STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING			
	PROVIDER OR SUPPLIE	ER	55 N M	ADDRESS, CITY, STATE, ZIP COD IISSION DR IAPOLIS, IN 46214	
(X4) ID PREFIX TAG	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0000					
Bldg. 00	IN00455250.  Complaint IN0045 to the allegations a R0306, R0351, R0  Survey date: Apri  Facility number: 0  Residential Census These State Reside accordance with 4	1 11, 2025 11840 s: 42 ential Findings are cited in	R 0000	Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the falleged or conclusions set for the Statement of Deficiencies Plan of Correction is prepared executed solely because it is required by the position of Ferand State Law. The Plan of Correction is submitted in orderespond to the allegation of offense and noncompliance domplaint on 04/11/2025. Pleacept this plan of correction the provider's credible allegatic compliance as of April XXXX, The provider respectfully requal desk review with paper compliance to be considered establishing that the provider substantial compliance.	ment facts th on The I and deral er to uring ase as on of 2025. eests
R 0296	410 IAC 16.2-5-6 Pharmaceutical S	5(b) Services - Noncompliance			
Bldg. 00	review, the facility training to ensure to staff. This deficient affect 42 of 42 rest facility.  Findings include:  Upon entry into the	ion, interview, and record railed to provide ongoing the competency of medication at practice had the potential to idents who resided in the e facility on 4/11/25 at 8:10 a.m. at a medication cart was left	R 0296	Submission of this Plan of Correction does not constitute admission or an agreement by provider of the truth of facts alleged or corrections set forth the statement of deficiencies. Plan of Correction is prepared submitted because of requirements under state and federal law. Please accept this Plan of Correction as our cred	y the n on The l and
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE
Brittanv M	cKinnev		HFA		05/02/2025

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.

State Form Event ID: YMM311 Facility ID: 011840 If continuation sheet Page 1 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
			B. WING			04/11/	2025
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
OLINANAIT	DI ACE MECT				ISSION DR		
SUMMIT	PLACE WEST			INDIAN	APOLIS, IN 46214		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	unattended. On top of the cart was an open				allegation of compliance.		
	Medication Admini	stration Record (MAR) book			Resident E was not affected b	у	
	with residents' conf	idential information visible.			the alleged deficient practice.	•	
	Cross reference R0.	35.			Resident E's eye drops were		
					re-ordered and an open date a	and	
	On 4/11/25 at 8:15	a.m. QMA 3 was observed as			expiration date were placed or		
	she passed medicati	ion to Resident E. QMA 3 was			bottle per policy. Resident F's		
	-	ster Resident E's eye drop but			medications were administere	d	
		administering it. Upon review			correctly and QMA 3 was		
	it was found that the	e eye drops did not have an			re-educated on medications w	hich	
		iration date on the bottle so it			should not be crushed, assurir		
		en administered. Cross			medication cart locked when	J	
	reference R0241.				unattended and keeping resid	ent	
					records confidential. Proper		
	On 4/11/25 at 8:15	a.m. Qualified Medication Aide			dosage of medications, proper		
		rved as she passed medication			destruction of medications and		
		he was preparing Resident E's			proper hand hygiene during m		
		ns QMA 3 had a medication			pass. QMA #3 has undergone		
	-	lligrams (mg) Hydroxyzine			review of General Orientation,		
		vas to give one 25 mg tablet.			Description and the QMA		
		ng tablet in half and put the			Orientation Checklist with		
		olet in a pill crusher sleeve and			signatures/dates indicating the	;	
		e 25 mg" on the sleeve. QMA 3			same.		
	then put the sleeve	with the half tablet in the top			No other residents were affect	ted	
	_	cation cart. Cross reference			by the alleged deficient practic	e.	
	R0306				QMA 3 was re-educated and a		
					nursing staff who pass		
	On 4/11/25 at 8:15	a.m. Qualified Medication Aide			medications were re-educated	on	
	(QMA) 3 was obser	rved as she passed			administration of medications		
	medications to five	residents. QMA 3 did not lock			a special focus on assuring da	ite	
	the medication cart	while it was unattended 7			opened and expiration dates a		
	times during the me	edication pass observation.			on medication as well as the		
	Cross reference R03	-			knowledge of locking carts at a	all	
					times when not attended, keep		
	On 4/11/25 at 8:15	a.m. QMA 3 was observed as			MAR closed when not attende	_	
		ion to Resident E. As she was			assuring confidentiality of reco	rds,	
	_	E's morning medications QMA			medications have proper dosa		
		s medications without using			proper destruction of medication	-	
		her hands before or after			and proper hand hygiene durir		
		ation. Cross reference R0414.			medication pass. The medicat	-	
	i		1				ı

