STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WHITEWATER COMMONS SENIOR LIVING	215 W HIGH ST LIBERTY, IN 47353

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00437363. Complaint IN00437363 - No deficiencies related to the allegations are cited. Survey dates: July 9, 10, 11, and 12, 2024 Facility number: 000510 Provider number: 155507 AIM number: 100285440 Census bed type: SNF/NF: 26 Total: 26 Census payor type: Medicare: 3 Medicaid: 20 Other: 3 Total: 26 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 16, 2024.	F 0000	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state and federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Blackmon	HFA	07/26/2024

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

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	or other residents. Based on observation, interview, and record review the facility failed to provide fresh ice water daily and failed to keep a call light and personal items within reach for 3 of 3 residents reviewed for choices (Resident 20, Resident 17 and Resident 2). Findings include: 1. During an observation and interview with Resident 20, on 7/9/24 at 12:59 p.m., she had a warm pitcher of water on her nightstand. The resident indicated she frequently went without fresh ice water and only received fresh fluids with meals. During an observation, on 7/10/24 at 10:58 a.m., Resident 20 had a water pitcher of water on her nightstand. Review of Resident 20's clinical record, on 7/12/24 at 11:32 a.m., indicated the diagnoses included, but were not limited to, diabetes, hypertension, anxiety, chronic kidney disease, and bladder disorder. The Admission Minimum Data Set (MDS) assessment, dated 6/21/24, indicated Resident 20 was cognitively intact for daily decision making. The resident was consistent and reasonable. The physician order for Resident 20, dated 6/18/24, indicated to offer additional 120 milliliters (ml) every shift. 2. During an observation and interview with Resident 17, on 7/9/24 at 1:27 p.m., her cell phone, water, magazines, TV remote, and call light was across the room and out of reach for the resident.	F 0558	Residents' 20, 17 and 2 were given fresh ice water. Resident 17's call light and personal items were placed within her reach. Staff was re-educated to assure fresh ice water passed every shift and resident call lights and personal items within reach at all times. All residents have the potential to be affected. Rounds conducted ensuring call lights and personal items in reach of resident as well as fresh ice water at bedside. The staff was re-educated on the above. The facility's policies for Fresh Ice Water, Call Lights and Personal Items were reviewed with no changes indicated at this time. The DON and/or her designee will conduct rounds twice a day (5x/week) for 4 weeks, daily (5x/week) x 4 weeks, weekly x 4 weeks and monthly thereafter ensuring fresh ice water at bedside, call lights and personal items at bedside. Should concerns be noted, immediate action shall occur. As a means of Quality Assurance, the DON and/or her designee will review any findings and subsequent corrective actions taken: Reporting to the facility's QAA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain	08/08/2024

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	The resident indicated the staff frequently forget to place her personal items and call light within her reach and she had to yell for help. The resident's call light was activated and Certified Nursing Assistant (CNA) 1 came into the room and indicated whoever assisted the resident to bed was responsible to ensure her call light and personal items were within her reach. CNA 1 placed all items in reach the resident. During an observation and interview with Resident 17, on 7/10/24 at 1:30 p.m., her personal items and water was across the room and out of reach. The resident indicated she had to push her call light frequently to alert staff her personal items were out of reach. The resident indicated she was unable to walk. Review of Resident 17's clinical record, on 7/10/24 at 12:52 p.m., indicated the diagnoses included, but were not limited to, peripheral vascular disease, congestive heart failure, anxiety, major depressive disorder, pain, diarrhea, insomnia, and difficulty walking. The Admission MDS assessment, dated 6/15/24, indicated Resident 17 was cognitively intact for daily decision making. The resident was consistent and reasonable. The State Optional MDS for Resident 17, dated 6/15/24, indicated she was dependent on two people for transfers. During an interview with the Director of Nursing (DON), on 7/11/24 at 12:40 p.m., they indicated nursing staff were responsible for ensuring water, call lights, and personal items were within reach of the residents. 3. The clinical record for Resident 2 was reviewed		compliance.	

