STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/19/2024

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INDEPENDENCE VILLAGE OF ZIONSVILLE EAST	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00432248. Complaint IN00432248 - No deficiencies related to the allegations are cited. Survey dates: June 18 and 19, 2024. Facility number: 012263 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 28, 2024.	R 0000		
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure newly hired employees had documented reference checks before hire and contact with residents for 2 of 3 new hire employee records reviewed. Findings include: On 6/19/24 at 1:00 p.m., 3 newly hired employees were randomly selected for employment record review. Certified Nursing Aide (CNA) 10 was hired on 2/27/24. Her employee record lacked documentation of references checks for consideration before or upon hire.	R 0116	The recruiting team was notified of the missing documents and sent them over to the facility. Access was granted to the facility to enable the ability to view said reference checks and print them if necessary. All hiring managers will retrieve reference checks via email or the shared website and print them for their files before their orientation day. All new hires, hired within last 60 days, will be audited the first week of every other month, starting July 2024, to ensure compliance and files are accurate. The Administrator is	07/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Miller	Executive Diirector	09/13/2024

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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	Certified Nursing Aide (CNA) 11 was hired on 2/12/24. Her employee record lacked documentation of references checks for consideration before or upon hire. During an interview 6/19/24 at 11:02 a.m., the Wellness Director (WD) indicated the facility had been without a Business Office Manager (BOM) for several months. In the position's vacancy, each department was responsible for their own records and employee files had not been maintained. On 6/19/24 at 11:20 a.m., the Executive Director (ED) provided a copy of current facility policy titled, "Staffing Requirements- Indiana RCF," reviewed 2/21/23. The policy indicated, " ...the administrator is responsible for the overall management of the facility ... 11. Staff must provide at least two (2) references ...." Evidence of a pre-employment reference checks were not provided by the time of the survey exit conference.		responsible for the proper employee file management and will run all orientations moving forward. An Employee File Audit sheet file will be held in Administrator Office. Employee File Checklist will be in each Employee's File and updated as needed and during bi-monthly audits.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure at least one staff member was present on each shift who was first aide, and Cardiopulmonary Resuscitation (CPR) certified to meet the potential needs of the residents for 26 of 46 shifts reviewed for staffing. This deficient practice had the potential to affect 73 of 73 residents who resided in the facility. Findings include:	R 0117	The administrator and Wellness Director will organize and coordinate a mass CPR and First Aide training certification for all QMA's on staff for the wellness team members to ensure current compliance. Any team member that does not have a current CPR license will be removed from the floor until it is recertified. All CPR licenses will be held in a binder in	07/21/2024

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	On 1/19/24 at 2:15 p.m., the actual worked nursing schedule for June 12th through the 18th was reviewed. More than half (26 of 46) of the shifts were not covered with either or both a 1st aide and CPR certified staff member On Wednesday the 12th, there was no evidence that a CPR certified staff member worked the second shift, and no 1st Aide certified staff member worked the second or third shifts. On Thursday the 13th, there was no evidence that a CPR certified staff member worked second or third shifts, and no 1st Aide certified staff member worked the second shift. On Friday the 14th, there was no evidence that a CPR certified, or 1st Aide certified staff member worked the third shift. On Saturday the 15th, there was no evidence that a CPR certified, or 1st Aide certified staff member worked the first, second or third shifts. On Sunday the 16th, there was no evidence that a CPR certified, or 1st Aide certified staff member worked the first, second or third shifts. On Monday the 17th, there was no evidence that a CPR certified staff member worked on the second shift and no 1st Aide certified staff member worked on the second or third shift. On Tuesday the 18th, there was no evidence that a CPR certificated staff member worked on the second shift and no 1st Aide certified staff member worked on the second or third shift. On 6/19/24 at 11:20 a.m., the Executive Director (ED) provided a copy of current facility policy		the Wellness Director's Office and updated bi-monthly. ="" p="">
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	titled, "Staffing Requirements- Indiana RCF," reviewed 2/21/23. The policy indicated, " ...the administrator is responsible for the overall management of the facility .... A minimum of one (1) awake staff person, with current CPR and first aid certificates, on site at all times ...." Evidence of coverage for the missing shifts was not able to be provided by the time of the survey exit conference.			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance Based on record review and interview, the facility failed to ensure employees received general and job-specific orientation upon hire for 3 of 3 newly hired employee records reviewed. Findings include: On 6/19/24 at 1:00 p.m., 3 newly hired employees were randomly selected for employment record review. Certified Nursing Aide (CNA) 10 was hired on 2/27/24. Her employee record lacked documentation she had received both General and Job-Specific Orientation. Certified Nursing Aide (CNA) 11 was hired on 2/12/24. Her employee record lacked documentation she had received both General and Job-Specific Orientation. The Lead Receptionist was hired on 1/16/24. Her employee record lacked documentation she had received both General and Job-Specific Orientation.	R 0119	The Administrator is responsible for proper employee file management and the Administrator or Designee if unavailable, will run all orientations moving forward to ensure Employee File Checklists are complete and accurate prior to starting their job. An Employee File Audit sheet file will be held in Administrator Office. The Employee File Checklist will be in each Employee's File and updated as needed and during bi-monthly audits. All TB Tests will be done prior to or on orientation day and read on first day of work. ="" p=""> ="" p=""> ="" p=""> ="" p="">	07/21/2024

