STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155693	A. BUILDING 00 B. WING	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

(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 a State Residential Licensure Survey. Survey dates: April 9, 10, 11, 15, 16, and 17, 2025 Facility number: 002955 Provider number: 155693 AIM number: 200346570 Census Bed Type: SNF/NF: 26 SNF: 27 Residential: 27 Total: 80 Census Payor Type: Medicare: 20 Medicaid: 22 Other: 11 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 24, 2025.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted April 17, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 9, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to store medications appropriately for 1 of 1 resident reviewed for self-administering medications. (Resident 19) Findings include:	F 0554	1. Resident 19 was affected by alleged deficient practice. No adverse effects noted. The medications were removed from the resident's room and stored per policy. 2. Like residents have the	05/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Cole	Area Executive Director	05/02/2025

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	During an observation, on 04/09/25 at 11:32 A.M., the top of Resident 19's nightstand by the door contained a bottle of nasal spray and two inhalers that were out in plain sight. During an observation, on 04/11/25 at 10:42 A.M., the top of the resident's nightstand by the door contained a bottle of nasal spray and two inhalers that were out in plain sight. During an observation, on 04/11/25 at 1:12 P.M., the top of the resident's nightstand by the door contained a bottle of nasal spray and two inhalers that were out in plain sight. During an observation, on 04/15/25 at 8:44 A.M., the top of the resident's nightstand by the door contained a bottle of nasal spray and two inhalers that were out in plain sight. During an interview, on 04/15/25 at 1:43 P.M., RN 8 indicated if a resident had medications at bedside, then they should have an assessment completed. During an interview, on 04/15/25 at 1:47 P.M., Corporate Clinical Support Nurse indicated if a resident had an assessment completed for medications at the bedside, then they didn't need to have a physician's order. During an interview, on 04/15/25 at 1:43 P.M., Corporate Clinical Support Nurse indicated the resident's self-administer assessment indicated the medications would be stored in the nursing cart and not in her room, so the medications should not have been in her room and per the facility policy there should be a physician's order to self-administer medications.		potential to be affected. Licensed nursing staff educated on Self Administration of Medications policy. 100% audit to ensure residents with self-administration of medication observations have properly stored medication. 3. As a measure of ongoing compliance, the DHS or designee will audit residents with self-administration of medications to ensure medications are stored according to policy weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	During an observation, on 04/15/25 at 2:00 P.M., Cooperate Minimum Data Set (MDS) Support was in Resident 19's room. The following medications were observed on the resident's nightstand in plain sight: - albuterol inhaler, - ipratropium bromide (nasal spray), - debrox (ear wax cleaner), and - Advair (inhaler). The resident indicated she had not used the debrox for a few weeks. The clinical record for Resident 19 was reviewed on 04/11/25 at 1:28 P.M. A Significant Change MDS assessment, dated 03/27/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, primary adrenocortical, anemia, heart failure, hypertension, diabetes, osteoporosis, anxiety, and depression. The resident had the following physician's order's: - An open-ended physician's order, with a start date of 11/11/23 for Advair, 2 puffs twice a day, - An open-ended physician's order, with a start date of 11/11/23 for albuterol inhaler 2 puffs as needed every 6 hours, - A discontinued order, dated 11/11/23 through 01/21/25, for ipratropium bromide, 1 spray, once a day, and - A discontinued order, dated 08/20/24 through 08/23/24, for Debrox, 4 drops each ear for 3 days. A Self-Administration of Medication Assessment, dated 04/30/24, indicated the resident could self-administer the following medications and they would be stored in the medication cart:			

