Crystal L Werner

PRINTED: 01/25/2024 FORM APPROVED OMB NO. 0938-039

01/24/2024

		X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. W	JILDING ING	00	COMPL 12/28/	
			D. W.	_	DDDEGG OWN OF THE STREET	12/20/	2020
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY		
TIMBER	CREEK VILLAGE				YVILLE, IN 46176		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG R 0000	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
17 0000							
Bldg. 00							
			R 0	000			
	This visit was for the Investigation of Complaint IN00411708.						
	_	1708. State deficiencies related re cited at R0217, R0241 and					
	Survey date: Decer	nber 27 and 28, 2023					
	Facility number: 014548 Residential Census: 41						
	These State Resider accordance with 41	ntial Findings are cited in 0 IAC 16.2-5.					
	Quality review com	upleted on January 2, 2024					
R 0217	410 IAC 16.2-5-2(e)(1-5)					
	Evaluation - Defici	iency					
Bldg. 00		pletion of an evaluation, the					
		opriately trained staff					
		entify and document the vided by the facility, as					
	follows:	vided by the lacility, as					
		ffered to the individual					
	resident shall be a						
	(A) scope;						
	(B) frequency;						
	(C) need; and						
	(D) preference; of the resident.						
		ffered shall be reviewed and					
	, ,	riate and discussed by the					
		ty as needs or desires					
	change. Either the	e facility or the resident may					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	E	TITLE		(X6) DATE

Any defiency statement 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 disclodays 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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Administrator

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
			B. WI	NG		12/28/	2023
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID	PROVIDENCENT AN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	request a service (3) The agreed up signed and dated of the service plar resident upon req (4) No identification services provided subsequent to the no need for a chan (5) If administration provision of reside both, is needed, a involved in identifit the services to be Based on interview failed to ensure 2 or injectable diabetic in plans reflect the fact preparation of the interview failed to ensure 2 or injectable diabetic in plans reflect the fact preparation of the interview failed to ensure 2 or injectable diabetic in plans reflect the fact preparation of the interview failed to ensure 2 or injectable diabetic in (Residents B and C). Findings include: 1. The clinical reconstruction on 12-27-23 at 10:1 but were not limited congestive heart fair most current medic 2023, included physmall [milligrams subcutaneously [un Humulin N insulin, twice daily with breath and resided at the conference of Resided dated 10-19-23, included play-23, included play-24, included play-	plan review. con service plan shall be by the resident, and a copy in shall be given to the uest. con and documentation of its needed if evaluations initial evaluation indicate inge in services. con of medications or the cential nursing services, or ilicensed nurse shall be cation and documentation of provided. and record review, the facility if 3 residents reviewed for medications had their service cility staff would assist with the injectable diabetic medications if would supervise the resident injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication. cord of Resident B was reviewed injected the medication.	R 02		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 to 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 as what corrective action will be conducted to identify all other residents with orders for inject diabetic medications. All additional residents with order injectable diabetic medications have their services plans updated.	se i he s & he n y and e able s for s will	01/31/2024

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	ľ í	JILDING	00	COMPL	
			B. WI			12/28/	
						.2,20	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					OGRESS PARKWAY		
IIMBER	CREEK VILLAGE			SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	assistance with inje	ections. A notion indicated			to reflect that staff will assist	with	
		l medication. An associated			the preparation of the injectal	ole	
	document, untitled	, but indicated to be a			diabetic medications & will		
		er "level of care," dated 8-1-23,			supervise the resident as the		
		ty's "Licensed/Certified Staff to			resident injects the medicatio	n.	
		ation," would administer her					
		l not indicate "Nurse			What measures will be		
	administered injections (weekly or monthly)." It				put into place or what syste		
	did not specify the facility staff would assist with				changes the facility will make	(e	
	the preparation of any injectable diabetic				to ensure that the deficient		
	medications and the facility staff would supervise				practice does not recur-		
	the resident when the resident injected the				Nurse and DON training will		
	medication.				include specific detail related	to	
					appropriate		
		h the Administrator on 12-27-23			inclusion/documentation with		
		shared the facility currently has			service plan(s) of the details t	for	
		QMA who can administer			administration of injectable		
		ted the facility does not have			diabetic medications.		
	-	's administer the insulin. She			l		
	_	taff assist the resident in			How the corrective action(-	
		g for their insulin, or whatever			will be monitored to ensure	the	
	-	hich may include dialing up the			deficient practice will not		
		other medication) dosage and			recur, i.e., what quality	4	
	_	ent while they inject the			assurance program will be p	out	
		dicated the specific action of			into place-		
		stering the medication with ility staff in the preparation of			100% of all service plans	ordoro	
		under direct supervision of a			developed for residents with of for injectable diabetic medical		
		er was not addressed in each			will be reviewed by the	110115	
	resident's service p				Administrator prior to		
	1001doin 5 doi vice p	±••11.			implementation for inclusion of	of the	
	2. The clinical reco	ord of Resident C was reviewed			details specific to the	J. 1110	
		5 p.m. His diagnoses included,			administration of injectable		
		d to, type 2 diabetes and			medications. An audit of all r	new	
	hypertensive heart disease with heart failure. His				and/or updated service plans		
		eation orders for December,			residents with orders for inject		
		rsician orders for Ozempic 8			diabetic medications will be		
		ns per milliliter], inject 1 mg			conducted monthly for 6 mon	ths.	
		ider the skin] once weekly and				.=-	
		n, 300 units/ml, inject 65 units					