State Form Event ID: YMM311 Facility ID: 011840 If continuation sheet Page 2 of 11

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 04/11/2025			
			D. WING	_	0 <del>4</del> /11/2020		
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD			
		-		MISSION DR			
SUMMIT	PLACE WEST		INDIAN	NAPOLIS, IN 46214			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
				carts were audited to ensure			
		p.m. QMA 3 indicated she had		medications had date opene			
		tation a week prior to the		expiration dates, an audit wa	S		
	medication pass ob	servation.		completed to assure staff			
	0 4/11/05 + 1.00	4 F (' D' (ED)		orientation was completed w			
		p.m. the Executive Director (ED)		signatures/dates indicating the	ne		
		QMA 3's employee file. The QMA 3 was hired on 3/28/25. In		same.	ation		
		file there was a general		The facility's policy of Medica Administration was reviewed			
		st that was filled out but had		no changes indicated at this			
		from the QMA or the trainer,		As a means to ensure ongoin			
	_	gned by the QMA but not		compliance, the			
		the supervisor but dated		Administrator/DON or design	ee		
		orientation checklist filled out		will audit medication carts for			
		MA but not dated and signed		undated medications/expirati	on		
	by the instructor bu			dates, and will monitor medic			
				administration to assure date	:		
	This citation relates	to Complaint IN00455250.		opened and expiration dates	are		
				on medication as well as the			
				knowledge of locking carts a			
				times when not attended, kee	· -		
				MAR closed when not attend			
				medications have proper dos	-		
				proper destruction of medica			
				and proper hand hygiene du	-		
				medication pass. These audi and monitoring will take place			
				Daily 5x per week, varied shi			
				4 weeks, 3x per week for 4 w			
				1x per week x 4 weeks and	CCRO,		
				monthly for 4 months. A			
				monitoring tool is in place			
				As a means of quality assura	nce,		
				the administrator will review			
				findings and subsequent con	ective		
				actions taken. The monitoring	g will		
				be increased or decreased if			
				indicated to maintain complia	ince		

State Form Event ID: YMM311 Facility ID: 011840 If continuation sheet Page 3 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
			B. W	B. WING			04/11/2025	
				CTREET	ADDRESS SITE STATE SID COD			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
CLIMANAIT					ISSION DR			
SUMMIT	PLACE WEST			INDIAN	IAPOLIS, IN 46214			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0300	410 IAC 16.2-5-6(	c)(4)					•	
Pharmaceutical Services - Deficiency								
Bldg. 00		•						
	Based on observation	on, interview, and record	R 0	300	1 Residents' E, F and H's		05/09/2025	
	review, the facility	failed to ensure that over the			unlabeled medications were			
	counter and prescrip	otion medications were			labeled per policy upon discov	ery.		
	properly labeled and	d dated in 1 of 1 medication			Undated drops were disposed	and		
	carts observed for n	nedication labeling and dating.			replaced.			
		-			2 An audit of the medication	n		
	Findings include:				carts was completed and any			
					medications without labels or			
	On 4/11/25 at 8:15 a	a.m. medication cart 1 was			dated opened/expiration were			
	observed during a medication pass. The				labeled/corrected according to			
	medications reviewe	ed during this medication pass			facility policy.			
	included but were n	ot limited to:			3 The facility policy for over	the		
					counter medications was revie	wed		
	1. Resident E had C	ombigan (an eye drop that			with no changes indicated at the	nis		
	treats Glaucoma) w	ith no open date or expiration			time. As a means to ensure			
	date on the bottle.				ongoing compliance, the			
	2. Resident F had a	box of Lidocaine 5% patches			administrator/DON or designed	e will		
	that were not labele				conduct medication cart audits	for		
		efresh Optic eye drops with no			unlabeled over the counter			
		ion date on the bottle.			medications and open			
		bottle of over-the-counter			date/expiration. These audits a			
	Aspirin that were no				monitoring will take place daily			
		box of Salonpas Lidocaine			per week, varied times/shifts x			
	patches that were no	ot labeled.			weeks, 3x per week for 4 weel	KS,		
					1x per week x 4 weeks and			
		p.m. the Corporate Executive			monthly for 3 months, to ensur			
		provided a copy of current			monitoring for no less than six			
	facility policy titled				months.			
		was undated. This policy			4 As a means of quality			
		dwritten legible label shall be			assurance, the administrator w	/ill		
	-	eation in a manner to ensure			review any findings and			
		label does not obscure			subsequent corrective actions			
		on the container including			taken. The frequency of the			
		th and expiration date. 3.) The			monitoring will be increased or			
		label placed by licensed			decreased if indicated to main	tain		
	facility staff on the				compliance			
	container/bottle sha	ll include the following:						