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	- Tylenol, - Tums, - eye drops, - inhalers, - ointments, and - medications set up by the facility and left at the bedside. The current facility policy, titled "Guidelines for Self-Administration of Medications", was provided by the Director of Nursing (DON) on 04/15/25 at 2:18 P.M. The policy indicated, "...To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan...Results of the assessment will be presented to the physician for evaluation and an order for self-medication...The medication will be kept in a locked drawer in the residents' room..." 3.1-11(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review, interview, and observation, the facility failed to follow physician's orders related to cardiac medication hold parameters and adequately assess and monitor a resident's skin impairment for 3 of 15 residents reviewed for Quality of Care. (Residents 10, 22, and 19) Findings include: 1. Resident 10's clinical record was reviewed on 04/10/25 at 2:27 PM. A Quarterly Minimum Data Set (MDS) assessment, dated 02/10/25, indicated the resident was cognitively intact. The resident's	F 0684	1. Residents 10, 22, and 19 were affected. Assessments completed immediately. No adverse reactions noted from alleged deficient practices. 2. All residents have the potential to be affected. Licensed nursing staff educated on cardiac hold parameters, skin assessments, and monitoring. 3. As a measure of ongoing compliance, the DHS or designee will perform random audits on 3	05/09/2025

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	diagnoses included, but were not limited to, hypertension, coronary artery disease, heart failure, and diabetes. A physician's order, with a start date of 09/24/24 and a discontinued date of 03/26/25, for amlodipine (a blood pressure medication), 10 milligrams (mg) once a day in the evening between 6:00 P.M. and 10:00 P.M. The medication was to be held if the systolic blood pressure (SBP) was below 110. The Vitals Reports for December 2024, and January, February, and March of 2025 were reviewed. The reports indicated the resident lack blood pressure assessments on the following dates when receiving the medication: - On 12/04/24 through 12/31/24, no blood pressure assessment was documented for the resident's amlodipine medication administration. - On 01/04/25 through 3/25/25, there was no documented blood pressure assessment for the resident's amlodipine medication administration. A physician's order, with a start date of 09/24/24 and a discontinued date of 03/26/25, for carvedilol (a blood pressure medication), 25 mg twice a day between 6:00 A.M. and 10:00 A.M., and between 6:00 P.M. and 10:00 P.M. The medication was to be held if the SBP was below 110. The December 2024, and January, February, and March 2025 Electronic Medication Administration Record (EMAR) lacked documented blood pressures for the medication administration. The Vitals Reports for December 2024, and January, February, and March of 2025 were		residents with cardiac hold parameters weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a measure of ongoing compliance, the DHS or designee will perform random skin assessments to ensure completed per order, on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	reviewed. The reports indicated the resident lack blood pressure assessments on the following dates when receiving the medication: - On 12/04/24 through 12/27/24, there were no documented blood pressure assessment for the resident's carvedilol medication administration between 6:00 A.M. and 10:00 A.M. - On 12/29/24 and 12/30/24, there were no documented blood pressure assessments for the resident carvedilol medication administration between 6:00 A.M. and 10:00 A.M. 2. The clinical record for Resident 22 was reviewed on 04/10/25 at 2:26 P.M. An Admission Minimum Data Set assessment, dated 02/20/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, multiple fractures of the ribs, anemia, atrial fibrillation, hypertension, diabetes, cerebrovascular accident, and malnutrition. A physician's order, dated 02/14/25 through 03/25/25, indicated the staff were to administer metoprolol (a blood pressure medication) 25 mg once a day from 6:00 A.M. to 10:00 A.M. The staff were to hold the medication if the systolic blood pressure was less than 100 or the heart rate was less than 50. A physician's order, dated 03/25/25 through 04/11/25, indicated the staff were to administer metoprolol 25 mg, twice a day from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. A Progress Note, dated 03/25/25, indicated the resident was to start metoprolol 25 mg, twice a day and the medication was to be held if the systolic blood pressure was less than 100 or the heart rate was less than 50.			