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PRINTED: 01/25/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ILDING	00	COMPL 12/28/	ETED
	ROVIDER OR SUPPLIER		990 PR	DDRESS, CITY, STATE, ZIP COD DGRESS PARKWAY /VILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
		ry morning and 60 units every d he had resided at the facility				
	dated 10-16-23, ind self-administer her assistance with inject staff administers all document, untitled, determination of he indicated the facility. Administer Medicat medications. It did administered injectified in the preparation of a medications and the the resident when the medication. In an interview with at 10:30 a.m., she slonly one certified Quinsulin. She indicate the nurses or QMA' added the facility stepreparing the dosing the injectable is, who correct insulin (or one observing the resident administration). She income in the resident administration and the medication and the medication and the medication and the medication and the resident administration and the medication and the medication and the resident administration and the medication and the medication and the medication and the resident administration administration and the resident administration and the resident ad	medications, but required no ctions. A notion indicated medication. An associated but indicated to be a r "level of care," dated 8-1-23, y's "Licensed/Certified Staff to tion," would administer her not indicate "Nurse ons (weekly or monthly)." It facility staff would assist with my injectable diabetic facility staff would supervise he resident injected the at the Administrator on 12-27-23 that the facility does not have a sadminister the insulin. She aff assist the resident in g for their insulin, or whatever hich may include dialing up the ther medication) dosage and ent while they inject the dicated the specific action of stering the medication with lity staff in the preparation of under direct supervision of a ger was not addressed in each				
		41 a.m., the Administrator an undated document entitled,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/28/2023	
	PROVIDER OR SUPPLIER CREEK VILLAGE	R	•	990 PR	DDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	Policy." This polic policy utilized by the indicated, "An eval resident will be consupdated at least send condition. Upon a Medical Provider and licensed nurse will the residentThe man evaluation of the cognitive, and ment activities of daily limedications. The evaluation of an evaluation of	g relates to Complaint						
R 0241 Bldg. 00	provision of reside							

