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	12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00411708. Complaint IN00411708. State deficiencies related to the allegations are cited at R0217, R0241 and R0243. Survey date: December 27 and 28, 2023 Facility number: 014548 Residential Census: 41 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 2, 2024	R 0000		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Crystal L Werner	Administrator	01/24/2024

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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	request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure 2 of 3 residents reviewed for injectable diabetic medications had their service plans reflect the facility staff would assist with the preparation of the injectable diabetic medications and the facility staff would supervise the resident when the resident injected the medication. (Residents B and C) Findings include: 1. The clinical record of Resident B was reviewed on 12-27-23 at 10:13 a.m. Her diagnoses included, but were not limited to, type 2 diabetes, congestive heart failure and hypertension. Her most current medication orders for December, 2023, included physician orders for Ozempic 2 mg/3 ml [milligrams per milliliter], inject subcutaneously [under the skin] once weekly and Humulin N insulin, inject 39 units subcutaneously twice daily with breakfast and dinner. It indicated she had resided at the facility for over one year. A review of Resident B's most recent service plan, dated 10-19-23, indicated she did not self-administer her medications, but required no	R 0217	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice-** The service plans for the two affected residents will each be updated to reflect that staff will assist with the preparation of the injectable diabetic medications & will supervise the resident as the resident injects the medication. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken-** A review of the MAR will be conducted to identify all other residents with orders for injectable diabetic medications. All additional residents with orders for injectable diabetic medications will have their services plans updated	01/31/2024

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	assistance with injections. A notion indicated staff administers all medication. An associated document, untitled, but indicated to be a determination of her "level of care," dated 8-1-23, indicated the facility's "Licensed/Certified Staff to Administer Medication," would administer her medications. It did not indicate "Nurse administered injections (weekly or monthly)." It did not specify the facility staff would assist with the preparation of any injectable diabetic medications and the facility staff would supervise the resident when the resident injected the medication. In an interview with the Administrator on 12-27-23 at 10:30 a.m., she shared the facility currently has only one certified QMA who can administer insulin. She indicated the facility does not have the nurses or QMA's administer the insulin. She added the facility staff assist the resident in preparing the dosing for their insulin, or whatever the injectable is, which may include dialing up the correct insulin (or other medication) dosage and observing the resident while they inject the medication. She indicated the specific action of the resident administering the medication with assistance from facility staff in the preparation of the medication and under direct supervision of a facility staff member was not addressed in each resident's service plan. 2. The clinical record of Resident C was reviewed on 12-27-23 at 3:35 p.m. His diagnoses included, but were not limited to, type 2 diabetes and hypertensive heart disease with heart failure. His most current medication orders for December, 2023, included physician orders for Ozempic 8 mg/3 ml [milligrams per milliliter], inject 1 mg subcutaneously [under the skin] once weekly and Toujeo Solo insulin, 300 units/ml, inject 65 units		to reflect that staff will assist with the preparation of the injectable diabetic medications & will supervise the resident as the resident injects the medication. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur-** Nurse and DON training will include specific detail related to appropriate inclusion/documentation within the service plan(s) of the details for administration of injectable diabetic medications. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place-** 100% of all service plans developed for residents with orders for injectable diabetic medications will be reviewed by the Administrator prior to implementation for inclusion of the details specific to the administration of injectable medications. An audit of all new and/or updated service plans for residents with orders for injectable diabetic medications will be conducted monthly for 6 months.	

