at 12:38 p.m., included, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	was not limited to, " ... 10 ... Gently wipe catheter from meatus downward approximately four inches. Do not rewipe catheter. Discard used wash cloth in plastic bag ... 12. Separate labia and wash urethral area first ... 14. Alternate from side to side wipe from front to back and from center of perineum outward. 15. Use a clean area of the washcloth with each wipe. Do not rewipe area unless using a clean area of the washcloth ... 17. Wash and rinse tip of penis in circular motion, starting at urethra moving outward ... 19. Continue washing down the penis to the scrotum outward ... 21. Gently pat dry area in same direction as washing ... 24. Clean anal area from front to back, using a clean area of washcloth with each wipe. Do not rewipe area, unless using a clean area of the washcloth ... 26. Gently pat area dry in same direction as when washing ..." The Indwelling Urinary Catheter Care, Emptying Drainage Bag and Catheter Removal policy, last reviewed December 2012, was provided by the IP (Infection Preventionist) on 5/11/23 at 2:00 p.m. The policy included, but was not limited to, "Catheter care and emptying of urinary drainage bag may be done by a licensed nurse or certified nurse aide ... 6. Using the non-dominant hand grasp the catheter tubing where it enters the meatus. 7. Using the dominant hand retrieve a wet soaped washcloth, cleanse the catheter in circular motion for about 10 cm [centimeters] (4 inches) ..." 3.1-41(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation, record review, and interview, the facility failed to ensure accurate documentation in the Controlled Substances Record sheet of the administered narcotics and appropriate storage and labeling of medications for 1 of 4 medications carts and 1 of 2 medication storage rooms observed. (100 Hall Cart and 100/200/300 Hall Storage Room) Findings include:	F 0755	1. RN was individually in-serviced on Inventory Control of Controlled Substances and Routine Reconciliation of Controlled Substances Policies. Counts corrected for Residents #2, #4, and #26. Lorazepam with no name was destroyed and medication received from pharmacy with proper resident	05/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	1. During an observation on 5/9/23 at 9:12 a.m., of the 100 Hall Medication Cart with LPN (Licensed Practical Nurse) 8 the following concerns were observed: a. Resident 26's lorazepam 2 mg/mL (milligrams per milliliter) bottle was stored in the unrefrigerated narcotic drawer on the medication cart. The medication labeling indicated to store the medication in the refrigerator at a temperature of 36 to 46 degrees Fahrenheit (F). There was approximately 25 mL of the medication in the bottle. The Controlled Substances Record sheet indicated the resident should have 26.25 mL of the medication remaining, with the last dose signed out on 5/9/23 at 4:03 a.m. During an interview on 5/9/23 at 9:14 a.m., LPN 8 indicated the medication was in the drawer because they had been giving it to the resident. It had been in the drawer for at least 2 hours. She had not given it to him, and she had not counted when she took the cart. The Infection Preventionist had counted the cart for her. She had not put the medication in the refrigerator when she took the cart. The medication frequently spilled because of the dropper style lid it had. The clinical record for Resident 26 was reviewed on 5/9/23 at 2:00 p.m. The resident's diagnoses included, but were not limited to, intermittent explosive disorder, bipolar disorder, and major depressive disorder. The physician's order, dated 5/8/23, indicated to administer 0.25 mL of lorazepam intensol 2 mg/mL solution every 2 hours as needed for anxiety. The resident's MAR (Medication Administration		name placed for Resident #52. New dropper lid received for Resident #26 lorazepam medication. 2. All residents have the potential to be affected by this deficient practice. All narcotic sheets counted to ensure number of medications match the records by DNS or designee. All medications were reviewed to ensure proper labeling and storage by DNS or designee. 3. Inventory Control of Controlled Substances, Routine Reconciliation of Controlled Substances, Storage and Expiration Dating of Medication, Biologicals Policies reviewed with no changes made (See Attachments F, G, and H). All licensed nursing staff were in-serviced on the above policy by 5-26-23. Nurse Management will observe controlled substances records and medication storage areas during GEMBA rounds. 4. DNS or designee will complete Medical Storage QA Tool (See Attachment I) weekly times 4 weeks, then monthly times 6 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's QAPI meeting and issues will be addressed and the above plan will be altered accordingly if 100% is not achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	Record), indicated the last dose of the medication was administered on 5/9/23 at 4:03 a.m. b. Resident 4's Tramadol 50 mg Controlled Substance Record Sheet, indicated the resident had a count of 8 tablets left. The last dose signed out on the sheet was on 5/9/23 at 7:34 a.m., by LPN 8. There were 9 tablets of the medication on the card. During an interview on 5/9/23 at 9:17 a.m., LPN 8 indicated she had given the medication to the resident that morning. She did not know why the count was not correct. The clinical record for Resident 4 was reviewed on 5/9/23 at 11:10 a.m. The diagnoses included, but were not limited to, spinal stenosis, carpal tunnel syndrome, and chronic pain syndrome. The physician's order, dated 5/5/23, indicated to administer tramadol 50 mg every 8 hours as needed. The resident's MAR indicated the medication had last been given on 5/9/23 at 7:34 a.m. by LPN 8. c. Resident 2's clonazepam 0.5 mg Controlled Substance Record sheet, indicated the resident had a count of 18 tablets remaining, with the last dose signed out on 5/9/23 at 2:00 p.m. The medication card contained a count of 19 tablets. During an interview on 5/9/23 at 9:18 a.m., LPN 8 indicated there were 19 tablets left on the card because she had signed out both the resident's 8:00 a.m. and 2:00 p.m. doses of the medication in advance. She had not yet given the 2:00 p.m. dose. Sometimes she forgot to sign medications out so she signed them out in advance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	The clinical record for Resident 2 was reviewed on 5/9/23 at 11:05 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder and generalized anxiety disorder. The physician's order, dated 1/6/23, indicated the resident received clonazepam 0.5 mg three times daily. The resident's MAR indicated the last dose was administered on 5/9/23 at 8:00 a.m. 2. During an observation on 5/9/23 at 9:28 a.m. of the 100/200/300 Hall Medication Storage room, there was an opened bottle of lorazepam 2 mg/mL in the narcotic box in the refrigerator with no pharmacy labeling. The medication lacked any identifying information for whom it belonged to, any prescriptive orders, or directions for use. During an interview on 5/9/23 at 9:30 a.m., LPN 8 indicated she believed the medication belonged to Resident 52 but she was not certain since it did not have a name. It looked to her that it had been pulled from the Pyxis system. When they pulled a medication from the Pyxis, they were supposed to put the name of the resident as well as the date the medication was opened. The clinical record for Resident 52 was reviewed on 5/9/23 at 11:25 a.m. The diagnoses included, but were not limited to, dementia, Alzheimer's disease, major depressive disorder, and anxiety disorder. The physician's order, dated 12/8/22, indicated the resident received 0.5 mL of lorazepam intensol 2 mg/mL every 4 hours as needed for seizure activity, restlessness, anxiety, and agitation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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