State Form Event ID: XNRD11 Facility ID: 014548 If continuation sheet Page 5 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPI			COMPL	ETED
			B. W	NG		12/28/	/2023
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
TIMPED	CDEEK VIII I ACE						
HINDER	CREEK VILLAGE			SHELD	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	shall be supervise	ed by a licensed nurse on					
	the premises or or	n call as follows:					
	(1) Medication sha	all 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		R 0	241	p="" xml:="" paraid="1411862335" paraeid="{4b8b2bd9-6548-4099-83		01/31/2024
					d8-97d9433846b3}{18}" what=	=""	
	to the physician ord	lers and properly transcribed			corrective="" action(s)="" will=	""	
	onto each resident's	clinical record for 2 of 3			be="" accomplished for=""		
	residents reviewed for injectable diabetic those=""		those="" residents="" found=""				
			to="" have="" been="" affected	!=""			
	Findings include:				by="" the="" deficient=""		
					practice- The MAR for the two		
					affected residents will be revie	wed	
		ord of Resident B was reviewed			and updated to correct the		
		3 a.m. Her diagnoses included,			transcription error and properly	y	
		d to, type 2 diabetes,			reflect the dose per the MD		
	_	lure and hypertension. Her			orders. How the facility v		
		ation orders for December,			identify other residents having	the	
		sician orders for Ozempic 2			potential to be affected by the		
		s per milliliters], inject			same deficient practice and w		
		der the skin] once weekly and			corrective action will be taken-	· A	
		inject 39 units subcutaneously			review of the MAR will be		
		eakfast and dinner. It indicated			conducted to identify all other		
	she had resided at the	he facility for over one year.			residents with orders for inject		
					diabetic medications who may		
		nt B's orders for Ozempic			have transcription errors and i		
		e, 2023, she was to receive			found, will be corrected to prop	perly	
	_	mg [milligrams] dose pen, inject			reflect the dose per the MD		
		lliliters] subcutaneously every			orders. Training will be condu		
		was indicated to have been			with all QMAs and LPNs regar	ding	
		22. A medication administration			the appropriate response to		
		uly, 2023, indicated she was to			identifying any discrepancy		
	_	mg dose pen (3 ml), inject 1 mg			between the MAR and the orig		
		week." This order did not			MD order responsibility to aler		
		of the 3 ml pen. According to			DON immediately so that a tim	-	
		orodisk's website for			correction can be made. Ho	W	
	_	edication is available in the			the corrective action(s) will be		
	following strengths	: 2 mg/1.5 ml, 4 mg/3 ml and 8			monitored to ensure the defici-	ent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG	00	COMPL	ETED
			B. WING			12/28/	2023
			CTD	EET A	DDBECC CITY CTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
TIMBED					OGRESS PARKWAY		
HIVIDER	CREEK VILLAGE		эп	ELD.	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC	j	DEFICIENCY)		DATE
	mg/3 ml.				practice will not recur, i.e., who	at	
	A review of the August, 2023 recapitulation				quality assurance program wil	be	
					put into place-		
	orders for Resident	B indicated she was to					
	_	Inj 2 mg/3 ml, inject 1.5 ml (1					
		once weekly. An order was					
		3 for Resident B to receive					
		mpic) 1 mg/dose (4mg/3					
		to the skin once a week." The					
		ust, 2023 MAR indicated the					
	same.						
	TEL C . 1 200						
		23 recapitulation orders					
		ele e e Mandaull, The desire					
		abq on Monday!" The dosing					
	· ·	yield a dose of 1 mg, but of 0.67 ding September, 2023 MAR					
		entry of "Ozempic Inj. 3 mg/2 ml					
		note 1 ml was underlined] subq					
	on Monday!"	lote I iii was underimed suoq					
	on wonday:						
	The October 2023	recapitulation orders indicated,					
		/3ml. Inject subcutaneously					
		nday." A handwritten					
		he dosage as "1 ml," which					
		ge of 0.67 mg. The October,					
	2023 MAR indicate	-					
	No additional order	changes for Ozempic were					
		8-26-23 order update to					
	administer 1 mg we	ekly. The MAR for November					
	and December, 202	3 reflected the order as,					
	"Ozempic Inj 2 mg/	/3ml. Inject 1ml subcutaneously					
	once a week on Mo	nday." This dosing of 1 ml					
	would have yield a	dose of 0.67 mg.					
		n the Administrator on 12-27-23					
		ndicated it appeared there may					
		nfusion with the terminologies					
	of milligram and m	illiliter, related to the strength of					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/28/2023
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO)D
TIMBER	CREEK VILLAGE			YVILLE, IN 46176	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
IAU	the Ozempic ordered 12-28-23 at 10:00 as she was unable to let the Ozempic after the nurses or QMA added the facility stop preparing the dosing the injectable is, who correct insulin (or conserving the resident medication. In an interview on the Ozempic orders correct and for some then in September, onto the MAR for Some them in Septemb	d. In a related interview on .m., the Administrator indicated ocate any additional orders for the orders in late August, 2023. In the Administrator on 12-27-23 thared the facility currently has pMA who can administer ted the facility does not have administer the insulin. She aff assist the resident in g for their insulin, or whatever nich may include dialing up the other medication) dosage and tent while they inject the shared it appeared to her as in place in August were the reason fell off of the MAR, 2023, they were handwritten deptember, 2023, using the term			DATE