State Form Event ID: YMM311 Facility ID: 011840 If continuation sheet Page 4 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/11/2025	
	PROVIDER OR SUPPLIER	<b>.</b>		55 N M	ADDRESS, CITY, STATE, ZIP COD ISSION DR IAPOLIS, IN 46214		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	resident name and p	ohysician name"		TAG	DEFICIENCY)		DATE
	This citation relates	s to Complaint IN00455250.					
R 0304	410 IAC 16.2-5-6(	(e) ervices - Deficiency					
Bldg. 00		•					
	review, the facility medication cart was secured while unatt to affect 42 of 42 refacility.  Findings include:  Upon entry into the it was observed that unattended. The card drawer of the cart was observed that unattended in the cart was observed that was observed the cart was observed that was observed that was observed that the cart was observed to a wa	a.m. Qualified Medication Aide	R 0.	304	1 Residents E and F were affected. QMA3 and the Nursing staff was re-educated on the medication administration policifor medication carts being lock when unattended and assuring medication is secured (not on of cart).  2 As all residents could be affected, nursing staff were re-educated on the medication administration policy. Medicating administration pass observation will be conducted to ensure promedication administration, focusing on assuring medication cart is locked when left unattended and no medication left on top of cart.  1 The facility's policy for medication administration was reviewed with no changes indicated at this time. As a medication ensure ongoing compliance	ng cy ked g top on on oper on as	05/09/2025
	medications that ha	side the medication cards and d been popped out of the to a medication cup on top of .			administrator/DON or designed conduct medication pass observations to assure medications are locked when unatten and no medications left unsections.	ation ded,	
	cart while preparing medications to get a	a.m. QMA 3 left the medication g Resident F's morning a patch from the medication ft the cart unattended, there			on top of cart. These audits ar monitoring will take place daily per week, varied times/shifts x weeks, 3x per week for 4 week	nd / 5x : 4	