The resident's Controlled Substance Record sheet, indicated the resident had received doses of lorazepam 2 mg/mL on 11/3/22 at 3:03 p.m., and 2/9/23 at 1:23 a.m.

The resident's MAR indicated the last dose of lorazepam 2 mg/mL she had received, was on 2/9/23 at 1:23 a.m.

During an interview on 5/9/23 at 9:54 a.m., The Infection Preventionist indicated two other nurses had conducted the count on the 100 hall cart that morning and she had taken the keys from one of those nurses until LPN 8 arrived. There had been no count from the hand off from the other nurse, to herself, or herself to LPN 8. She had not opened the medication cart or counted it.

During an interview on 5/12/23 at 10:55 a.m., the Infection Preventionist indicated they typically conducted a count when staff handed off the keys. LPN 8 was running late that morning, so she had told the off-going nurse she would take the cart until she got there. She got the keys from the nurse and handed the keys to LPN 8 when she got there. There should have been a count between the night shift nurse and LPN 8. Staff were always to give report and always count the narcotics and sign them off on the book. They always counted any time it changed hands.

The Storage and Expiration Dating of Medications, Biologicals policy, last revised 7/21/22, provided on 5/9/23 at 2:10 p.m. by the DON (Director of Nursing), included but was not limited to, " ... Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions ... 10. Facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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
	should ensure that medications and biologicals are stored at their appropriate temperatures according to the United states Pharmacopeia guidelines for temperature ranges ... 10.2 Refrigeration: 36 - 46 F... 12.3 Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security..." The Inventory Control of Controlled Substances policy, last revised on 1/1/22, provided on 5/9/23 at 2:10 p.m. by the DON, included, but was not limited to, " ...Procedure...1.1 Facility should maintain separate individual controlled substance records on all Schedule II medications and any medication with a potential for abuse or diversion in the form of a declining inventory using the 'Controlled Substances Declining Inventory Record'. These records should include ... Date and time of administration... Quantity remaining...Name and signature of person administering the medication ... Facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least daily and document the results on a 'Controlled Substance Count Verification/Shift Count Sheet'..." 3.1-25(b)(3)			