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PRINTED: 01/25/2024 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE COMPI 12/28	
	PROVIDER OR SUPPLIEF		990 PF	ADDRESS, CITY, STATE, ZIP COI ROGRESS PARKWAY BYVILLE, IN 46176)	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF Toujeo Solo insulin	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 1, 300 units/ml, inject 65 units ry morning and 60 units every	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	for over one year.	on discharge summary, dated				
	remained unchange 2 mg of the 8 mg/3r every week. The coadministration recondad a typewritten en inject (unclear) sub Monday." At the p	nis current Ozempic orders d for that time period, to inject ml strength subcutaneously prresponding medication rd (MAR) for September, 2023 htry of, "Ozempic Inj. 8 mg/3ml, cutaneously once a week on oint of the unclear portion of				
	mg." An unidentified hos	dwritten entry indicating, "1 spital document, dated 9-4-23, "Ozempic 2mg/dose 8mg/3ml				
	other updated order October, 2023 recap reflected the same, the medication on M	subcut qweek [weekly]." No s were located prior to the pitulation orders, which with clarification to administer Mondays of each week. The R reflected the same.				
	attending physician indicated, "Ozempi week." This order obe utilized. Anothe 10-24-23, from an a indicated, "semaglu subcutaneous pen in subcutaneously eve	ated 10-21-23, from the 's office for Resident C, c 1 mg subcutaneous every did not reflect the strength to re medication list, dated area hospital for Resident C, ttide 2 mg dose (8mg/3 ml) njector Ozempic, 1 mg ry week." No additional re located through the exit date				
	of the survey. This	information was the same on rders and the MAR for				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/28/2023		
	PROVIDER OR SUPPLIER		990 PR	ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ION SHOULD BE COMPLETION THE APPROPRIATE	
	In an interview with at 10:30 a.m., she she only one certified Q insulin. She indicate the nurses or QMA' added the facility st preparing the dosing the injectable is, who correct insulin (or or observing the reside medication. The Administrator procedure entitled, 12-28-23 at 11:38 a current policy utilized document indicated a medication programe regard to medication who wish to self-adto have the facility of Medical Provider's discharge orders, the Provider's order for and kept in the Resichronological order firstCurrent medical dosage, frequency, indicationsThe Discharge orders, the monto use. Any discreptorrectedWhen the changes in the design Nursing will verify changesInjectable only by licensed per administration policing Self-administered; [staff; Administered]	the Administrator on 12-27-23 hared the facility currently has pMA who can administer ed the facility does not have a administer the insulin. She aff assist the resident in g for their insulin, or whatever hich may include dialing up the ther medication) dosage and ent while they inject the provided a copy of an undated him while they inject the provided a copy of an undated him a regimen, on the intermedication of the intermedication of the intermedication or wish provided the intermedications and intermedication or derivation or d				

State Form Event ID: XNRD11 Facility ID: 014548 If continuation sheet Page 10 of 14

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING	<u></u>	12/28/2023
			STREET	T ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	t		ROGRESS PARKWAY	
TIMBER	CREEK VILLAGE			BYVILLE, IN 46176	
	T			1	T
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ff if permitted by State Law	TAG	Daniela.ve.	DATE
	Regulations"	if it permitted by State Law			
	Regulations				
	This Residential tag	g relates to Complaint			
	IN00411708.	complaint			
	11.00111700.				
	2.5-4(e)(1)				
	(-)(-)				
R 0243	410 IAC 16.2-5-4(e)(3)			
	Health Services -	Deficiency			
Bldg. 00	(3) The individual	administering the			
	medication shall document the administration				
	in the individual 's	s medication and treatment			
	records that indica	ate the:			
	(A) time;				
	l ` '	cation or treatment;			
	(C) dosage (if applicable); and				
	(D) name or initials of the person				
	administering the	and record review, the facility	D 0242	-"" > \A/b of course of its	01/21/2024
		ility staff who administered	R 0243	="" p=""> What corrective	01/31/2024
	medications to resid	-		action(s) will be accomplished for those	
	documentation to a			residents found to have been	n
		dministered for 2 of 3 residents		affected by the deficient	"
		able diabetic medications.		practice- The MAR for the two	
	(Residents B and C			affected residents will be revie	I
				and updated by each individua	
	Findings include:			QMA or LPN who administere	d
				medication to these residents	to
		ord of Resident B was reviewed		accurately reflect all	
		3 a.m. Her diagnoses included,		medication administered,	
		d to, type 2 diabetes,		especially for any missing	
	_	lure and hypertension. Her		documentation for the months	of
		ation orders for December,		December 2023 and January	
		sician orders for Ozempic 2		2024.	
		s per milliliter], inject der the skin] once weekly and		How the facility will	na
		inject 39 units subcutaneously		identify other residents having the potential to be affected by	
		eakfast and dinner. It indicated		the same deficient practice a	=
	I -	he facility for over one year.		what corrective action will be	
		101 0 . 011 0 j 041.	1	at oon ootive action will be	٠ ١