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	The February and March 2025 EMAR lacked documented blood pressure or heart rates for the medication administration. The Vitals Report for February and March 2025 lacked documented heart rates or blood pressures for the following dates and times: - 02/14/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 02/22/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 02/24/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 02/28/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 03/04/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 03/05/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 03/13/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 03/20/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 03/21/25 from 6:00 A.M. to 10:00 A.M., no heart rate was documented, - 03/25/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 03/26/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 03/27/25 from 6:00 A.M. to 10:00 A.M., and 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 03/28/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 03/29/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 03/30/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented,			

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	- 03/31/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 04/01/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 04/02/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 04/03/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 04/04/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 04/05/25 from 6:00 A.M. to 10:00 A.M., no heart rate or blood pressure was documented, - 04/06/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, - 04/07/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented, and - 04/09/25 from 6:00 P.M. to 10:00 P.M., no heart rate or blood pressure was documented. During an interview, on 04/16/25 at 12:57 P.M., RN 8 indicated if a resident had hold parameters on medications, he would obtain the vitals before administering the medication and would not administer the medication if vitals were outside the parameters. The current facility policy titled, "Medication Orders", with a revised date of 11/18, was provided by the Director of Nursing on 04/16/25 at 1:40 P.M. The policy indicated, "...Medications are administered only upon clear, complete, and signed order..." 3. During an observation and interview, on 04/09/25 at 11:32 A.M., Resident 19 had an undated, pink foam bandage on her left lower arm that was covering the bandage. The resident indicated she had bumped it on her over bed table and a nurse had put a bandage on it.			

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	During an observation and interview, on 04/16/25 at 10:15 A.M., Resident 19 was sitting on her bed. The resident had a protective sleeve over her left lower arm. The resident pulled the sleeve down and there was a scabbed skin tear that was covered with wound closure strips (thin sticky bandages applied to skin to help wounds stay closed as they healed) on it. The resident indicated she had the sleeve on her arm to protect her from hitting it again. The clinical record lacked any documentation, or any orders related to the area to the left lower arm. During an interview, on 04/16/25 at 12:57 P.M., RN 8 indicated when a resident had a new skin concern that required more than Band-Aid then the wound nurse would be notified, and an order would be initiated. The resident would also have an assessment completed for the area. The skin impairment would be measured weekly. He wasn't sure what the resident had done to her arm. It looked like a skin tear, and someone placed wound closure strips on it. He would think the resident should have an order to monitor the area. During an interview, on 04/16/25 at 1:18 P.M., the Wound Nurse indicated if a resident had a skin impairment, she would be made aware and then start an appropriate treatment. The skin impairments would be assessed weekly. When a nurse found a new skin impairment, they should make a progress note and have an assessment completed. She was unaware of Resident 19 had skin impairments to her left lower arm. The staff should have made her aware of it. The current facility policy titled, "Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines", with a revised date of 04/09/25 was			

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	provided by the Corporate Clinical Support on 04/16/25 at 1:51 P.M. The policy indicated, "...Skin Tear/Laceration...Complete Skin Tear/Laceration Incident in the Electronic Health Record by an RN/LPN [Licensed Practical Nurse] along with the template/assessment progress note. IDT [Interdisplinary Team] should review this timely and wound nurse or designee complete an assessment in wound management...Continue to monitor weekly in wound management..." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to follow the current nursing standards of practice when providing Activities of Daily Living (ADL) care to residents with impaired mobility that were at risk for falls for 2 of 4 residents reviewed for accidents. (Residents 41 and 47) Findings include: 1. During an observation, on 04/16/25 at 9:38 A.M., Certified Nurse Aide (CNA) 4 was on the right side of Resident 41's bed. The resident was lying in the bed on her back. CNA 4 indicated to the resident that she was going to perform personal care. The resident's incontinent brief was removed, and care was provided. CNA 4 had the resident roll onto her left side, away from the CNA. The CNA rolled the resident and the resident held on to the corner of the nightstand on the left side of her bed with her right hand. The resident's body was approximately one foot from the edge of the bed. There were no other staff in the room and the resident's bed lacked side rails.	F 0689	1. Residents 41 and 47 were affected by alleged deficient practice. No adverse reactions noted. 2. All like residents have the potential to be affected. Nursing staff educated on ADL care for residents with impaired mobility who are at risk of falls. 3. As a measure of ongoing compliance, the DHS or designee will conduct 3 random ADL care audits weekly x4 weeks, then every other week x2 months, then monthly x3 months to ensure ADL care is completed per careplan. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan	05/09/2025