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	on 7/11/2024 at 11:15 a.m. The medical diagnosis included edema. A Quarterly MDS Assessment, dated 6/13/2024, indicated Resident 2 was set up assistance for eating and drinking. A physician order, dated 12/16/2022, indicated Resident 2 drank thin liquids. During an interview and observation with Resident 2, on 7/9/2024 at 12:57 p.m., indicated that he had warm water in a pitcher at the beside with no ice present. Resident 2 stated, "This is the same water from yesterday and it is warm." Resident 2 indicated the staff rarely pass fresh ice water. During an interview and observation with Resident 2, on 7/11/2024 at 11:46 a.m., indicated that he had warm water in a pitcher at the beside with no ice present. Resident 2 indicated the staff did not pass ice water to him at all within the last day and the water in his pitcher was "stale and warm". During an interview with the DON, on 7/11/24 at 12:40 p.m., she indicated nursing staff are responsible for ensuring water, call lights, and personal items are within reach. A policy, entitled "Water, Fresh Ice", was provided by the Executive Director on 7/12/2024 at 10:15 a.m. The policy indicated, " ... Fresh drinking water shall be provided to each resident and be available to each resident at all times ..." 3.1-3(v)(1)			

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F 0689 SS=G 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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. 1. Based on observation, interview, and record review, the facility failed to ensure staff effectively implemented fall prevention interventions while using an assistive device in the shower to prevent accidents for 1 of 3 residents reviewed for accidents. This deficient practice resulted in Resident 6 experiencing a fall that required hospitalization for the treatment of a subarachnoid hemorrhage. 2. The facility failed to ensure fall interventions were in place while utilizing an assistive device for 1 of 2 residents reviewed for positioning and mobility. (Resident 23) Findings include: 1. Resident 6's record was reviewed, on 7/11/24 at 10:38 a.m., and diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage, chronic pain syndrome, polyosteoarthritis, morbid (severe) obesity, and muscle weakness. The record indicated Resident 6 was hospitalized, from 4/13/24-4/17/24, after falling off a shower bed. The record indicated Resident 6 sustained a subarachnoid hemorrhage as a result from the fall.	F 0689	Resident 6's fall interventions reviewed upon return from hospital. New interventions were put into place, including the use of the reclining shower chair for showers to provide increased safety with showers. C.N.A. 3 was re-educated on the proper use of the shower bed including but not limited to: side rails up with pins properly in place, shower bed casters locked and never allowing a resident to lean outside of the frame of the shower bed. Resident 23 fall interventions reviewed with no changes indicated at this time. C.N.A. 2 was re-educated concerning resident 23's interventions for positioning and transporting resident in the Broda Chair to assure feet have clearance from the floor. All residents have the potential to be affected. Care plans and interventions for residents at risk for falls were reviewed with no changes indicated at this time. Staff was re-educated on Fall	08/08/2024