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	subcutaneously every morning and 60 units every evening. It indicated he had resided at the facility for over one year. A review of Resident C's most recent service plan, dated 10-16-23, indicated he did not self-administer her medications, but required no assistance with injections. A notion indicated staff administers all medication. An associated document, untitled, but indicated to be a determination of her "level of care," dated 8-1-23, indicated the facility's "Licensed/Certified Staff to Administer Medication," would administer her medications. It did not indicate "Nurse administered injections (weekly or monthly)." It did not specify the facility staff would assist with the preparation of any injectable diabetic medications and the facility staff would supervise the resident when the resident injected the medication. In an interview with the Administrator on 12-27-23 at 10:30 a.m., she shared the facility currently has only one certified QMA who can administer insulin. She indicated the facility does not have the nurses or QMA's administer the insulin. She added the facility staff assist the resident in preparing the dosing for their insulin, or whatever the injectable is, which may include dialing up the correct insulin (or other medication) dosage and observing the resident while they inject the medication. She indicated the specific action of the resident administering the medication with assistance from facility staff in the preparation of the medication and under direct supervision of a facility staff member was not addressed in each resident's service plan. On 12-28-23 at 11:41 a.m., the Administrator provided a copy of an undated document entitled,			

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	"Assessment and Evaluation of Resident Needs Policy." This policy was identified as the current policy utilized by the facility. This policy indicated, "An evaluation of the needs of each resident will be conducted prior to admission and updated at least semiannually and upon change in condition. Upon a change in condition, the Medical Provider and POA are notified. A licensed nurse will evaluate the nursing needs of the resident...The needs assessment will include an evaluation of the following...physical, cognitive, and mental status...independence in the activities of daily living...ability to self-administer medications. The evaluation will be documented in writing and kept in the facility. Following completion of an evaluation, the facility, using appropriately trained staff members, will identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference of the resident. (2) The services offered will be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change This Residential tag relates to Complaint IN00411708. 2.5-2(e)(1)(A) 2.5-2(e)(1)(B) 2.5-2(e)(1)(C) 2.5-2(e)(1)(D) 2.5-2(e)(2)			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and			

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	shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure each injectable diabetic medication was properly administered according to the physician orders and properly transcribed onto each resident's clinical record for 2 of 3 residents reviewed for injectable diabetic medications. (Residents B and C) Findings include: 1. The clinical record of Resident B was reviewed on 12-27-23 at 10:13 a.m. Her diagnoses included, but were not limited to, type 2 diabetes, congestive heart failure and hypertension. Her most current medication orders for December, 2023, included physician orders for Ozempic 2 mg/3 ml [milligrams per milliliters], inject subcutaneously [under the skin] once weekly and Humulin N insulin, inject 39 units subcutaneously twice daily with breakfast and dinner. It indicated she had resided at the facility for over one year. A review of Resident B's orders for Ozempic indicated as of June, 2023, she was to receive "Ozempic 0.25-0.5 mg [milligrams] dose pen, inject 0.5 mg (0.4 ml [milliliters] subcutaneously every week." This order was indicated to have been initiated on 11-18-22. A medication administration record (MAR) for July, 2023, indicated she was to receive "Ozempic 1 mg dose pen (3 ml), inject 1 mg into the skin once a week." This order did not specify the strength of the 3 ml pen. According to the manufacturer Norodisk's website for "Ozempic," this medication is available in the following strengths: 2 mg/1.5 ml, 4 mg/3 ml and 8	R 0241	p="" xml:="" paraid="1411862335" paraeid="{4b8b2bd9-6548-4099-83d8-97d9433846b3}{18}" what="" corrective="" action(s)="" will="" be="" accomplished for="" those="" residents="" found="" to="" have="" been="" affected="" by="" the="" deficient="" practice- The MAR for the two affected residents will be reviewed and updated to correct the transcription error and properly reflect the dose per the MD orders. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken- A review of the MAR will be conducted to identify all other residents with orders for injectable diabetic medications who may have transcription errors and if found, will be corrected to properly reflect the dose per the MD orders. Training will be conducted with all QMAs and LPNs regarding the appropriate response to identifying any discrepancy between the MAR and the original MD order responsibility to alert the DON immediately so that a timely correction can be made. How the corrective action(s) will be monitored to ensure the deficient	01/31/2024