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	During an interview 6/19/24 at 11:02 a.m., the Wellness Director (WD) indicated the facility had been without a Business Office Manager (BOM) for several months. In the position's vacancy, each department was responsible for their own records and employee files had not been maintained. On 6/19/24 at 11:20 a.m., the Executive Director (ED) provided a copy of current facility policy titled, "Staffing Requirements- Indiana RCF," reviewed 2/21/23. The policy indicated, " ...the administrator is responsible for the overall management of the facility ... Staff must complete a community orientation as outlined in the Training Requirements Indiana ...." The policy lacked specifications/requirements to the Residential Care Facility rule, R11(d) " ...prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work...." The policy lacked specifications/requirements to the Residential Care Facility rules, R123 (h) " ...the facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following ... (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills ...." Evidence of General and Job-Specific Orientations were not provided by the time of the survey exit conference.			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance			

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	Based on record review and interview, the facility failed to ensure employees received/provided documentation of a physical health screen before employment and contact with residents for 3 of 3 newly hired employee records reviewed. Findings include: On 6/19/24 at 1:00 p.m., 6 randomly selected employees were sampled for employment record review. Certified Nursing Aide, (CNA) 10, hired 2/27/24, did not have a health screen on file. CNA 11, hired 2/12/24, did not have a health screen on file. Lead Receptionist, hired 1/16/24, did not have a health screen on file. During an interview 6/19/24 at 11:02 a.m., the Wellness Director (WD) indicated the facility had been without a Business Office Manager (BOM) for several months. In the position's vacancy, each department was responsible for their own records and employee files had not been maintained. On 6/19/24 at 11:20 a.m., the Executive Director (ED) provided a copy of current facility policy titled, "Staffing Requirements- Indiana RCF," reviewed 2/21/23. The policy indicated, " ...the administrator is responsible for the overall management of the facility ... 11. Staff must have a tuberculin test as outlined in the Tuberculosis Infection Control Plan Indiana ...." The policy lacked specifications/requirements to the Residential Care Facility rule, "R121 (3) ... the	R 0121	The Administrator is responsible for proper employee file management and the Administrator or Designee if unavailable, will run all orientations moving forward to ensure Employee File Checklists are complete and accurate prior to starting their job. An Employee File Audit sheet file will be held in Administrator Office. The Employee File Checklist will be in each Employee's File and updated as needed and during bi-monthly audits. All TB Tests will be done prior to or on orientation day and read on first day of work. ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	07/21/2024