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	CNA 4 stayed on the right side of the bed during the entire observation of care. The clinical record for Resident 41 was reviewed on 04/10/25 at 3:04 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/13/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, senile degeneration of the brain, hemiplegia and hemiparesis, weakness, unspecified fall, anemia, hypertension, neurogenic bladder, diabetes, Alzheimer's disease, anxiety, and depression. The resident had impairments to one side of their upper extremities and both lower extremities. The resident was dependent on staff for bed mobility and rolling left and right. An open-ended physician's order, with a start date of 03/26/25, indicated the resident required a mechanical lift for transfers. The resident's complete Plan of Care included, but was not limited to, the following: - A Care Plan that indicated the resident had a cerebrovascular accident with hemiparesis/hemiplegia and had a neurogenic bladder. The resident required staff assistance with ADLs, with a start date of 02/28/24, and revised on date of 02/25/25, and - A Care Plan that indicated the resident was at risk for falling related to incontinence, medications, history of falls, a need for staff assistance with ADL care, and weakness, with start date of 02/28/24, and a revised on date of 02/25/25. 2. During an observation, on 04/16/25 at 10:23 A.M., CNA 11 let Resident 47 know that she was		will be reviewed and updated as warranted.	

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	going to provide care. The CNA was on the left side of the resident's bed and never left it. She removed the resident's incontinent brief and provided care for the resident. She turned the resident on her right side away from the CNA and provided care to the resident's backside. A portion of the resident's head was hanging off the right side of the bed. The resident's body core was approximately one foot from the edge of the bed. There were no side rails on the bed or other staff in the room. The clinical record for Resident 47 was reviewed on 04/11/25 at 9:39 A.M. An Annual MDS assessment, dated 01/31/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, other toxic encephalopathy, aphasia, cerebrovascular accident, seizure disorder, hemiplegia and hemiparesis, weakness, depression. The resident had impairments on both sides of the lower extremities. The resident was dependent on staff for bed mobility. A current, open-ended physician's order with a start date of 01/22/25 indicated the resident required a mechanical lift for all transfers. The resident's complete Plan of Care included, but was not limited to, the following: - A Care Plan that indicated the resident had a cerebrovascular accident with aphasia and hemiplegia/hemiparesis affecting the right side. The resident required staff assistance with ADL care, with a start date of 02/29/24 and revised on date of 04/10/25, - A Care Plan that indicated the resident was at risk for falling related to diagnoses, medications,			

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	155693	A. BUILDING 00 B. WING	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

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	incontinence, a need for staff assistance with ADL care, and weakness, with a start date of 02/29/24 and revised on date of 04/10/25, - A Care Plan that indicated the resident had an impairment in functional status related to diagnoses, medications, incontinence, a need for staff assistance with ADL care, and weakness, with a start date of 02/29/24 and revised on date of 04/10/25. A Progress Note, dated 02/18/25 at 6:19 P.M., indicated the resident was in the lobby with activities when the resident leaned forward in her chair and fell to the floor. During an interview, on 04/16/25 at 10:34 A.M., CNA 9 indicated when she was assisting a resident with care in bed by herself, she would turn the resident away from her. She would ensure the resident was closer to her so they wouldn't roll out of the bed. There had been no staff in-servicing recently on how to turn dependent residents in bed. During an interview, on 04/16/25 at 10:36 A.M., Qualified Medication Aide (QMA) 10 indicated if she was turning a dependent resident in bed by herself, she would pull the resident toward her to ensure they weren't close to the edge of the bed and then turn the resident away from her. Depending on the resident's level of care, she would sometimes get a second staff member to help. During an interview, on 04/16/25 at 10:39 A.M., the Director of Nursing (DON) indicated when providing care for dependent residents by themselves, the staff should use the draw sheet and pull the resident to them and then roll them			