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	A Quarterly Minimum Data Set (MDS) assessment, dated 2/6/24, indicated Resident 6 was "dependent- helper does ALL of the effort" with shower/bathing, personal hygiene, and bed mobility (rolling left to right). Resident 6 required two staff person assistance with transfers and had "impairment on both sides" to the upper and lower extremities. The MDS indicated that Resident 6 was cognitively intact for daily decision making and was consistent and reasonable for daily decision making. A written statement from the former maintenance staff, dated 4/13/24 and signed, indicated the following, " ...Called in Saturday morning around 10:40 a.m. to fix a shower bed that someone had fallen out of. Upon my inspection of the shower bed I found that the pins which hold the siderails up were missing. I went to the hardware store and bought enough bolts of the right size and length to keep the rails in upright position and secure for the shower bed in the 200 hallway. I then went to check the bed in the 100 hallway and secured it as well...." The hospital discharge summary, dated 4/17/24, indicated the resident suffered a traumatic brain injury which commonly causes confusion, dizziness, memory loss, nausea, and a headache. A care plan for "Potential for Fear and Anxiety" was initiated, on 4/19/24, and indicated the following, " ...the resident has the potential for fear and anxiety due to recent fall out of a shower bed...." A care plan titled "ADL [Activities of Daily Living] Assist Required", initiated on 5/13/22 and revised on 4/29/24, indicated the following, "The resident [Resident 6] requires up to x2 [times two]		Prevention with a special focus on shower bed safety and transporting residents in Broda/Geri chair and wheel chair safety assuring feet have clearance from the floor. The facility's Fall Prevention Policy was reviewed with no changes indicated at this time. Staff was re-educated on Fall Prevention with a special focus on shower bed safety and transporting residents in Broda/Geri chair and wheel chair safety assuring feet have clearance from the floor. The DON and/or designee will monitor showers and transport of residents in wheelchair/Broda/Geri chairs twice a day for 4 weeks (5x/week), daily (5x/week) x 4 weeks, weekly x 4 weeks and monthly thereafter to assure proper use of the shower bed and proper transport of residents in wheelchair/Broda/Geri chairs. Should a concern be noted, immediate action shall occur. As a means of Quality Assurance, the DON and/or her designee will review any findings and subsequent corrective actions taken: Reporting to the facility's QAA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance.	

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	staff". The "x2 staff" was handwritten on the paper care plan without a date to indicate when Resident 6 was to need staff assistance with two people and for what specific ADL task. An observation was conducted, on 7/11/24 at 11:46 a.m., with the Nurse Consultant. The shower bed was observed to have a pipe rail bed frame with two side rails, which required the insertion of two pins on each side to hold the rail. Each pin was observed to be attached to the side rails with a gray strap. The frame was observed to have four legs with attached, locking wheels. During an interview with Certified Nursing Assistant (CNA) 3, on 7/11/24 at 11:08 a.m., she indicated that she was getting Resident 6 onto the shower bed and had the bed rails in the "up" position. She indicated she rolled Resident 6 onto her left side to wash her backside and when Resident 6 reached for the siderail, the rail broke off the shower bed, and Resident 6 fell off the bed, and landed on the floor headfirst. CNA 3 indicated the pins were in place before the shower began but came out once Resident 6 put weight on the railing. An interview with CNA 3, on 7/11/24 at 11:48 a.m., indicated she had not locked the shower bed wheels before or after Resident 6 was placed onto the shower bed. CNA 3 indicated she normally did not lock the wheels and she was not familiar with the shower beds. CNA 3 indicated she had only given one shower during clinicals, and, during orientation, shower beds were not covered that much. An interview with Resident 6, on 7/11/24 at 1:55 p.m., indicated the shower bed was not pushed all the way up against the shower wall and there were			

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	no siderails up. She indicated she was always told to reach for the handicap rail attached to the wall when turning because the shower bed rails were broken. Resident 6 indicated when CNA 3 instructed her to roll onto her left side, she reached for the handicap rail as she was always instructed to do, but she could not reach it, and the bed rolled, and she fell off the bed onto her head hitting the floor. Resident 6 indicated she knew the wheels were not locked that day. Resident 6 indicated she had a lot of head pain due to the fall and continued to have tingling above her right eyebrow and it still hurt at times. During an observation and interview with Resident 6, on 7/12/24 at 10:58 a.m., she was observed sitting in a mobilized wheelchair and indicated she was dependent on all her daily activities, especially mobility and bathing. An interview with the Executive Director (ED), on 7/11/24 at 12:29 p.m., indicated she was notified of the fall on 4/13/24, and Resident 6 slid off the shower bed. The pins broke and was the root cause of the fall. The ED indicated that the former maintenance staff came into the facility Saturday, believed to be 4/13/24, and stated the pins were gone. So, he (former maintenance staff) got new pins to put onto the shower bed. The ED indicated she was not aware that the brakes were not locked on the shower bed. A policy for "Showering a Resident" was provided by the Executive Director, on 7/11/24 at 2:18 p.m., and indicated the following, " ...Assist resident into shower and lock wheels of shower chair ..." A document titled "PVC Healthcare Equipment Owner's Manual" was provided by the ED on			