State Form Event ID: YMM311 Facility ID: 011840 If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ILDING	instruction 00	(X3) DATE : COMPL <b>04/11</b> /	ETED	
	PROVIDER OR SUPPLIEF			55 N MI	NDDRESS, CITY, STATE, ZIP COD SSION DR APOLIS, IN 46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
R 0306	medication cards ar popped out of the medication cup on to the medication cup on to the medication cup on the medication cup of titled, "Medication undated. The policy medication cart shot hazardous material Always lock the Moout of visual range."  This citation relates 410 IAC 16.2-5-6(	to Complaint IN00455250.			1x per week x 4 weeks and monthly for 3 months, to ensur monitoring for no less than six months.  3 As a means of quality assurance, the administrator were view any findings and subsequent corrective actions taken. The frequency of the monitoring will be increased or decreased if indicated to maint compliance	rill	
Bidg. 00	Based on observation reviews, the facility unadministered medisposed of. This dopotential to affect 3 proper medication of Findings include:  On 4/11/25 at 8:15 (QMA) 3 was observed to Resident E. As slamorning medication card that had 50 mit tablets. The order would work to the same than the same to the same than the same tablets. The order would be same to the same tablets. The order would be same tablets.	ons, interviews and record failed to ensure that dications were properly efficient practice had the of 5 residents reviewed for disposal.  a.m. Qualified Medication Aide eved as she passed medication he was preparing Resident E's as QMA 3 had a medication diligrams (mg) Hydroxyzine was to give one 25 mg tablet. In the graph of the control of the con	R 03	306	Residents' E, F, H and I were affected. The pharmacy was notified, and the correct medication dose was ordered resident E. A medication cart audit was completed to locate unfound dropped medication for resident F and disposed per facility policy. QMA 3 and 4 we re-educated on transfer of pills from card to cup (i.e., not per bhand) the proper destruction of medications and assuring pharmacy notified of proper dosage of medications for residents.  2 Medication administration pass observation will be conducted to ensure proper medication administration, focusing on assuring medication.	for the or ere bare f	05/09/2025

State Form Event ID: YMM311 Facility ID: 011840 If continuation sheet Page 6 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  04/11/2025	
	PROVIDER OR SUPPLIER	R	55 N M	ADDRESS, CITY, STATE, ZIP COD IISSION DR NAPOLIS, IN 46214	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		a.m. QMA 3 indicated she put		destruction for dropped,	
		e sleeve, so it didn't go to		contaminated, refused or una	
		d she should have also written		return for credit medications.	
		and room number on the		pharmacy will be notified of a	-
	sleeve as well.			medication with improper dos	age
				to assure proper doses of	
		a.m. QMA 3 was observed as		medications available. Nursin	g
	-	ions to Resident F. As she		staff were re-educated on	
		dent F's morning medications		medication administration, the	
		he medications that were to be		medication destruction policy	
		edications that were not to be		proper dosages of medication	ns.
		s holding the medications that		1 The facility's policy for	
		hed in her hand, she dropped		medication destruction was	
	_	edication cart drawer and was		reviewed with no changes	
		MA 3 then popped out a		indicated at this time. As a me	
	replacement pill and	d left the unfound pill in the		e, the	
	cart.			administrator/DON/designee	will
				conduct medication pass	
		5 a.m. QMA 3 was observed as		observations to assure any	
		ions to Resident H As she was		refused; dropped, contaminat	red
		H's morning medications an		medication is destroyed per	
	_	ell out of the medication card		policy, and assure proper	
		popping the pill out of the card.		medication doses are availab	
		pill in a medication cup with		The observations will take pla	nce
		it and put the medication cup		daily 5x per week, varied	
	in the top drawer of	f the medication cart.		times/shifts x 4 weeks, 3x per	
	0 4/11/05 : 11.07			week for 4 weeks, 1x per week	
		a.m. QMA 3 indicated she will		weeks and monthly for 3 mor	
	destroy the unadmin	nistered pill later.		to ensure monitoring for no le	SS
	0 4/11/05 + 11 1/	0164.2		than six months.	
		5 a.m. QMA 3 was observed as		3 As a means of quality	:11
	*	ions to Resident I. As she was		assurance, the administrator	WIII
		I's morning medications QMA card that had Vitamin D3		review any findings and	
				subsequent corrective actions	5
		s ordered for 1 capsule to be		taken. The frequency of the	\n_
		nesdays. QMA 3 popped the ne card and into the medication		monitoring will be increased of	
				decreased if indicated to main	ntain
		ng the medication she was who questioned whether the		compliance	
	**	e today. QMA 3 took the			
	vitamin D3 was du	e iouay. QiviA 3 iook ine			

State Form Event ID: YMM311 Facility ID: 011840 If continuation sheet Page 7 of 11