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		12/28/	2023
				CTREET A	ADDRESS SITV STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD OGRESS PARKWAY		
TIMDED	CREEK VILLAGE						
HINDER	CREEK VILLAGE			SHELD	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					taken- A review of the MAR wi	ill be	
	A review of the med	dication administration records			conducted to identify all other		
	(MAR) for Septemb	ber, October, November and			residents with orders for inject		
	December, 2023, fo	or the administration of her			diabetic medications who may		
	physician-ordered (Ozempic and Humulin-N insulin			have missing documentation o	of	
	failed to acknowled	lge the administration of these			medication administration. All		
	medications as evidenced by a lack of initialing				additional residents with order	s for	
	the correct date bloc			injectable diabetic medications	3		
	to the resident. Those dates are as listed below.				with missing documentation w	ill	
	-Ozempic: 9-11-23 and 9-18-23.				have the documentation updat	ted	
	-Humulin-N insulin: 7:00 a.m. dose on 9-14-23,				to accurately		
	9-15-23, 9-16-23, 9-17-23, 9-18-23, 9-27-23, 9-28-23,				reflect the administration of		
	9-30-23, 11-4-23, 11-5-23, 11-22-23, 12-15-23,				all injectable diabetic		
	12-20-23 and 12-21-23. 8:00 p.m. dose on 9-6-23,				medications. What		
	9-7-23, 9-11-23, 9-1	18-23, 9-25-23, 9-26-23 and			measures will be put into pla	ce	
	9-27-23,10-2-23, 10	0-9-23, 10-16-23, 10-24-23,			or what systemic changes th	е	
	11-6-23, 11-7-23, 1	1-11-23, 11-27-23,12-15-23, and			facility will make to ensure th	nat	
	12-20-23.				the deficient practice does no	ot	
					recur- Training will be conduct	ted	
		h the Administrator on 12-27-23			with all QMAs and LPNs		
		hared the facility currently has			regarding appropriate		
		QMA who can administer			documentation of medication		
		ted the facility does not have			administration for injectable		
		's administer the insulin. She			diabetic medications. All		
	•	taff assist the resident in			duplicate documentation forms	s will	
		g for their insulin, or whatever			be removed from the binder		
		nich may include dialing up the			containing the MAR. How		
	,	other medication) dosage and			the corrective action(s) will b	е	
	•	ent while they inject the			monitored to ensure the		
	medication.				deficient practice will not		
					recur, i.e., what quality		
		ord of Resident C was reviewed			assurance program will be po		
		p.m. His diagnoses included,			into place- 100% of all MARs		
		d to, type 2 diabetes and			residents with orders for inject	able	
		disease with heart failure. His			diabetic medications will be		
		ation orders for December,			reviewed by the DON daily for	3	
		sician orders for Ozempic 8			months, then spot checked 3		
		as per milliliter], inject 1 mg			times weekly for 3 months.		
		der the skin] once weekly and			The Administrator will addition	nally	
	Toujeo Solo insulin	n, 300 units/ml, inject 65 units			review the MAR weekly for 6		

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i '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/28/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 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	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
TAG	subcutaneously every evening. It indicates for over one year. A review of the med (MAR) for Septemb December, 2023, for physician-ordered Confailed to acknowled medications by a law block for each medications by a law block for each medications. -Ozempic: 9-18-23 - Toujeo: Morning of 9-27-23, 9-28-23, 112-21-23, 12-25-23 - Toujeo: Evening of 9-18-23, 12-26-23. In an interview with at 10:30 a.m., she shouly one certified Quinsulin. She indicate the nurses or QMA' added the facility st preparing the dosing the injectable is, who correct insulin (or or observing the reside medication. The Administrator procedure entitled, 12-28-23 at 11:38 a current policy utilized document indicated Administration will nurse or Qualified Murse or Qualified Mu	dication administration records or, October, November and or the administration of her Dzempic and Humulin-N insuling the administration of these ck of initialing the correct date dication. Those dates are as and 12-11-23. Hose: 9-18-23, 9-23-23, 9-24-23, 11-5-23, 11-30-23, 12-15-23, and 12-26-23. Hose: 9-6-23, 9-11-23, 9-17-23, and 12-27-23. In the Administrator on 12-27-23 that deficitly does not have a sadminister the facility does not have a sadminister the insulin. She aff assist the resident in g for their insulin, or whatever the have include dialing up the ther medication) dosage and ent while they inject the ded by the facility. This	TAG	CROSS-REFERENCED TO THE APPROPRIA	for table			
	1	•	1					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU) MULTIPLE CONSTRUCTION . BUILDING <u>00</u> . WING		(X3) DATE SURVEY COMPLETED 12/28/2023	
NAME OF PROVIDER OR SUPPLIER TIMBER CREEK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 990 PROGRESS PARKWAY SHELBYVILLE, IN 46176				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		BE .	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	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 inkWhen 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 staffAll medication errors are						
	reported immediately to the Director of Nursing						
	(or designee). Errors may include the						
	followingMissed doseMedication ordered, but						
	not givenInsulin 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 I	Law Regulations					
	This Residential tag IN00411708.	relates to Complaint					
	2.5-4(e)(3)(D)						

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