STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00433744 . Complaint IN00433744. No deficiencies related to the allegations are cited. Survey dates: May 13, 14, 15, 16, and 17, 2024. Facility number: 000305 Provider number: 155625 AIM number: 100287200 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 3 Medicaid: 53 Other: 18 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 23, 2024.	F 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiency, or any violation of regulation.** **The provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegations of Compliance and requests a desk review in lieu of a post survey review on or after June 9, 2024.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra Dee McKinley	HFA	06/04/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for a resident's blood pressure medication for 1 of 18 residents reviewed for quality of care. (Resident 34) Findings include: A Quarterly MDS (Minimum Data Set) assessment, dated 02/24/24, indicated Resident 34 was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, and hypertension. The resident's current physician's orders included an opened-ended order, with a start date of 11/16/22, for staff to administer Resident 34's losartan (a blood pressure medication). The resident was to receive 100 mg (milligrams) once a day. The medication was to be held if his SBP (Systolic Blood Pressure) was less than 110. The March and April 2024 EMAR (Electronic Medication Administration Records) indicated the resident received the medication when his SBP was less than 110 on the following dates: - On 03/14/24, the resident's SBP was 101, - On 03/30/24, the resident's SBP was 104, - On 04/08/24, the resident's SBP was 100, and - On 04/17/24, the resident's SBP was 108. During an interview on 05/17/24 at 2:51 P.M., LPN (Licensed Practical Nurse) 3 indicated if a resident had hold parameters for a blood pressure medication, the blood pressure should be assessed. If the resident's blood pressure was too	F 0684	**It is the standard of this facility to follow the physicians' orders related to hold parameters for a resident's blood pressure medication.** **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #34's EMARs were reviewed on 06/03/24 at which time physician was contacted and notified of Losartan being given outside hold parameter orders on 03/14/24, 03/30/24, 04/08/24, and 04/17/24. No new physician's orders were received. **2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents having hold parameters related to their blood pressure medication have the potential to be affected by the alleged deficient practice. A hold parameters audit was completed on all resident who have hold parameters for the last 30 days to ensure they were followed. Audit were completed on 06/03/24 by DNS/Designee. **3) What measures will be put into place or what systemic**	06/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
	low, staff were to hold the resident's medication and document it on the EMAR. During an interview on 05/17/24 at 3:32 P.M., the DON (Director of Nursing) indicated they did not have a facility policy on following MD orders, it was just standard nursing practice. 3.1-37(a)		**changes will be made to ensure that the deficient practice does not recur?** The DON or designee in-serviced facility nurses on following physicians' orders related to hold parameters for blood pressure medication on 6/15/24. The DON or designee will review blood pressure medications with hold parameters daily during the clinical meeting. **4) 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? ·** To ensure compliance the DNS/Designee will complete blood pressure medication reviews if they include hold parameters CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. **The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination.** **5) Completion Date: 6/15/24**	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure medications were available and document medication administration for 1 of 14 residents reviewed for pharmacy services. (Resident 1) Findings include:	F 0755	**It is the standard of this facility to ensure medications are available and document medication administration.** **1) What corrective action will be accomplished for those residents found to have been**	06/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1.a. During an observation and interview on 05/17/24 at 12:57 P.M., Resident 1 was sitting in his wheelchair in his room. The resident had no current concerns with receiving his medications. The clinical record for Resident 1 was reviewed on 05/16/24 at 9:46 P.M. An Annual MDS (Minimum Data Set) assessment, dated 02/26/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, seizure disorder, depression, hypertension, and spinal stenosis. An open-ended physician's order, with a start date of 05/04/23, indicated the resident was to have phenytoin (an anticonvulsant medication) 150 mg (milligrams), adminiustered three times a day. The April and May 2024 EMAR/ETAR (Electronic Medication Administration/Electronic Treatment Administration Record) indicated the medication was not administered due to the drug/item being unavailable for the following dates and times: - On 04/10/24 at 8:00 P.M., - On 04/11/24 at 8:00 A.M., and 2:00 P.M., - On 04/12/24 at 8:00 P.M., and - On 05/13/24 at 8:00 A.M., 2:00 P.M., and 8:00 P.M. The resident's record lacked documentation of the physician's notification when the medication was not administered. During an interview on 05/17/24 at 2:36 P.M., RN 2 indicated phenytoin was only available in the emergency drug kit in a 100 mg capsule and Resident 1's dose was 150 mg tablet. They were		**affected by the deficient practice?** Resident #1's EMARs were reviewed on 06/03/24 at which time physician was contacted and notified of Phenytoin being unavailable on 04/10/24, 04/11/24, 04/12/24, and 05/13/24, as well has Cyclobenzaprine 04/16/24, 05/06/24, and 05/08/24. No additional MD orders were received. **2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents receiving medications from pharmacy have the potential to be affected by the alleged deficient practice. All medications were reviewed by DNS/Designee to ensure medications are available as ordered by the MD. All nurses have been re-educated on notifying the physician if a resident does not receive a medication in the clinical record. **3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses have been re-educated on Receiving Pharmacy Products and Services from Pharmacy on 6/15/24. The DON/ADON will complete daily audits on scheduled days of work to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