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	away from them. She would hope the staff would keep their hand on the resident so they wouldn't roll out of bed. There was always a risk for anything. During an interview, on 04/17/25 at 11:00 A.M., QMA 13 indicated the resident was dependent on staff for all care. She was able to roll the resident in bed by herself but at times she needed help. The resident was not able to turn in the bed by herself. During an interview, on 04/16/25 at 12:47 P.M., the DON indicated she would expect the CNAs to follow that they learned in the CNA class. During an interview, on 04/16/25 at 1:01 P.M., the DON indicated there were no facility policies related to bed mobility for dependent residents, and they would just follow the individualized plan of care. The current "Indiana Nurse Aide Curriculum-Procedure #55: Occupied Bed" was reviewed on 04/16/25. The procedure indicated, "...The caregiver will raise the side rail on far side of bed (if rail not in use, ensure there is a second caregiver on the opposite side of the bed to ensure that the resident does not roll over the side of bed). Assist resident to turn onto side moving away from you toward raised side rail (or second caregiver)..." 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on record review and interview, the facility	F 0693	1. Resident 9 was affected	05/09/2025

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	failed to monitor and provide gastrostomy tube (g-tube) maintenance for 1 of 2 residents reviewed for tube feeding. (Resident 9) Findings include: Resident 9's clinical record was reviewed on 04/10/25 at 2:44 P.M. An Admission Minimum Data Set assessment, dated 03/04/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, Chronic Obstructive Pulmonary Disease (COPD), and ulcerative colitis. An Admission Assessment Observation Report indicated the resident was admitted to the facility on 02/26/25. The Nutrition section of the assessment indicated the resident had a gastrostomy tube. The resident resided in the facility in December of 2024 until she was discharged back home in January of 2025. She was readmitted to the facility on 02/26/25 until 03/28/25, when she went to the hospital for a COPD exacerbation. The resident returned to the facility on 04/03/25 and remained there. During an interview, on 04/16/25 at 4:09 P.M., Licensed Practical Nurse 12 indicated she was familiar with the resident. The resident had admitted and discharged from the facility a few times in the last several months. The resident came to the facility with the g-tube. She did not ever receive enteral feeding or medications through the g-tube. When a resident had a g-tube, nursing staff would normally check for placement, monitor the insertion site for drainage and signs of infection, and flush the g-tube once a shift.		by alleged deficient practice. No adverse reactions noted. 2. All like residents have the potential to be affected. Licensed nursing staff educated on G tube care and maintenance. 100% audit on all like residents to ensure G tube care and maintenance orders are present. 3. As a measure of ongoing compliance, the DHS or designee will audit G tube orders to ensure proper implementation weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	The resident's current physician's orders included, but were not limited to, the following: - An open-ended order, with a start date of 04/06/25, to change the g-tube feed irrigation set daily, - An open-ended order, with a start date of 04/06/25, to flush the g-tube with 30 milliliters of water twice a day, and - An open-ended order, with a start date of 04/06/25, for g-tube site care twice a day. The resident's record lacked documentation of any physician's orders related to g-tube care from 02/26/25 through 03/28/25. During that time frame, there was no documentation that indicated the g-tube was monitored or flushed with any regularity and there was no care plan related to the g-tube. During an interview, on 04/17/25 at 10:31 A.M., the Director of Nursing indicated the facility did not have a policy for care of a resident with a g-tube, it would be resident specific and would follow the physician's orders. There should be a care plan related to the g-tube. 3.1-44(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to store medications appropriately for 2 of 4 medication carts observed (100 Hall Medication Cart and 300 Hall Medication Cart). Finding Include:	F 0761	1. No adverse effects noted related to medication being left on top of the cart or loose tablets in the drawers of the cart. No adverse reactions due to undated medications. Medications that	05/09/2025

