09/25/2024 PRINTED:

CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072  NAME OF PROVIDER OR SUPPLIER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/26/2024			
		STREET ADDRESS, CITY, STATE, ZIP COD 2002 ALBANY ST							
BEECH GROVE MEADOWS			BEECH GROVE, IN 46107						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	D BE COMPLETION COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE			
F 0000									
Bldg. 00		Recertification and State This visit included a State are Survey.	F 00	000	No response needed				
	Survey dates: Febr 2024	ruary 19, 20, 21, 22, 23, and 26,							
	Facility number: 0 Provider number: 1002	155072							
	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	x:							
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.							
	Quality review con	npleted March 1, 2024.							
F 0732 SS=C	483.35(g)(1)-(4) Posted Nurse Sta	ffing Information							

F 0732

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on observation, interview, and record

review, the facility failed to ensure the posted

worked for 3 of 3 observations.

nurse staffing document reflected the actual hours

Bldg. 00

TITLE

This plan of correction constitutes

this facility's written allegation of

compliance for the deficiencies

(X6) DATE

03/19/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Z2HK11 Facility ID: 000029 If continuation sheet Page 1 of 7

PRINTED: 09/25/2024 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 COMPLETED 00 B. WING 02/26/2024 155072 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2002 ALBANY ST **BEECH GROVE MEADOWS** BEECH GROVE. IN 46107 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE cited. The submission of this plan Findings included. correction is not an admission of On 2/19/24 at 8:40 a.m., the Staff Posting Report document was observed in the front lobby sitting agreement with the deficiencies or on a table in a clear frame. The Staff Posting conclusions contained in the Report was observed to not include the actual Indiana hours worked by staff. Department of Health's inspection Report. Beech Grove Meadows On 2/20/24 at 8:20 a.m., the Staff Posting Report respectfully requests document was observed in the front lobby sitting consideration for a desk review of on a table in a clear frame. The Staff Posting this plan of correction in lieu of Report was observed to not include the actual post hours worked by staff. survey revisit. On 2/21/24 at 7:55 a.m., the Staff Posting Report Deficiency ID: F 0732 document was observed in the front lobby sitting on a table in a clear frame. The Staff Posting Completion Date: 3/19/24 Report was observed to not include the actual hours worked by staff. Plan of Correction Text: 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 What corrective actions will be hours were posted in the facility. The DON was accomplished for those unaware the actual hours worked were to be residents found to have been posted. affected by the deficient practice? On 2/21/24 at 3:55 p.m., the DON provided a policy titled Posted Nurse Staffing Data and Retention -No residents were affected by Requirements, dated July 2023, and indicated it the alleged deficient practice. was the current policy being used by the facility. A review of the policy indicated "...Procedure: 1. The posted nurse staffing hours ...d The total number and actual hours worked by include the actual worked nursing the following categories of licensed and hours and is posted and updated unlicensed staff directly responsible for resident daily. care per shift: i. Registered nurses ii. Licensed practical nurses iii. Certified nurse aides." How other residents having the potential to be affected by

the same deficient practice will

## DE CE

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EPARTMENT OF HEALTH AND HUN	FORM APPROVE							
ENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>	COMPLETED					
	155072	B. WING	02/26/2024					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072		A. BUILDING B. WING	COMPLETED 02/26/2024				
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL D LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	be identified and what corrective actions will be taken?	DATE		
				-Staff education will be comple by the DNS/designee on or bef 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 comple by DNS/designee on or before March 19, 2024, with Nursing managers addressing the appropriate posting of nursing staffing.	eted		
				-The DNS/designee will review daily staff posting to ensure the appropriate documentation and information is present.	e		
				How the corrective actions we be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be purinto place?			
				-To ensure compliance the DNS/designee will review the destruction pasting deity for one	laily		

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staffing posting daily for one month and then weekly for three

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DEPARTMENT	FOI	FORM APPROVED						
ENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED	
		155072	B. WING			02/26	02/26/2024	
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			2	2002 AL	DDRESS, CITY, STATE, ZIP COD BANY ST GROVE, IN 46107	•		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		1	ID PROVIDER'S PLAN OF CORRECTION		)N	(X5)		