	not able to obtain the medication out of the emergency drug kit because it wasn't the same form. If the resident's medication wasn't available to administer, then she would call the pharmacy and ask if the medication had been ordered. The pharmacy would sometimes STAT medications and they would get them in a few hours, or they would come the next business day. The physician should have been notified each time the medication was not administered to see if something else needed to be given. 1.b. An open-ended physician's order with a start date of 05/04/23, indicated the resident was to take cyclobenzaprine 10 mg, every 8 hours for spinal stenosis. The April and May 2024 EMAR/ETAR lacked documentation the resident had received the medication on the following dates and times: - On 04/16/24 at 10:00 P.M., - On 05/06/24 at 10:00 P.M., and - On 05/08/24 at 10:00 P.M. During an interview on 05/17/24 at 1:08 P.M., LPN (Licensed Practical Nurse) 4 indicated there should always be something documented in the EMAR. There should never be a blank. The current facility policy titled, "Receiving Pharmacy Products and Services from Pharmacy", with a revision date of 01/01/13, was provided by the DON (Director of Nursing) on 05/18/24 at 5:26 P.M. The policy indicated, "...Facility staff should reorder medications using an electronic list of resident and medications due or by use of barcode technology..." The current facility policy titled, "Receiving		all notifications are being followed when a medication is not available. Any noted concerns notification will be addressed immediately with the nurse on duty and noted on the daily audit form. The daily audits completed by DON/ADON will be turned into the Administrator on scheduled days of work as proof of ongoing compliance. **4) 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?** To ensure compliance the DNS/Designee will complete a medication availability CQI audit, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. **The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination.** **5) Completion Date: 6/15/24**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
	Pharmacy Products and Services from Pharmacy" was provided by the DON on 05/17/24 at 3:34 P.M. The policy indicated, "...Document necessary medication administration/treatment information [e.g...when medication are given...]..." 3.1-25(b)(3) 3.1-25(g)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to label and store	F 0761	**It is the standard of this facility to ensure label and store**	06/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
	medications appropriately for 1 of 2 medication storage refrigerators observed. (100/200 Hall Medication Storage Refrigerator) Findings include: The Medication Room for the 100/200 Halls was observed with RN 3 on 05/17/24 at 1:07 P.M. The 100/200 Hall Medication Storage Refrigerator contained an open vial of TB (Tuberculin) serum with no label indicating when it was opened. The vial was one quarter full. During an interview on 05/17/24 at 1:17 P.M., RN 3 indicated the TB serum package indicated the vial was received from the pharmacy on 04/10/23. The serum was good for 28 or 30 days after it was opened. There was no "opened on" date on the vial of serum, the box the serum came in, or the plastic bag the box was in. The serum should have been labeled when it was first opened. She was unsure of when the TB serum was last administered. The serum was received over a year ago. The TB serum package insert was provided by the DON (Director of Nursing on 05/17/24 at 2:28 P.M. The directions for storage indicated, "...vials in use more than 30 days should be discarded..." The current facility policy, titled "Medication Storage Guidance", and dated 2023, was provided by the DON on 05/17/24 at 2:28 P.M. The policy indicated, "...Tuberculin Tests...Date when opened and discard unused portion after 30 days..." 3.1-25(o)		**medications appropriately.** **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The TB serum has been replaced and has been labeled with current date opened. **2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All new admission receiving 2 step TB series have the potential to be affected by the alleged deficient practice. All TB serums were audited x1 by the DON to ensure that they are currently labeled with an open date. All nurses have been re-educated on labeling and storage of drugs policy. **3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses have been re-educated on Medication Storage Guidance policy on 6/15/24. The DON/ADON will complete daily audits on scheduled days of work to ensure all policies related to labeling and storage of medications are being followed. Any noted concerns with labeling and storage of medications will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(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
			addressed immediately with the nurse on duty and noted on the daily audit form. The daily audits completed by DON/ADON will be turned into the Administrator on scheduled days of work as proof of ongoing compliance. **4)** **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? ·** To ensure compliance the DNS/Designee will complete medication storage CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination. **5) Completion Date: 6/15/24**	