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00	COMPLETED 04/11/2025				
	ROVIDER OR SUPPLIER		55 N M	ADDRESS, CITY, STATE, ZIP COD ISSION DR APOLIS, IN 46214				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ICIENCY MUST BE PRECEDED BY FULL  PREFIX  PREFIX  PREFIX  PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	put it in the medicate drawer of the medicate pill.  On 4/11/25 at 11:20 indicated they would be medicated to the medicated they would be medicated to the medicated they would be medicated to the me	e out of the medication cup and cion cup that was in the top cation cart with the other extra  a.m. both QMA 3 and QMA 4 d destroy the unadministered						
	Director (Corp. ED) facility policy titled Refused, Contamina Returned for Credit policy indicated, " disposed of immedi sharps container on	i p.m. the Corporate Executive provided a copy of current , "Medication Destruction, ated/Dropped, or Unable to be ," that was undated. This medication(s) will be ately per placement in the the medication cart (to allow on of medication pass)"						
	(ED) provided a coptitled, "Medication and undated. The policy order calls for the ac (half tablet, etc.) The pharmacy supplier cadminister. Nursing	p.m. the Executive Director by of a current facility policy Administration", that was indicated, "27. When an dministration of a partial tablet be facility will require that the dispense that drug ready to personnel should not attempt theses absolutely necessary"						
R 0351		to Complaint IN00455250.						
Bldg. 00	410 IAC 16.2-5-8. Clinical Records -							
	review, the facility to confidential information while the Medication (MAR) book was le	on, interview, and record failed to ensure resident ation was properly concealed on Administration Record off unattended. This had the 2 of 42 residents who resided	R 0351	1 No residents were affected 2 No other residents were affected. QMA 3 was re-educated on the importance of confidentiality of resident reconstruction. Nursing staff re-educated on	ated			

State Form Event ID: YMM311 Facility ID: 011840 If continuation sheet Page 8 of 11