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	1. During a continuous observation on 04/09/25 from 10:25 A.M. to 10:31 A.M., a box that contained one albuterol cartridge was sitting on top of the 100 Hall Medication Cart. A Certified Nurse Aide (CNA) and a housekeeper walked by the medication cart. At 10:31 A.M., RN 8 placed the box inside the 100 Hall Medication Cart. The 100 Hall Medication Cart was observed on 04/10/25 at 10:39 A.M., with RN 8. The second drawer contained the following: - one small white oval pill, and - one small white round pill. During an interview on 04/17/25 at 1:59 P.M., RN 8 indicated the box containing the albuterol vial should not have been sitting unattended on top of the medication cart and loose pills should not be in the drawers of the medication cart. 2. The 300 Hall Medication Cart was observed with Licensed Practical Nurse (LPN) 7 on 04/10/25 at 10:45 A.M. The following were observed in the top drawer: - A half full insulin pen belonging to Resident 46 with an opened date of 02/17/25, and - A full insulin pen belonging to Resident 5 that had no opened date. During an interview, on 04/10/25 at 10:47 A.M., LPN 7 indicated insulin pens should be dated when placed in the medication cart and were only good for 28 days. Resident 46 had not received any injections from that insulin pen, he had moved rooms, and his medications were in a different medication cart.		were not properly stored, labeled or dated were removed from the medication cart and disposed of properly per policy. 2. All residents have the potential to be affected. Licensed nursing staff educated on Medication Administration-General Guidelines. Medication carts were audited to ensure all medications were properly stored, labeled, and dated with no additional findings. 3. As a measure of ongoing compliance, the DHS or designee will conduct random medication cart audits to ensure proper storage, labeling and dating of items weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	The current facility policy titled, "MEDICATION STORAGE IN THE FACILITY", was provided by the Director of Nursing (DON) on 04/17/25 at 2:08 P.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed facility personnel, pharmacy personnel, or facility personnel lawfully authorized to administer medications..." 3.1-25(j) 3.1-25(o)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on record review, observation, and interview, the facility failed to follow infection control guidelines related to Enhanced Barrier Precautions (EBP) for 1 of 4 observations of high-contact resident care activities. (Resident 9) Findings include: Resident 9's clinical record was reviewed on 04/10/25 at 2:44 P.M. An Admission Minimum Data Set assessment, dated 03/04/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, Chronic Obstructive Pulmonary Disease (COPD), and ulcerative colitis. The resident had a gastrostomy tube (g-tube). The resident's current physician's orders included, but were not limited to, an open-ended order, with a start date of 04/03/25, that indicated the resident was in EBP and staff were to wear a gown and gloves at minimum during high-contact care	F 0880	1. Resident 9 was affected by alleged deficient practice. No adverse reactions noted. 2. All like residents have the potential to be affected. Nursing staff educated on enhanced barrier precautions. 3. As a measure of ongoing compliance, the DHS or designee will conduct random audits on 3 like residents to ensure proper PPE utilization weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan	05/09/2025

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	activities. During an observation, on 04/17/25 at 1:01 P.M., the resident's door had a sign on it that indicated staff were to "STOP" and that the resident was in "ENHANCED BARRIER PRECAUTIONS". Everyone must wear gloves and a gown when providing care, including device care or use of a feeding tube. RN 8 entered the resident's room and provided g-tube care without donning a gown. During an interview, on 04/17/25 at 1:10 P.M., RN 8 indicated the resident was in EBP, he should have worn a gown while working with the resident's g-tube. The current facility policy, titled "Enhanced Barrier Precautions (EBP) Standard Operating Procedure", dated 04/01/24, was provided by the Director of Nursing on 04/17/25 at 1:51 P.M. The policy indicated, "...EBP will be in place during high-contact care activities for residents with the following conditions...indwelling medical devices...feeding tubes...at minimum, staff shall wear gloves and gowns during high-contact care activities..." 3.1-18(b)		will be reviewed and updated as warranted.	
F 9999 Bldg. 00	410 IAC 16.2-5-1.4 Personnel Sec. 1.4. (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in	F 9999	1. CNA 3, 4 and 5 were affected by the alleged deficient practice. No adverse reactions noted. No residents were affected. 2. All new employees have the potential to be affected. Department leaders educated on	05/09/2025