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	mg/3 ml. A review of the August, 2023 recapitulation orders for Resident B indicated she was to receive, "Ozempic Inj 2 mg/3 ml, inject 1.5 ml (1 mg) subcutaneously once weekly. An order was received on 8-26-23 for Resident B to receive "semaglutide (Ozempic) 1 mg/dose (4mg/3 ml)...inject 1 mg into the skin once a week." The corresponding August, 2023 MAR indicated the same. The September, 2023 recapitulation orders reflected this as, "Ozempic Inj 2 mg/3 ml, [administer] 1 ml subq on Monday!" The dosing of 1 ml would not yield a dose of 1 mg, but of 0.67 mg. The corresponding September, 2023 MAR had a handwritten entry of "Ozempic Inj. 3 mg/2 ml [administer] 1 ml [note 1 ml was underlined] subq on Monday!" The October, 2023 recapitulation orders indicated, "Ozempic Inj 2 mg/3ml. Inject subcutaneously once a week on Monday." A handwritten notation indicated the dosage as "1 ml," which would yield a dosage of 0.67 mg. The October, 2023 MAR indicated the same. No additional order changes for Ozempic were identified after the 8-26-23 order update to administer 1 mg weekly. The MAR for November and December, 2023 reflected the order as, "Ozempic Inj 2 mg/3ml. Inject 1ml subcutaneously once a week on Monday." This dosing of 1 ml would have yield a dose of 0.67 mg. In an interview with the Administrator on 12-27-23 at 11:15 a.m., she indicated it appeared there may have been some confusion with the terminologies of milligram and milliliter, related to the strength of		practice will not recur, i.e., what quality assurance program will be put into place-	

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	the Ozempic ordered. In a related interview on 12-28-23 at 10:00 a.m., the Administrator indicated she was unable to locate any additional orders for the Ozempic after the orders in late August, 2023. In an interview with the Administrator on 12-27-23 at 10:30 a.m., she shared the facility currently has only one certified QMA who can administer insulin. She indicated the facility does not have the nurses or QMA's administer the insulin. She added the facility staff assist the resident in preparing the dosing for their insulin, or whatever the injectable is, which may include dialing up the correct insulin (or other medication) dosage and observing the resident while they inject the medication. In an interview on 12-27-23 at 3:55 p.m., with the Administrator, she shared it appeared to her as the Ozempic orders in place in August were correct and for some reason fell off of the MAR, then in September, 2023, they were handwritten onto the MAR for September, 2023, using the term "ML" instead of "MG." In another interview with the Administrator on 12-27-23 at 4:15 p.m., she indicated she and a facility QMA were looking at the Ozempic pens. "They do not give you the option of dialing in the number of milliliters, just the number of of milligrams." 2. The clinical record of Resident C was reviewed on 12-27-23 at 3:35 p.m. His diagnoses included, but were not limited to, type 2 diabetes and hypertensive heart disease with heart failure. His most current medication orders for December, 2023, included physician orders for Ozempic 8 mg/3 ml [milligrams per milliliter], inject 1 mg subcutaneously [under the skin] once weekly and			

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	Toujeo Solo insulin, 300 units/ml, inject 65 units subcutaneously every morning and 60 units every evening. It indicated he had resided at the facility for over one year. A post-hospitalization discharge summary, dated 8-29-23, indicated his current Ozempic orders remained unchanged for that time period, to inject 2 mg of the 8 mg/3ml strength subcutaneously every week. The corresponding medication administration record (MAR) for September, 2023 had a typewritten entry of, "Ozempic Inj. 8 mg/3ml, inject (unclear) subcutaneously once a week on Monday." At the point of the unclear portion of the entry was a handwritten entry indicating, "1 mg." An unidentified hospital document, dated 9-4-23, indicated orders for, "Ozempic 2mg/dose 8mg/3ml pen injector, 1 mg subcut qweek [weekly]." No other updated orders were located prior to the October, 2023 recapitulation orders, which reflected the same, with clarification to administer the medication on Mondays of each week. The corresponding MAR reflected the same. A medication list, dated 10-21-23, from the attending physician's office for Resident C, indicated, "Ozempic 1 mg subcutaneous every week." This order did not reflect the strength to be utilized. Another medication list, dated 10-24-23, from an area hospital for Resident C, indicated, "semaglutide 2 mg dose (8mg/3 ml) subcutaneous pen injector Ozempic, 1 mg subcutaneously every week." No additional Ozempic orders were located through the exit date of the survey. This information was the same on the recapitulation orders and the MAR for November and December, 2023.			