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	facility shall maintain a health record of each employee that includes reports of all employment-related health screenings ...." Evidence of a pre-employment health screens were not provided by the time of the survey exit conference.			
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on record review and interview, the facility failed to ensure employee personnel files were maintained with current, accurate and required documentation for 3 of 3 newly hired employee records reviewed. Findings include: On 6/19/24 at 1:00 p.m., 3 newly hired employees were randomly selected for employment record review. Certified Nursing Aide, (CNA) 10 was hired on 2/27/24. Her employee file lacked documentation and/or evidence of the following: pre-employment reference checks, a health screen, General Orientation, Job-Specific Orientation, a signed acknowledgement of her job description did not have evidence of Residents Rights and Dementia training. CNA 11 was hired on 2/12/24. Her employee file lacked documentation and/or evidence of the following: a pre-employment health screen, General Orientation, Job-Specific Orientation, a signed acknowledgement of her job description did not have evidence of Residents Rights and Dementia training.	R 0123	The Administrator is responsible for proper employee file management and the Administrator or Designee if unavailable, will run all orientations moving forward to ensure Employee File Checklists are complete and accurate prior to starting their job. An Employee File Audit sheet file will be held in Administrator Office. The Employee File Checklist will be in each Employee's File and updated as needed and during bi-monthly audits. ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" span=""> ="" p=""> ="" p="">	07/22/2024

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	The Lead Receptionist was hired on 1/16/24. Her employee file lacked documentation and/or evidence of the following: a pre-employment health screen, General Orientation and Job-Specific Orientation. During an interview 6/19/24 at 11:02 a.m., the Wellness Director (WD) indicated the facility had been without a Business Office Manager (BOM) for several months. In the position's vacancy, each department was responsible for their own records and employee files had not been maintained. On 6/19/24 at 11:20 a.m., the Executive Director (ED) provided a copy of current facility policy titled, "Staffing Requirements- Indiana RCF," reviewed 2/21/23. The policy indicated, " ...the administrator is responsible for the overall management of the facility ...." Evidence of the above required documents were not provided by the time of the survey exit conference.			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency Based on observations, interviews and record reviews, the facility failed to ensure resident's environments remained free from the potential for accidents when bedrails were applied but not monitored or maintained in a safe operating condition for 5 of 5 residents reviewed for bedrails (Residents 49, 51, 62, 64 and 66). Findings include: On 6/19/24 from 9:37 a.m. until 9:56 a.m., a general tour of the secured memory care unit apartments	R 0148	All bed assistive devices have been removed from beds and/or negotiated risk forms have been completed. All hospice companies and families have been notified of changes and staff to be re-educated at monthly all staff meeting. Wellness Director to get negotiated risk forms for new move ins in case topic arises. Facility working to reduce amount of hospice companies to reduce	07/22/2024

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	was conducted. Resident 49 was observed as he appeared to be asleep on his bed. It appeared as if he had sat down on the side of the bed, and laid down to the side. His feet remained on the floor and his torso was in the middle of the bed. When his name was called, he opened his eyes and repositioned himself with the use of a half side rail which was installed to both sides of his bed. The rail clanked and wobbled as he applied his grip to pull himself up. Resident 49 sat up and indicated, "I almost slid off there didn't I?" When asked about his rail he indicated, it was "loose" but it worked. Resident 51's bed was observed. A small mobility bar was installed to the open side of her bed near the head of the bed. It was installed via a bar under the mattress. Resident 62's bed was observed. Bilateral side rails were installed on his bed. They wobbled up and down. Resident 64's bed was observed. An oval, half-moon shaped mobility bar was installed to the right side of his bed. It was "secured" in place by a bar under the mattress and was very easily manipulated and slid away from the mattress with a gentle pull. Resident 66's bed was observed. Bilateral side rails were installed on her bed. They were loose and wobbled both up and down and side to side. On 6/19/24 at 10:05 a.m., Residents 49, 51, 62, 64 and 66's medical record were reviewed for the indication and use of bed rails and/or mobility aides.		chances of siderails being inappropriately delivered and installed.	

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	The records lacked documentation of physician's orders for side rails/mobility aides. The records lacked initial and/or ongoing assessments of the side rails/mobility aides. The Resident's Service Plans lacked documentation of the use and/or instructions The records lacked indication for the use of the side rails/mobility aides either for mobility/safety and or restraint. During an interview on 6/19/24 at 11:02 a.m., the Wellness Director (WD) indicated, any assistive device and/or mobility aides should be used only when ordered by the physician and assessed to be safe and appropriate with ongoing monitoring to ensure safe and effective use. On 6/19/24 at 1:50 p.m., the WD provided a copy of current facility policy titled, "Bedside Mobility Aides," reviewed 11/27/23. The policy indicated, " ...Our communities allow for the use of certain bedside mobility aides with an appropriate Healthcare Provider order and after review by the Wellness Director. All staff should adhere to the following ... side rails of any length are not allowed ... all residents utilizing bedside mobility aides should have a Negotiated Agreement, or other state required form completed, making sure all risks are full disclosed ... a Healthcare provider must indicated that the bedside mobility aid is to be used for movement and positioning ... Specific instructions related to bedside mobility aides and their use should be documented on the resident's service plan, reviewed with staff, and updated regularly per existing standards or upon a residents change in condition ... The use of bedside mobility aids should be reviewed at the			