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	accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to obtain references for 3 of 10 employee files reviewed. (CNA 3, 4, and 5) Findings include: On 04/15/25 at 10:15 A.M., the employee files were provided by the Business Office Manager (BOM). The following employee files were reviewed and indicated the following: - CNA (Certified Nurse Aide) 3, reference check results, closed without result, - CNA 4, reference check results, closed without result, and - CNA 5, reference check results, closed without result. On 04/15/25 at 11:01 A.M., the BOM indicated the corporate office sent out requests for personal references. If the references the potential employee provided didn't reply to the request for information from the corporate office there would be nothing to place in the employee files. The current facility policy titled, "Employment Verification and Reference Checks" was provided by the BOM on 04/15/25 at 11:15 A.M. The policy indicated, "...Completed references or employment verifications forms for each employee should be placed in the employee's personnel file when hired..."		importance of reference check completion prior to employment. 3. As a measure of ongoing compliance, the Business Office Manager (BOM) or designee will audit 3 new employee files to ensure reference checks have been completed per policy weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and	R 0000	**Preparation or execution of this plan of correction does not**	

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	State Licensure Survey. Survey dates: April 9, 10, 11, 15, 16, and 17, 2025 Facility number: 002955 Residential Census: 27 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.		**constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted April 17, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 9, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance Based on record review and interview, the facility failed to provide annual tuberculin (TB) tests for 3 of 7 residents reviewed for annual TB testing. (Residents 508, 406, and 519) Findings include: 1. The clinical record for Resident 508 was reviewed on 04/17/25 at 2:00 P.M. The resident was admitted to the facility on 04/06/22. The resident's diagnoses included, but were not limited to, wedge compression fracture and	R 0412	1. Residents 508, 406, and 519 were affected by alleged deficient practice. No adverse reactions noted. 2. All residents have the potential to be affected. Licensed nursing staff educated on annual administration of TB tests. 100% audit completed on AL residents to ensure annual TB skin tests have been	05/09/2025

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	Parkinson's disease. The resident's last documented TB testing was completed on 04/20/22. 2. The clinical record for Resident 406 was reviewed on 04/17/25 at 2:03 P.M. The resident was admitted to the facility on 12/20/23. The resident's diagnoses included, but were not limited to, chronic kidney disease and dementia. The resident's last documented TB testing was completed on 12/12/23. 3. The clinical record for Resident 519 was reviewed on 04/17/25 at 2:05 P.M. The resident was admitted to the facility on 04/20/23 and discharged 01/16/25. The resident's diagnosis included, but was not limited to, atrial fibrillation. The resident's last documented TB testing was completed on 03/18/22. During an interview, on 04/17/25 at 02:17 P.M., the Infection Preventionist indicated the residents did not have a current annual TB test or risk assessment completed. During an interview, on 04/17/25 at 2:19 P.M., the Director of Nursing (DON) indicated there was no active TB in the facility. The current facility policy titled, "AL [Assisted Living] Tuberculin Testing Guidelines", with a revision date of 04/17/24, was provided by the DON on 04/17/25 at 2:25 P.M. The policy indicated, "...To ensure residents are free of tuberculin...Testing shall be repeated according to state regulations..."		administered. 3. As a measure of ongoing compliance, the DHS or designee will conduct audits on 3 random residents to ensure TB tests were administered per policy weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	