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	In an interview with the Administrator on 12-27-23 at 10:30 a.m., she shared the facility currently has only one certified QMA who can administer insulin. She indicated the facility does not have the nurses or QMA's administer the insulin. She added the facility staff assist the resident in preparing the dosing for their insulin, or whatever the injectable is, which may include dialing up the correct insulin (or other medication) dosage and observing the resident while they inject the medication. The Administrator provided a copy of an undated procedure entitled, "Medication Program," on 12-28-23 at 11:38 a.m. It was indicated to be the current policy utilized by the facility. This document indicated, "This community will provide a medication program offering two options with regard to medication regimen," for those residents who wish to self-administer medications or wish to have the facility oversee their medications...All Medical Provider's Orders (i.e., prescriptions, discharge orders, telephone, faxes, Medical Provider's order form, etc.) will be signed, dated, and kept in the Resident's medical chart in chronological order, with the most current order first...Current medication orders to include dosage, frequency, time, route of medications and indications...The Director of Nursing (or designee) will review the monthly MAR's for accuracy prior to use. Any discrepancies will be corrected...When the person who records the changes in the designee [sic], the Director of Nursing will verify the accuracy of the changes...Injectable medications will be given only by licensed personnel (see QMA Insulin administration policy)...Insulin may only be: Self-administered; [or] Administered by licensed staff; Administered by certified trained Staff if permitted by State Law Regulations; Assisted by			

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	certified trained staff if permitted by State Law Regulations...." This Residential tag relates to Complaint IN00411708. 2.5-4(e)(1)			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure facility staff who administered medications to residents completed the documentation to accurately reflect the medications were administered for 2 of 3 residents reviewed for injectable diabetic medications. (Residents B and C) Findings include: 1. The clinical record of Resident B was reviewed on 12-27-23 at 10:13 a.m. Her diagnoses included, but were not limited to, type 2 diabetes, congestive heart failure and hypertension. Her most current medication orders for December, 2023, included physician orders for Ozempic 2 mg/3 ml [milligrams per milliliter], inject subcutaneously [under the skin] once weekly and Humulin N insulin, inject 39 units subcutaneously twice daily with breakfast and dinner. It indicated she had resided at the facility for over one year.	R 0243	="" p=""> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice-** The MAR for the two affected residents will be reviewed and updated by each individual QMA or LPN who administered medication to these residents to accurately reflect all medication administered, especially for any missing documentation for the months of December 2023 and January 2024. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	01/31/2024