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	time for the scheduled resident reevaluation or upon a change in condition ... IF the resident is on hospice, and hospice is providing a bed, the bed and any bedside mobility aide used must comply with this policy ...."			
R 0150 Bldg. 00	410 IAC 16.2-5-1.5(g) Sanitation & Safety Standards -Noncompliance Based on record review and interview, the facility failed to ensure Resident's pets maintained current vaccinations and obtained a vaccination record before permitting the pet into the community for 2 of 5 Resident pet records reviewed (Resident 6 and 32). Findings include: During the survey entrance conference on 6/18/24 at 10:00 a.m., the facility's current Pet Policy and vaccination records for all animals were requested of the Executive Director (ED). On 6/18/24 at 2:00 p.m., the ED provided a copy of Residents 6's pet vaccination record and the current facility policy. At that time, the ED indicated, Resident 32's pet did not have vaccination records on file. The pet had lived in the community for approximately 8 months. On 6/18/24 at 2:05 p.m., Resident 6's pet record was reviewed. The pet's Rabies vaccination expired on 11/5/23. The record lacked documentation of a current Rabies vaccination. The facility policy was titled, "Pet Policy- Unsecured Areas," reviewed 8/1/17. The policy indicated, "the purpose of the Pet- Unsecured	R 0150	The Administrator and Life Enrichment Director will keep identical files of all current and incoming pet vaccination records and set Outlook calendar reminders and alerts to keep track electronically, along with quarterly review, again set with electronic calendar reminders.	07/22/2024

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	Areas policy is to protect and enhance our resident and visitor experiences while maintaining the health, well-being and safety of all residents, guests and employees ... Before a pet moved into a licensed assisted living area it requires review and approval of the Regional Director of Wellness ... all residents with pets residing within the community must submit an annual health record ... The resident/responsible party agrees to register and immunize the pet in accordance with local laws and requirements ...." Evidence of a an updated pet vaccinations were not provided by the time of the survey exit conference.			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on record review and interview, the facility failed to hold a medication when a resident's vital signs were outside the ordered parameters for 1 of 1 resident (Resident 66). Findings include: On 6/18/24 at 11:16 a.m., a record review was conducted for Resident 66. She had the following diagnoses which included but were not limited to dementia, hypertension, hyperlipidemia and chronic pain. Resident 66 had orders for metoprolol (a medication used to treat hypertension) 50 milligrams (mg) by mouth one time daily related to essential hypertension. Hold medication for pulse less than 60. Resident 66 had a pulse less than 60 and metoprolol was given on the following days.	R 0247	Wellness director to reeducate all Medication Aides on proper medication administration policies and procedures and are hiring LPNs to replace the QMAs on most shifts to reduce med errors. Residents on parameters will all be reviewed by NP weekly at wellness meeting for perpetuity. All possible residents were at risk for these oversights and any parameters will be monitored daily by wellness director.	07/22/2024

