STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN 46107

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 19, 20, 21, 22, 23, and 26, 2024 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Census Bed Type: SNF/NF: 15 SNF: 8 NF: 53 Residential: 9 Total: 85 Census Payor Type: Medicare: 8 Medicaid: 56 Other: 12 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 1, 2024.	F 0000	No response needed	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure the posted nurse staffing document reflected the actual hours worked for 3 of 3 observations.	F 0732	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies	03/19/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings included. On 2/19/24 at 8:40 a.m., the Staff Posting Report document was observed in the front lobby sitting on a table in a clear frame. The Staff Posting Report was observed to not include the actual hours worked by staff. On 2/20/24 at 8:20 a.m., the Staff Posting Report document was observed in the front lobby sitting on a table in a clear frame. The Staff Posting Report was observed to not include the actual hours worked by staff. On 2/21/24 at 7:55 a.m., the Staff Posting Report document was observed in the front lobby sitting on a table in a clear frame. The Staff Posting Report was observed to not include the actual hours worked by staff. During an interview on 2/21/24 at 11:40 a.m., the Director of Nursing (DON) indicated the front lobby was the only location the posted staffing hours were posted in the facility. The DON was unaware the actual hours worked were to be posted. On 2/21/24 at 3:55 p.m., the DON provided a policy titled Posted Nurse Staffing Data and Retention Requirements, dated July 2023, and indicated it was the current policy being used by the facility. A review of the policy indicated "...Procedure: 1. ...d The total number and actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: i. Registered nurses ii. Licensed practical nurses iii. Certified nurse aides."		cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection Report. Beech Grove Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. Deficiency ID: F _ **0732** Completion Date: 3/19/24 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** -No residents were affected by the alleged deficient practice. The posted nurse staffing hours include the actual worked nursing hours and is posted and updated daily. **How other residents having the potential to be affected by the same deficient practice will**	

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			be identified and what corrective actions will be taken? -Staff education will be completed by the DNS/designee on or before March 19, 2024, with Nursing managers addressing the appropriate posting of nursing staffing. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** -Staff education will be completed by DNS/designee on or before March 19, 2024, with Nursing managers addressing the appropriate posting of nursing staffing. -The DNS/designee will review the daily staff posting to ensure the appropriate documentation and information is present. **How the corrective actions 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 review the daily staffing posting daily for one month and then weekly for three	

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			months and monthly for 5 months. If a 95% threshold is not achieved as reviewed in the CQI Committee an action plan will be developed.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medications were stored in accordance with accepted principles for 1 of 3 medication carts reviewed and two random observations of treatment carts. Medication and treatment carts were unlocked and insulin did not have an open date. (300 Hall Medication Cart, 300 Hall Treatment Cart) Findings include: 1. On 2/19/24 at 8:55 a.m., a treatment cart located near the 300-hall nurse's station was observed to be unlocked. No staff were observed in the immediate area at that time. On 2/19/24 from 10:30 a.m. to 10:33 a.m., a medication cart located in the hall and next to next to the 300-hall nurse's station was observed. The medication cart was observed to be unlocked. Inside the cart were multiple syringes and a variety of resident's medications. On top of the cart was a pair of metal scissors. An unidentified staff person was sitting inside the nurse's station area facing the four foot tall half wall. The staff person was facing the opposite direction from	F 0761	Deficiency ID: F _ **0761** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**-No resident identified has been affected by this practice. -The medications with no open date were immediately removed from the medication cart.-The medication carts that were not locked were immediately locked. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**-All residents taking insulin have the potential to be affected by the alleged practice.-All residents have the potential to be affected by unlocked medication and treatment carts. -a 1X audit will be completed by the DNS/designee to ensure all applicable open medications were labeled with open dates.-Staff education will be	03/19/2024