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	A review of the medication administration records (MAR) for September, October, November and December, 2023, for the administration of her physician-ordered Ozempic and Humulin-N insulin failed to acknowledge the administration of these medications as evidenced by a lack of initialing the correct date block for each medication given to the resident. Those dates are as listed below. -Ozempic: 9-11-23 and 9-18-23. -Humulin-N insulin: 7:00 a.m. dose on 9-14-23, 9-15-23, 9-16-23, 9-17-23, 9-18-23, 9-27-23, 9-28-23, 9-30-23, 11-4-23, 11-5-23, 11-22-23, 12-15-23, 12-20-23 and 12-21-23. 8:00 p.m. dose on 9-6-23, 9-7-23, 9-11-23, 9-18-23, 9-25-23, 9-26-23 and 9-27-23,10-2-23, 10-9-23, 10-16-23, 10-24-23, 11-6-23, 11-7-23, 11-11-23, 11-27-23,12-15-23, and 12-20-23. In an interview with the Administrator on 12-27-23 at 10:30 a.m., she shared the facility currently has only one certified QMA who can administer insulin. She indicated the facility does not have the nurses or QMA's administer the insulin. She added the facility staff assist the resident in preparing the dosing for their insulin, or whatever the injectable is, which may include dialing up the correct insulin (or other medication) dosage and observing the resident while they inject the medication. 2. The clinical record of Resident C was reviewed on 12-27-23 at 3:35 p.m. His diagnoses included, but were not limited to, type 2 diabetes and hypertensive heart disease with heart failure. His most current medication orders for December, 2023, included physician orders for Ozempic 8 mg/3 ml [milligrams per milliliter], inject 1 mg subcutaneously [under the skin] once weekly and Toujeo Solo insulin, 300 units/ml, inject 65 units		**taken-** A review of the MAR will be conducted to identify all other residents with orders for injectable diabetic medications who may have missing documentation of medication administration. All additional residents with orders for injectable diabetic medications with missing documentation will have the documentation updated to accurately reflect the administration of all injectable diabetic medications. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur-** Training will be conducted with all QMAs and LPNs regarding appropriate documentation of medication administration for injectable diabetic medications. All duplicate documentation forms will be removed from the binder containing the MAR. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place-** 100% of all MARs for residents with orders for injectable diabetic medications will be reviewed by the DON daily for 3 months, then spot checked 3 times weekly for 3 months. The Administrator will additionally review the MAR weekly for 6	

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	12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

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	subcutaneously every morning and 60 units every evening. It indicated he had resided at the facility for over one year. A review of the medication administration records (MAR) for September, October, November and December, 2023, for the administration of her physician-ordered Ozempic and Humulin-N insulin failed to acknowledge the administration of these medications by a lack of initialing the correct date block for each medication. Those dates are as listed below. -Ozempic: 9-18-23 and 12-11-23. -Toujeo: Morning dose: 9-18-23, 9-23-23, 9-24-23, 9-27-23, 9-28-23, 11-5-23, 11-30-23, 12-15-23, 12-21-23, 12-25-23 and 12-26-23. -Toujeo: Evening dose: 9-6-23, 9-11-23, 9-17-23, 9-18-23, 9-26-23, 11-21-23, 11-26-23, 11-27-23, 12-18-23, 12-26-23 and 12-27-23. In an interview with the Administrator on 12-27-23 at 10:30 a.m., she shared the facility currently has only one certified QMA who can administer insulin. She indicated the facility does not have the nurses or QMA's administer the insulin. She added the facility staff assist the resident in preparing the dosing for their insulin, or whatever the injectable is, which may include dialing up the correct insulin (or other medication) dosage and observing the resident while they inject the medication. The Administrator provided a copy of an undated procedure entitled, "Medication Program," on 12-28-23 at 11:38 a.m. It was indicated to be the current policy utilized by the facility. This document indicated, "...Medication Administration will be provided by a licensed nurse or Qualified Medication Aid (QMA) as ordered by the physician and will be supervised		months. An audit of all new and/or updated service plans for residents with orders for injectable diabetic medications will be conducted monthly for 6 months.	

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	by the Director of Nursing. The licensed nurse or QMA will document the medication administration in the MAR, indicating time, name of medication, dose and initials of the person administering the medication. Injectable medications will be given only by licensed personnel (see QMA Insulin administration policy)...Staff will document a medication is given by initialing the block on the MAR using blue or black ink...When a resident refuses medication or treatment, staff will circle the block on the MAR for the corresponding medication. The reason for the refusal should be recorded on the back of the MAR and include the initials of the staff...All medication errors are reported immediately to the Director of Nursing (or designee). Errors may include the following...Missed dose--Medication ordered, but not given...Insulin may only be: Self-administered; [or] Administered by licensed staff; Administered by certified trained Staff if permitted by State Law Regulations; Assisted by certified trained staff if permitted by State Law Regulations...." This Residential tag relates to Complaint IN00411708. 2.5-4(e)(3)(D)			