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	a.) On 4/20/24: pulse was 54 b.) On 4/28/24: pulse was 48 c.) On 5/1/24: pulse was 55 d.) On 5/20/24: pulse was 54 e.) On 6/1/24: pulse was 59 f.) On 6/2/24: pulse was 52 g.) On 6/16/24: pulse was 59 Resident 66's record lacked documenation of the medication error and notification of the physician. On 6/19/24 at 2:15 p.m., during an interview with the Wellness Director, she acknowledged the medication errors. A policy titled "Medication Administration" was provided by the Wellness Director on 6/19/24 at 1:19 p.m. It indicated, " ... Medication will be administered to residents as prescribed ...".			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure all foods were dated, a cooler maintained the correct temperature, trash cans had lids, and a janitor's bucket in the kitchen did not have dirty water for 2 of 2 observations of the kitchen. Findings include: On 6/18/24 at 9:47 a.m., the kitchen tour was completed with the Dining Room Lead (DRL). A janitor bucket filled with dirty water, a cloudy, wrinkled film was observed on top of the water was observed in the kitchen. The DRL indicated it should have been emptied. The janitor bucket was	R 0273	Executive Chef was on medical leave while findings occurred. Executive Chef is currently restaffing and retraining his culinary team on food safety and company policies. Sous Chef position has been posted for some time and awaiting qualified candidates to help maintain quality standards. Executive Chef has work orders into maintenance for hand sinks, is ordering new trashcan lids and has maintenance coming to work on fridge temps and PM equipment. Sous Chef usually supports while	07/22/2024

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	observed within approximately 8 feet of the nearest food preparation (prep) table. The janitor sink area was an open area without a door. The janitor's sink, on the floor, was dirty with blackened debris around the sink's edges. On 6/18/24 at 9:49 a.m., Cook 5 indicated the Sous Chef 7 was in charge while the facility's Chef 13 was off on medical leave. A large trash can, with trash inside, without a lid, was observed in the kitchen. Breakfast was finished and Cook 5 indicating she was starting on lunch. In the walk-in refrigerator, several items did not have dates: a. A plastic bag of shredded cheese. b. Feta cheese wrapped in plastic wrap. c. Parmesan cheese. d. Cream cheese. e. A browned head of lettuce. f. Three plastic bags of cole slaw. g. Two plastic bags of broccoli slaw. On 6/18/24 at 9:59 a.m., The DRL asked Cook 5 to throw out the browned lettuce. On 6/18/24 at 10:00 a.m., Cook 5 was observed dating the plastic bags of cole slaw and broccoli slaw. In the walk-in freezer, 3 uncovered ice cream sundaes were observed with no date. Another open trash can with no lid was observed beside the deep fryer. A cooler called the Make Table was observed to be 50 degrees Fahrenheit (F). Some of the food		Executive Chef's are on leave to avoid these opportunities. Chef to maintain cleaning logs and supervising completion daily and shift lead to manage on days off.	

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	stored in the top part of the cooler were: a. American cheese slices b. Tomatoes c. Pickles d. Onion e. Lettuce On 6/18/24 at 11: 22 a.m., a second observation of the kitchen was completed was Sous Chef 7. She indicated she was in charge while the Chef 13 was out on medical leave. On 6/18/24 at 11:23 a.m., the large trash can was observed with no lid. Sous Chef 7 indicated the large trash can should have had a lid on it. Sous Chef 7 checked the temperatures of the Make Table cooler foods. After finding the American cheese and pickles were at 42 degrees F., she indicated to Cook 5, all the foods in the Make Table would be discarded. On 6/18/24 at 11:18 a.m., Sous Chef 7 indicated the Make Table cooler should have been serviced. She was unaware whether Chef 13 requested a service on the cooler before he left for medical leave. A current policy, titled, "Department Specific Procedures - Culinary Services," dated 2/17/22, was provided by the Executive Director (ED), on 6/19/24 at 10:04 a.m. A review of the policy indicated, " ...Items below must be maintained at the Serve Safe ® recommended temperatures: a. All potentially hazardous food must be kept at 41 degrees F or less ..." A current policy, titled, "Trash Removal," dated 1/26/23, was provided by the Executive Director (ED), on 6/19/24 at 10:04 a.m. A review of the			