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	where the medication cart was located. The staff person was working intently on the computer and had not looked up or acknowledged that anyone was nearby during that time. Multiple residents were observed in the therapy room which was located approximately 12 feet from the nurse's station. No other staff were visible in the area. On 2/21/24 at 3:00 p.m., Registered Nurse (RN) 2 was observed to position a medication cart in the 100-hall near Room 107. RN 2 retrieved supplies and medication from the medication cart. RN 2 was observed to walk away from the medication cart to enter a resident's room located across the hall from the medication cart. The medication cart was observed to be unlocked. No other staff were visible in the area. During an interview at that time, RN 2 indicated the cart was to be kept locked when left unattended by staff. On 2/21/24 from 3:05 p.m. to 3:13 p.m., a treatment cart located in the 300-hall between rooms 330 and 328 was observed. The treatment cart was observed to be unlocked. Inside the unlocked treatment cart were multiple medications and supplies including, but not limited to, santyl ointment (used to remove damaged tissue from chronic skin ulcers); diclofenac sodium topical gel 1% (used to treat pain and swelling caused by osteoarthritis of the knees); and bandages. No staff were visible in the area during that time. During an interview on 2/21/24 at 3:15 p.m., the Director of Nursing Services (DNS) indicated the medication and treatment carts were to be kept locked when unattended by staff. On 2/21/24 at 3:55 p.m., the DNS provided a copy of the LTC (Long Term Care) Facility's Pharmacy Services and Procedures Manual policy, dated		completed by the DNS/designee on or before March 19, 2024, with licensed nurses and QMA's on medication labeling with open dates as applicable.-Staff education will be completed by the DNS/designee on or before March 19, 2024, with the licensed nurses and QMA's ensuring medication and treatment carts are to remain locked when left unattended. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**-Staff education will be completed by the DNS/designee on or before March 19, 2024, with licensed nurses and QMA's on medication labeling with open dates as applicable. -Staff education will be completed by the DNS/designee on or before March 19, 2024, with the licensed nurses and QMA's ensuring medication and treatment carts are to remain locked when left unattended.-Medication carts will be audited daily by nurse managers/designee to ensure all open medications are labeled with open dates as applicable. Any concerns will be addressed immediately.-Medication and treatment carts will be audited daily by nurse managers/designee to ensure that all carts remain locked when not attended. Any concerns will be addressed immediately. **How the**	

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	7/21/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...facility should ensure that all meds [medications] and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors..." 2. On 2/20/24 at 1:20 p.m., the 300 Hall Medication Cart was observed. The following medications were not labeled indicating a date the medications were opened. - One opened vial of Insulin Lispro (an injectable medication used to treat Diabetes Mellitus) 100 units/ml (milliliter). - One used Insulin Glargine (an injectable medication used to treat Diabetes Mellitus) Flex Pen 100 units/ml. - One Levemir (an injectable medication used to treat Diabetes Mellitus) Flex Pen 100 units/ml. - One Lantus Solostar Insulin (an injectable medication used to treat Diabetes Mellitus) Flex Pen. During an interview at that time, LPN 3 indicated the vials and Pens should have been dated at the time they were opened. On 2/21/24 at 11:40 a.m., the Director of Nursing provided a policy titled, Storage and Expiration Dating of Medications, Biologicals, dated 2/2002, and indicated it was the current policy being used by the facility. A review of the policy indicated "....5. Once any medication or biological package is opened; Facility should follow manufacturer or supplier guidelines with respect to expirations dates for open medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened."		**corrective actions 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 the Medication Storage Review CQI audit tool for six months with audits being completed once weekly for one month and then monthly for 5 months by a nurse manager/designee. The Medication Storage Review CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.- To ensure compliance the DNS/Designee will complete a medication/treatment cart audit tool for six months with audits being completed once weekly for one month and then monthly for 5 months by a nurse manager/designee. The medication/treatment cart audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be	

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	3.1-25(j) 3.1-25(m)		developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: February 19, 20, 21, 22, 23, and 26, 2024 Facility number: 000029 Residential Census: 9 Beech Grove Meadows was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	No response needed	