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	7/11/24 at 2:18 p.m. The document indicated the following, "...never allow the user to lean outside of the frame of the equipment ...always apply the brakes on casters when needed...." The document did not indicate any weight limit specifications but only referenced "always abide by weight limit capacities for each product". 2. The clinical record for Resident 23 was reviewed on 7/12/2024 at 10:45 a.m. The medical diagnosis included Alzheimer's disease. A Quarterly Minimum Data Set Assessment, dated 6/21/2024, indicated Resident 23 was not cognitively intact and dependent on transportation with her manual wheelchair. A fall care plan, reviewed on 4/15/2024, indicated that Resident 23 was at risk for falls related to weakness and dementia. An intervention to ensure that Resident 23 was utilizing her assistive device as indicated, including her Broda chair (a type of manual wheelchair). An in-service for Resident 23, dated 4/7/2024, was provided by the Director of Nursing on 7/10/2024 at 2:30 p.m. The document indicated that Resident 23 is to have her wheelchair dipped "when in transit to raise feet form ground." During an observation, on 7/10/2024 at 1:21 p.m., Resident 23 was sitting in her wheelchair in the common area by the nurses' station. CNA 2 pulled Resident 23 backwards in her wheelchair in the common area into the tiled hallway. Resident 23's feet were noted to be contacting the ground during the backwards motion. CNA 2 paused momentum, tilted the wheelchair back some, then began a forward momentum to take Resident 23 to her room. Resident 23's feet were noted to make contact intermittently during the forward			

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	momentum. During an interview with CNA 2, on 7/10/2024 at 1:23 p.m., CNA 2 indicated that staff did not use foot pedals with Resident 23. She indicated that Resident 23's feet touch the floor "sometimes" when she transports Resident 23 in the wheelchair, and that nursing staff are "working with PT [Physical Therapy]" about a new wheelchair. During an interview with Certified Occupational Therapy Assistant (COTA), on 7/10/2024 at 1:46 p.m., indicated that she was familiar with Resident 23 and her use of a "pedal Broda chair". COTA indicated that this chair was selected as the most appropriate option because it would allow Resident 23 to have versatility in her movements and body mechanics. Resident 23 does not utilize foot pedals with it due to her non-functional purposeful movements. Staff are to "dip" the chair back so that Resident 23's feet have clearance from the floor when assisting her with transportation. A policy entitled, "FALL PREVENTIONS PROGRAM", was provided by the Administrator on 7/11/2024 at 2:18 p.m. The policy indicated the purpose of the policy was to identify residents who are at risk for falls and subsequently implement appropriate individualized fall prevention interventions. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review the facility failed to store a Bi Pap facial mask and nebulizer mouthpiece in a bag to maintain good infection control practices for 1 of 4 residents reviewed for respiratory therapy (Resident 17). Findings include: During an observation, on 7/09/24 at 1:31 p.m., Resident 17's Bi Pap (airway support administered through a mask) facial mask was lying on the nightstand and not in a bag. The facial mask had brown substance around the facial mask. During an observation, on 7/10/24 at 10:57 a.m., Resident 17 was sitting in her geriatric chair and her nebulizer machine mouthpiece was lying on the bedside table with no bag. During an observation and interview, on 7/10/24 at 1:30 p.m., Resident 17's nebulizer machine mouthpiece was lying on the bedside table with no bag. The resident indicated some nurses put the nebulizer mouthpiece in a bag and some do not. Review of the record for Resident 17, on 7/10/24 at 12:52 p.m., indicated the resident's diagnoses included, but were not limited to, peripheral	F 0695	Resident 17's Bipap mask was cleaned; nebulizer mouthpiece was changed out and both placed in a dated plastic bag. Staff was re-educated on the proper storage of respiratory equipment when not in use. All residents have the potential to b affected. The DON conducted rounds assuring Bipap masks oxygen tubing, nebulizer mouth piece were stored correctly with no further issues noted. Staff re-educated on the proper storage of respiratory equipment when not in use. The facility's Nebulizer Hand held policy was reviewed with no changes indicated at this time. The DON and/or her designee will conduct rounds twice a day (5x/week) for 4 weeks, daily (5x/week) x 4 weeks, weekly x 4 weeks and monthly thereafter ensuring Respiratory equipment stored properly in dated plastic bag. Should a concern be noted, immediate action shall occur. As a means of Quality Assurance, the DON and/or her designee will review any findings and	08/08/2024

