

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER  WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP COD 689 PRO MED LANE CARMEL, IN 46032		
(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
R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00427994.</p> <p>Complaint IN00427994-No deficiencies related to the allegations are cited.</p> <p>Survey dates: November 7 and 8 2024.</p> <p>Facility number: 013510</p> <p>Residential Census: 85</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review was completed on November 13, 2024.</p>	R 0000		
R 0117  Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency</p> <p>Based on interview and record review, the facility failed to ensure a Licensed Practical Nurse (LPN) did not work with an expired license for 1 of 10 LPNs reviewed for staff license. (LPN 2)</p> <p>Finding includes:</p> <p>The staffing records were reviewed on 11/8/24 at 10:00 a.m. When reviewing licenses, LPN 2's license expiration date was 10/31/24.</p> <p>A Medication Administration Record (MAR) indicated Resident 69 had administrations of medications by LPN 2 on the following days: 11/2/24</p>	R 0117	<p>Facility will audit licensure binder monthly for expired licenses, looking two months in advance to ensure licenses are up to date. An audit checklist is in place as of 11/11/2024 with names, titles, expiration dates of licenses, and expiration within two months, which will require two signatures of approval from the Business Office Manager or designee and the Executive Director or designee.</p>	11/11/2024

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

TITLE

(X6) DATE

Nicholas Halstead

Executive Director

11/27/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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	<p>11/3/24 11/5/24 11/6/24</p> <p>The LPN had been working and passing medications after their license had expired.</p> <p>During an interview, on 11/8/24 at 11:20 a.m., the Executive Director (ED) indicated LPN 2 had not renewed her license by 10/31/24. The business office manager was responsible for keeping track of licenses and kept the binder in her office. LPN 2 had been on the schedule and working until today.</p> <p>A current job description, titled "Licensed Practical Nurse," dated as revised September 2017 and received from the ED on 11/8/24 at 11:45 a.m., indicated "...QUALIFICATIONS. A current and unencumbered LPN license in the state in which Community is located...."</p>			