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
			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	F 0761	Deficiency ID: F _ <b>0761</b>	03/19/2024
	Based on observation, interview, and record	F 0/61	What corrective actions will be	03/19/2024
	review, the facility failed to ensure medications		accomplished for those	
	were stored in accordance with accepted		residents found to have been	
	principles for 1 of 3 medication carts reviewed and		affected by the deficient	
	two random observations of treatment carts.		practice?-No resident identified	
	Medication and treatment carts were unlocked		has been affected by this practice.	
	and insulin did not have an open date. (300 Hall		-The medications with no open	
	Medication Cart, 300 Hall Treatment Cart)		date were immediately removed	
	Medication cart, 500 Hair Freatment cart)		from the medication cartThe	
	Findings include:		medication carts that were not	
	T manigo merade.		locked were immediately locked.	
	1. On 2/19/24 at 8:55 a.m., a treatment cart located		How other residents having the	
	near the 300-hall nurse's station was observed to		potential to be affected by the	
	be unlocked. No staff were observed in the		same deficient practice will be	
	immediate area at that time.		identified and what corrective	
			actions will be taken?-All	
	On 2/19/24 from 10:30 a.m. to 10:33 a.m., a		residents taking insulin have the	
	medication cart located in the hall and next to next		potential to be affected by the	
	to the 300-hall nurse's station was observed. The		alleged practiceAll residents	
	medication cart was observed to be unlocked.		have the potential to be affected	
	Inside the cart were multiple syringes and a		by unlocked medication and	
	variety of resident's medications. On top of the		treatment cartsa 1X audit will be	
	cart was a pair of metal scissors. An unidentified		completed by the DNS/designee	
	staff person was sitting inside the nurse's station		to ensure all applicable open	
	area facing the four foot tall half wall. The staff		medications were labeled with	
	person was facing the opposite direction from	ĺ	open datesStaff education will be	1

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/26/2024		
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>		T ADDRESS, CITY, STATE, ZIP COD	1	
	GROVE MEADOWS			ALBANY ST H GROVE, IN 46107		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE	E COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		on cart was located. The staff		completed by the DNS/desig	nee	
		g intently on the computer and		on or before March 19, 2024		
	-	or acknowledged that anyone		licensed nurses and QMA's	on	
		that time. Multiple residents		medication labeling with ope	n	
		e therapy room which was		dates as applicableStaff		
		ely 12 feet from the nurse's		education will be completed	-	
	station. No other st	aff were visible in the area.		DNS/designee on or before		
				19, 2024, with the licensed r		
		p.m., Registered Nurse (RN) 2		and QMA's ensuring medica		
		sition a medication cart in the		and treatment carts are to re		
		107. RN 2 retrieved supplies		locked when left unattended		
		m the medication cart. RN 2		What measures will be put	into	
		lk away from the medication		place or what systemic		
		ent's room located across the		changes will be made to		
		ation cart. The medication cart		ensure that the deficient		
		unlocked. No other staff were		practice does not recur?-Staff		
		During an interview at that		education will be completed by the		
		d the cart was to be kept locked		DNS/designee on or before		
	when left unattende	d by staff.		19, 2024, with licensed nurs		
				and QMA's on medication la	<u> </u>	
		05 p.m. to 3:13 p.m., a treatment		with open dates as applicable		
		00-hall between rooms 330 and		-Staff education will be comp		
		The treatment cart was		by the DNS/designee on or I		
		cked. Inside the unlocked		March 19, 2024, with the lice	ensed	
		multiple medications and		nurses and QMA's ensuring		
		but not limited to, santyl		medication and treatment ca		
	· ·	emove damaged tissue from		are to remain locked when le		
	· ·	; diclofenac sodium topical gel		unattendedMedication cart	S WIII	
		nin and swelling caused by		be audited daily by nurse		
		knees); and bandages. No		managers/designee to ensur		
	stati were visible in	the area during that time.		open medications are labele		
	Dumin a a :: : '	v on 2/21/24 of 2.15 ·· ·· 41 -		open dates as applicable. A	ıny	
	_	on 2/21/24 at 3:15 p.m., the		concerns will be addressed		
	· ·	Services (DNS) indicated the		immediatelyMedication and		
		tment carts were to be kept		treatment carts will be audite		
	locked when unatte	nded by staff.		daily by nurse managers/des	-	
	0 2/21/24 : 2.55	4 DNG 11 1		to ensure that all carts rema		
	· ·	p.m., the DNS provided a copy		locked when not attended. A	ny	
		Ferm Care) Facility's Pharmacy		concerns will be addressed		
	Services and Procedures Manual policy, dated			immediately. How the		