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	vascular disease, congestive heart failure, anxiety, major depressive disorder, pain, diarrhea, insomnia, and difficulty walking. The Admission Minimum Data Set (MDS) assessment for Resident 17, dated 6/15/24, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The physician recapitulation orders for Resident 17, dated July 2024, indicated resident received a nebulizer treatment three times and a day and every four hours, as needed, for shortness of breath and congestion related to congestive heart failure. The resident had ordered BI-PAP mask at bedtime with 2 liters per minute setting. The resident was ordered oxygen 2 liters continuous/intermittent every shift. During an interview with the Director of Nursing (DON), on 7/11/24 at 12:40 p.m., they indicated nursing staff and respiratory staff were responsible to ensure the residents respiratory equipment was stored in a bag for infection control measures. The nebulizer handheld policy provided by the DON, on 7/12/24 at 10:25 a.m., and indicated upon completion of the treatment the delivery device would be placed in a bag labeled with the resident's name and date to be maintained at the bedside. An interview conducted with the DON, on 7/12/24 at 11:30 a.m., indicated Bi pap mask were to be stored in a bag for infection control purposes. 3.1-47(a)(6)		subsequent corrective actions taken: Reporting to the facility's QAA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance.	

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	155507	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WHITEWATER COMMONS SENIOR LIVING	215 W HIGH ST LIBERTY, IN 47353

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to provide and administer a resident's medication, as ordered, for 1 of 1 resident reviewed for antibiotic use. (Resident 18)	F 0755	Resident 18's order was clarified and transcribed correctly in the MAR. In an effort to identify other	08/08/2024

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	Findings include: The clinical record for Resident 18 was reviewed on 7/10/24 at 11:17 a.m. The diagnosis included, but were not limited to, urinary tract infection. The chronic urinary tract infection care plan, last revised 7/1/24, indicated the goal was for Resident 18 to be free from signs and symptoms of urinary tract infection. Two of the interventions were to administer medications as ordered and Macrobid 100 milligrams (mg) on Monday, Wednesday, and Friday for 36 doses. The 6/20/24, Urology Visit Summary indicated, "Chief Complaint as stated by patient: f/u [follow up] UTI [urinary tract infection.] How long have you been experiencing this issue?: weeks....What improves/worsens this issue?: Requesting ongoing low dose abx [antibiotic....] PLAN...pt [patient] here for more UTI...Will get str [straight] cath [catheter] cx [culture] sent out and start on low dose preventative antibx [antibiotic] based on it for 3 months." The 7/1/24, 11:00 a.m. nurse's note indicated Resident 18's urologist's office called and gave a new order for Macrobid 100 mg by mouth every Monday, Wednesday, and Friday for 36 does related to UTI. The physician's orders indicated Macrobid capsule of 100 mg, once a day, every other day, and only given on Monday, Wednesday, and Friday, starting 7/3/24. The July 2024 MAR (medication administration record) indicated the Macrobid was scheduled to be given every other day, instead of scheduled to		residents who may be affected, review of all resident medication administration records was conducted to assure proper transcription of orders. No further issues noted. The facility's Medication Administration policy was reviewed with no changes indicated at this time. The DON and/or her designee will monitor Physicians orders and transcription to the MAR on a daily basis on scheduled work days x 4 weeks and 3x per week x4 weeks, weekly x 4 weeks and monthly thereafter to assure proper transcription of physician orders. Should a concern be noted, immediate action shall occur. As a means of Quality Assurance, the DON and/or her designee will review any findings and subsequent corrective actions taken: Reporting to the facility's QAA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance.	