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  04/11/2025	
	PROVIDER OR SUPPLIER		55 N M	ADDRESS, CITY, STATE, ZIP COD ISSION DR IAPOLIS, IN 46214	
(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 APPROPRIA DEFICIENCY)  maintaining confidentiality of	(X5) COMPLETION DATE
	it was observed that unattended. On top book with resident ovisible.  On 4/11/25 at 8:15 at (QMA) 3 was obser medications to five properly conceal the confidential residen during the medication.  On 4/11/25 at 12:24 (ED) provided a coptitled, "Medication undated. The policy resident information MAR/TAR/cart is less that the confidential resident information and the confidential resident information and the confidential resident information and the confidential residential residenti	residents. QMA 3 did not e MAR book, leaving t information visible 5 times on pass observation.  4 p.m. the Executive Director by of a current facility policy Administration", that was indicated, "2. Confidential must be concealed when the		resident records. Medication administration pass observation conducted to assure confidentiality of records.  1 The facility's policy for medication administration was reviewed with no changes indicated. As a means to ensure ongoing compliance, the administrator/DON or designe conduct medication pass observations to assure nursing staff is maintaining confidentiate of resident records. These aud will take place daily 5x per we varied times/shifts x 4 weeks, per week for 4 weeks, 1x per varied times/shifts x 4 weeks, per week for 4 weeks, 1x per varied times with monthly for 3 months, to ensure monitoring no less than six months.  3 As a means of quality assurance, the administrator varied any findings and subsequent corrective actions taken. The frequency of the monitoring will be increased of decreased if indicated to main compliance	e will g ality dits ek, 3x week for
R 0414	410 IAC 16.2-5-12 Infection Control -	` '			
Bldg. 00	review, the facility: had a sanitary envir Medication Aide (Q hands before or afte not clean a shared b	on, interview, and record failed to ensure that residents comment when a Qualified (MA) 3 did not wash their or handling medications, did lood glucometer (meter used cood sugar) before or after	R 0414	1 Residents E and F had n negative outcomes. QMA 3 a nursing staff were re-educated infection control with a special focus on hand hygiene, transfipills to cup, medication pass, a glucometer use.	nd d on er of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ILDING	ONSTRUCTION  00	(X3) DATE COMPL <b>04/11</b> /	ETED	
	PROVIDER OR SUPPLIE	₹		55 N M	ADDRESS, CITY, STATE, ZIP COD ISSION DR		
SUMMIT	PLACE WEST			INDIAN	IAPOLIS, IN 46214		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e gloves appropriately. This			2 No other Residents were		
	-	ffected 5 of 5 Residents			affected. However, as all resid	lents	
	1	H and I) observed during a			could be affected, nursing stat	f	
	medication pass.				was re-educated on infection		
					control with a special focus on		
	Findings include:				hand hygiene medication pass		
					and glucometer use. Resident		
		a.m. QMA 3 was observed as			specific blood glucometers are	e in	
	-	ion to Resident E. As she was			place.		
		E's morning medications QMA			1 The facility's policy for		
		s medications without using			medication pass was reviewed		
	-	ther hands before or after			with no changes indicated. As	а	
	handling the medication.				means to ensure ongoing		
					compliance nursing staff has b		
		a.m. QMA 3 was observed as			re-educated on infection contr	ol	
	-	ion to Resident E. As she was			with a special focus on hand		
		E's morning medications QMA			hygiene, medication		
		hout sanitizing her hands and			administration, care and		
		nds to do various tasks,			cleansing/disinfecting of		
		ated items and surfaces before tions to Resident E with the			glucometer. Resident specific	_	
		MA 3 took her gloves off after			blood glucometers are in place The administrator/DON or	<b>5.</b>	
		t's room and did not sanitize			designee will conduct medicat	ion	
	her hands.	is foom and did not samuze			pass observations to assure	1011	
	ner nanas.				nursing staff is maintaining pro	ner	
	On 4/11/25 at 8:45	a.m. QMA 3 was observed as			infection control during medica	-	
		ion to Resident F. As she was			administration and glucometer		
	-	F's morning medications QMA			use. These audits will take pla		
		lications that were to be			daily 5x per week, varied		
	•	redications that were not to be			times/shifts x 4 weeks, 3x per		
	crushed. As QMA	3 did this she handled the			week for 4 weeks, 1x per wee	kx4	
	· ·	ere not to be crushed without			weeks and monthly for 3 mont		
	using gloves or san	itizing her hands before or			to ensure monitoring for no les		
	after handling the r				than six months.		
	-				3 As a means of quality		
	On 4/11/25 at 9:15	a.m. QMA 3 was observed as			assurance, the administrator v	vill	
	she took Resident I	s blood sugar. QMA 3 put			review any findings and		
		sanitizing her hands. Without			subsequent corrective actions		
		l glucometer QMA 3 performed			taken. The frequency of the		
	a finger stick and to	ested Resident F's blood sugar.			monitoring will be increased o	r	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. WING			04/11/2025		
	PROVIDER OR SUPPLIEF	R		55 N MI	ADDRESS, CITY, STATE, ZIP COD SSION DR APOLIS, IN 46214			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		NCY 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)	ATE	DATE	
		ner gloves, QMA 3 put			decreased if indicated to mair	ntain		
		lication cups containing			compliance	· com		
		ng medications. After passing			compliance			
		ations QMA 3 took her gloves						
	off, but did not sani	· · · · · · · · · · · · · · · · · · ·						
	On 4/11/25 at 9·25	a.m. QMA 3 indicated, the						
		he was using to test Resident						
	1	h was a shared meter for all						
		ility who get their blood sugar						
	tested.							
	On 4/11/25 at 12:24	4 p.m. the Executive Director						
		py of a current facility policy						
	titled, "Medication	Administration", that was						
	undated. The policy	y indicated, "Infection						
	Control: 1. Wash ha	ands with soap and water. Prior						
	to beginning med p	ass3. use alcohol gel or						
	foam between each	resident unless using soap						
	and water. 4. Never	r touch medications with hands						
	"							
	On 4/11/25 at 12:27	4 p.m. the Executive Director						
		py of the operators' manual for						
		er that the facility uses for						
		titled, "Evencare G2 Blood						
		g System", that was undated.						
	· ·	ed, " Cleansing and						
		ter and lancing device is very						
		evention of infectious disease						
	"	cremion of infectious disease						
	This citation relates	s to Complaint IN00455250.						
		_		İ				

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