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	policy indicated, " ...All trash cans for the kitchen will have a lid on at all times whether cans are used or unused. Culinary will have used and unused trash cans with a lid on at all times ...." Other policies to address the concerns, as stated above, were requested on 9/19/24 at 9:38 a.m., of the ED, but were not provided by the end of the survey exit conference.			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance Based on observation, interview, and record review, the facility failed to ensure medications were secured for self-administration residents according to policy for 2 of 4 residents reviewed for self-medication administration (Resident 14 and 36). Findings include: 1. On 6/18/24 at 11:56 a.m., Resident 14's medications were reviewed in her apartment. On her night stand, she had: a Eliquis (anticoagulant) 2.5 milligrams (mg) b. Amiodarone (for irregular heartbeat) 200 mg In an unlocked plastic container, next to her living room recliner, she had: a Furosemide (for edema) b. Venlafaxine (for depression) 75 mg c. Gabapentin (for neuropathy) 300 mg d. Metformin (for hyperglycemia) 500 mg e. Metoprolol (for high blood pressure) 25 mg f. Atorvastatin (for hyperlipidemia) 20 mg During an interview, on 6/18/24 at 12:05 p.m., Resident 14 indicated when she and her husband	R 0295	Administrator has purchased cabinet locks and will install on all residents that self-administer medications. Wellness Director to educate all self-administering residents on new process for having to lock up medications when not in use and locking apartment doors as well. Bi-weekly checks from wellness team/ nurses to see if doors are locked and cabinets closed will help ensure compliance. Check sheets for door/lock/cabinet checks will be help in resident care supervisor's office. Wellness Director to bring up at weekly wellness meeting and test random resident's doors. Those residents who fail to comply may lose the ability to self-administer.	07/22/2024

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	go to a doctor's appointment, outside the facility, they do not lock their door. On 6/19/24 at 1:50 p.m., her clinical record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus (blood sugar disorder), depression, hypertension (high blood sugar), and atrial fibrillation (heart rhythm disorder). 2. On 6/18/24 at 1:03 p.m., Resident 36's medications were reviewed in her apartment. She indicated she kept all her medications in a bedroom drawer. a Hydrochlorothiazide (for edema, hypertension) 25 mg b. Carvedilol (for high blood pressure) 2.5 mg c. Lisinopril (for high blood pressure) 40 mg d. Nifedipine (for high blood pressure) 60 mg e. Risperidone (to treat behavioral problems) 0.5 mg f. Aspirin (anticoagulant) 81 mg g. Blink eye drops (for dry eye syndrome) On 6/18/24 at 1:25 p.m., Resident 36 was observed leaving her apartment unlocked when she left to go downstairs. On 6/19/24 at 1:55 p.m., her clinical record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and heart failure. A current policy, titled, "Medication - Resident Self Administration," dated 6/10/22, was provided by the Executive Director (ED), on 6/19/24 at 10:04 a.m. A review of the policy indicated, " ...All medications must be secured in a locked storage container including medications requiring			

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	refrigeration ...Responsibility for medication storage, administration, and refills shall be outlined on the resident's service plan ...."			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency Based on record review and interview, the facility failed to label over the counter medications, date medications, and remove expired medications for 1 of 1 medication refrigerator and 1 medication cart. Findings include: 1. On 6/18/24 at 10:32 a.m. the medication room refrigerator was observed in the presence of QMA 6. The refrigerator was stuck and difficult to open. The freezer portion of the refrigerator was covered with approximately 6 inches of ice and water was dripping from the refrigerator. The temperature was 40 degrees. 2. Resident 50 had a bottle of lorazepam 2 mg/ml (milligrams/milliliters) in the refrigerator. The bottle lacked a date to indicate when it was opened. 3. Resident 68 had a bottle of lorazepam 2 mg/ml in the refrigerator. The bottle lacked a date to indicate when it was opened. 4.) Resident 52 had a bottle of Xalatan in the medication cart. The bottle lacked a date to indicate when it was opened. 5.) Resident 48 had a container of Metamucil. It lacked a label. 6.) Resident 53 had a bottle of melatonin 3 mg. It lacked a label.	R 0298	New fridges have been purchased to replace the old frozen fridges. Medication policy is attached. More nurses are being hired for improved consistency and med management and administration. The QMAs and Nurses will do a cart and nurses station purge and cleaning to make all med carts current and accurate and more organized. New Administrative Nurse is to be hired to help purge files, audit fridges and carts.	07/22/2024

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	7.) Resident 64 had a bottle of vitamin D3 50 mcg/2000IU with no label. 8.) There was a bottle of fish oil in the medication cart. It lacked a name and label. On 6/18/24 at 10:45 a.m. QMA witnessed identification of medications lacking labels, expiration dates and dates to indicate when opended. On 6/18/24 at 2:10 p.m. and again on 6/19/24 at 10:45 a.m., a policy for medication storage was requested of the Wellness Director. The policy was not received at the time of exit.			