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	be given on Monday, Wednesday, and Friday only. It indicated Resident 18 received the Macrobid on the following dates: Wednesday 7/3/24, Friday 7/5/24, and Sunday 7/7/24. It indicated the medication was not administered on 7/9/24, because it was supposed to be given on Monday, Wednesday, and Friday and was given yesterday (7/8/24.) It indicated it was not given on 7/11/24 because it was to be given on Monday, Wednesday, and Friday. An interview was conducted with the DON (Director of Nursing) on 7/12/24 at 12:17 p.m. She reviewed the July 2024 MAR and indicated the Macrobid was set up to be administered incorrectly as every other day and should have been set up to be administered on Monday, Wednesday, and Friday only. An observation of Resident 18's Macrobid inside the medication cart was made with the DON on 7/12/24 at 12:23 p.m. There were 36 capsules sent from the pharmacy and four were missing. The Medication Administration policy was provided by the DON on 7/15/24 at 1:35 p.m. It indicated, "Guidelines For Medication Administration: 1. Medications are administered to residents only as prescribed and only be person licensed or qualified to do so....4. Read orders carefully to be sure that they are understood. Clarify any questions with the charge nurse or the physician. Carefully repeat and clarify verbal orders, if received....10. Always observe the six rights of giving each medication. Right Resident, Right Medicine, Right Time, Right Dose, Right Route, Right Documentation." 3.1-25(a) 3.1-25(b)(1)			

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F 9999 Bldg. 00		F 9999	No residents were affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Administrator and the Nursing Management team were re-educated on the current policy for reporting unusual occurrences. Staff has been re-educated on timely notification of unusual occurrences, including but not limited to major injury. The facility policy for reporting unusual occurrences was reviewed with no changes indicated at this time. The Administrator and the Nursing Management team were re-educated on the current policy for reporting unusual occurrences. Staff has been re-educated on timely notification of unusual occurrences, including but not limited to major injury. The Administrator will monitor all Unusual Occurrences with a special focus on major injury, to assure proper reporting of such. This monitoring will occur daily on scheduled work days for 4 weeks, weekly for 4 weeks monthly thereafter. Shall concerns be noted, immediate action shall occur. As a means of Quality Assurance, the Administrator and/or her designee will review any findings and subsequent corrective actions	08/08/2024

Based on interview and record review, the facility failed to report a fall with major injury resulting in hospitalization to IDOH (Indiana Department of Health) for 1 of 1 resident reviewed for accidents with major injury. (Resident 6)

Finding include:

The clinical record for Resident 6 was reviewed, on 7/11/24 at 10:38 a.m., and indicated that the resident was hospitalized 4/13/24-4/17/24 as a result of falling off a shower bed. The record indicated that Resident 6 sustained a subarachnoid hemorrhage as a result from this fall.

An interview with the Executive Director (ED), on 7/11/24 at 12:29 p.m., indicated that she was informed of Resident 6 falling off a shower bed on 4/13/24. She indicated that she was out of town and spoke with Resident 6's husband who told her that she was under observation and did not obtain a fracture from the fall. The ED indicated that by the time she got back into town it was past twenty-four hours. The ED indicated that she would normally report a fall with a major injury.

A policy for "Unusual Occurrences" was provided by the ED, on 7/11/24 at 2:18 p.m., and included, but was not limited to, ..." within 24 hours of emailing the Incident Reporting Form, the complete information about the incident [MUST BE] entered into the Online Incident Reporting System and include the date and time the Incident Reporting Form was emailed. If both the Online Incident Reporting System and the email system is not available, the information can be reported by

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	calling... and leaving a voicemail ... Should an unusual occurrence be reported, initial notification should be made to applicable agencies by the Administrator or his/her designee immediately upon determining a situation exists (or existed) this is reportable...."		taken: Reporting to the facility's QAA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance.	