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
1		155072	B. WING			02/26/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					LBANY ST		
BEECH GROVE MEADOWS					1 GROVE, IN 46107		
			-		1	1	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		ted it was the current policy in			corrective actions will be		
		A review of the document			monitored to ensure the		
	1	y should ensure that all meds			deficient practice will not		
		piologicals, including treatment			recur, i.e., what quality	4	
	I	stored in a locked cabinet/cart on room that is inaccessible by			assurance program will be p	ut	
	residents and visito	-			into place?-To ensure	النبده	
		20 p.m., the 300 Hall Medication			compliance the DNS/Designe		
		The following medications			complete the Medication Stora	age	
		2			Review CQI audit tool for six		
	were opened.	dicating a date the medications			months with audits being		
	•	of Insulin Lispro (an injectable			completed once weekly for on		
	_	treat Diabetes Mellitus) 100			month and then monthly for 5 months by a nurse		
	units/ml (milliliter)				_		
		Glargine (an injectable			manager/designee. The	ΟI	
		treat Diabetes Mellitus) Flex			Medication Storage Review C audit tool will be reviewed mo		
	Pen 100 units/ml.	treat Diabetes Memitus) Frex			by the CQI committee for six	iluliy	
		injectable medication used to			months after which the CQI te	om	
		itus) Flex Pen 100 units/ml.			will re-evaluate the continued		
		tar Insulin (an injectable			for the audit. If a 95% thresho		
		treat Diabetes Mellitus) Flex			not achieved an action plan w		
	Pen.	treat Diabetes Meintus) Flex			developed. Deficiency in this	III DE	
	T CII.				practice will result in disciplina	arv.	
	During an interview	v at that time, LPN 3 indicated			action up to and including	ai y	
		should have been dated at the			termination of the responsible		
	time they were open				employee To ensure complia		
	lime they were open	illou.			the DNS/Designee will complete		
	On 2/21/24 at 11:40	a.m., the Director of Nursing			medication/treatment cart aud		
		tled, Storage and Expiration			tool for six months with audits		
		ons, Biologicals, dated 2/2002,			being completed once weekly		
	-	s the current policy being used			one month and then monthly t		
		eview of the policy indicated			months by a nurse	01 0	
	1 .	edication or biological package			manager/designee. The		
	1	should follow manufacturer or			medication/treatment cart aud	lit	
		with respect to expirations			tool will be reviewed monthly		
		ications. Facility staff should			the CQI committee for six mor	-	
	_	ned on the primary medication			after which the CQI team will		
	_	tle, inhaler) when the			re-evaluate the continued nee	d for	
	* '				the audit. If a 95% threshold		
	medication has a shortened expiration date once opened or opened."				not achieved an action plan w		

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

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155072	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/26/2024			
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2002 ALBANY ST BEECH GROVE, IN 46107					
(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)	ΓE	(X5) COMPLETION DATE	
	3.1-25(j) 3.1-25(m)				developed. Deficiency in this practice will result in disciplina action up to and including termination of the responsible employee.	ry		
R 0000								
Bldg. 00	Survey. This visit i State Licensure Sur	State Residential Licensure ncluded a Recertification and vey.  uary 19, 20, 21, 22, 23, and 26,	R 00	000	No response needed			
	Facility number: 00	00029						
	Residential Census:	9						
		ows was found to be in 0 IAC 16.2-5 in regard to the censure Survey.						

State Form Event ID: Z2HK11 Facility ID: 000029 If continuation sheet Page 7 of 7