STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00419089. Complaint IN00419089 - No deficiencies related to the allegations are cited. Survey dates: March 26 and 27, 2024 Facility number: 013880 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 4, 2024.	R 0000		
R 0030 Bldg. 00	410 IAC 16.2-5-1.2(e)(1-6) Residents' Rights - Noncompliance (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Libby Mellinger	Administrator	04/17/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
	entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form.			
	Based on observation, interview, and record review, the facility failed to submit an Alzheimer's/Dementia Special Care Unit disclosure form in a timely manner for the dementia care unit for 44 of 44 residents who resided on the dementia unit. Findings include: On 3/26/24 upon survey entrance, the secured Alzheimer's/Dementia unit was initially observed. There were 44 residents who resided on the unit. On 3/27/24 at 1:30 p.m., the Executive Director (ED) provided a copy of the dementia disclosure form. It was dated 12/1/22. During an interview on 3/27/24 at 1:35 p.m., the ED indicated she remembered completing a Disclosure Form for 2023 but was unable to find it. The ED indicated there was no Disclosure Form policy, but it was required to be submitted annually via the Residential Regulations. A disclosure form for 2023 was not provided by the survey exit conference.	R 0030	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. R0300 ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No residents were affected ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** No residents affected ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:***	03/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
			Executive Director or Designee will update disclosures in a timely manner. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Administrator or designee will set reminders to ensure disclosures are updated timely. ***By what date the systemic changes will be completed:*** Completed/Updated 3/28/2024	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (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 accordance with IC 16-28-13-3. Based on observation and interview, the facility failed to obtain fingerprints as part of a background check prior to allowing an employee to work at the facility as an employee for 1 of 1 employee who required fingerprints (LPN 12). Findings include: Employee 12 was hired on 3/14/24. She had a background check completed on 3/13/24 and 3/26/24. The initial request was made, and her first name was spelled incorrectly. Another request	R 0116	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. R0116 - Personnel **What corrective actions will be accomplished for those residents found to have been affected by the finding:**	03/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
	was submitted on 3/26/24. The results came back "inconclusive" and fingerprints were recommended. On 3/27/24 at 1:20 p.m., the Executive Director (ED) indicated employees were not permitted to work without a completed background check. The original background check was completed with the incorrect name and once it was repeated the Business Office Manager (BOM) allowed her to begin working, with the background check pending. The ED was notified of the concern and indicated LPN 12 was suspended until her background check results were received. The ED indicated there was not a policy related to criminal background checks. It was something they do with every new hire.		No residents were found to be affected **How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:** All residents had the potential to be affected. No residents were found to be affected. **What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Business office manager or designee will be inserviced immediately and ongoing each month for 3 months **How the corrective action(s) will be monitored to ensure the finding will not recur**: Background checks will be reviewed by Administrator or designee prior to staff employment. No staff will begin work without background checks and/or fingerprints being completed per policy. **By what date the systematic changes will be completed**: 03/28/2024	
R 0156 Bldg. 00	410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency (m) The facility's food supplies shall meet the standards of 410 IAC 7-24. Based on observation, interview, and record	R 0156	The creation and submission of	04/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
	review, the facility failed to ensure food was served under sanitary conditions related to hand hygiene, while serving the lunch meal for 1 of 15 residents in the main dining hall. Findings include: On 3/26/24 at 11:51 a.m., Food Service Employee 7 was observed delivering a lunch tray to Resident 17. Food Service Employee 7 was observed placing her ungloved and unwashed hand on top of Resident 17's hamburger bun, while she attempted to cut the hamburger in half. During an interview on 3/27/24 at 9:30 a.m., the Dietary Manager (DM) indicated servers should not touch the resident's food and gloves were required whenever food was directly handled by staff members. During an interview on 3/27/24 at 9:55 a.m., the Executive Director (ED) indicated staff should not touch food with ungloved or unwashed hands, as it could pose an infection control risk. On 3/17/26 at 8:37 a.m., the ED provided the current policy titled, "Hand Washing," revised 10/2022. The policy indicated, " ...To promote the control of infections, each staff member should wash their hands often. At minimum, employees shall wash their hands at the following times ... Before handling food ...."		this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. 0156-Sanitation and Safety Standards What corrective actions will be accomplished for those residents found to have been affected by the finding: No residents were found to be affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No residents were found to be affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: All dining room staff will be inserviced regarding hand washing and infection control policy. Five staff members will be randomly selected to complete test regarding handwashing and infection control each month for 3 months. All new employees will be inserviced regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
			handwashing and infection control. How the corrective action(s) will be monitored to ensure the finding will not recur: Culinary Director or designee will conduct inservice and random testing each month for 3 months. Culinary Director or designee will monitor meal service a minimum of 5 meals per week for 3 months and a minimum of 2 meals per week ongoing. By what date the systematic changes will be completed: 04/19/2024	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interviews, the facility failed to hold a blood pressure medication per the parameters for 1 of 5 residents reviewed for medication errors. Findings include: On 3/26/24 at 2:02 p.m., a record review was completed for Resident C. She had the following diagnoses which included but were not limited to dementia and hypertension (HTN). Resident C had an order for metoprolol succinate extended release (ER) 50 mg take 1 tablet two times daily for HTN. The order had a parameter to hold the medication if systolic blood pressure	R 0247	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. R0247 – Health Services What corrective actions will be accomplished for those residents found to have been affected by the finding: No residents were found to be affected. How will you identify other	04/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
	(SBP) was less than 110. Associated adverse effects included: claudication, unstable diabetes, depression, diarrhea, first degree atrioventricular block, pruritis, skin rash, bradycardia, dizziness, and fatigue. The medication was administered when the systolic blood pressure was less than 110 on the following dates and times. a. 3/2/24 at 5 p.m., her SBP was 106/76. b. 3/4/24 at 8:00 a.m., her SBP was 104/62. c. 3/5/24 at 8:00 a.m., her SBP was 105/65. d. 3/6/24 at 5:00 p.m., her SBP was 103/57. e. 3/7/24 at 8:00 a.m., her SBP was 107/63. f. 3/19/24 at 8:00 a.m., her SBP was 107/54. g. 3/21/24 at 8:00 a.m., her SBP was 102/60. h. 3/24/24 at 8:00 a.m., her SBP was 105/70. i. 3/25/24 at 8:00 a.m., her SBP was 101/61. j. 3/25/24 at 5:00 p.m., her SBP was 100/63. On 3/27/24 at 11:30 a.m., the Wellness Coordinator indicated she called the employees that administered the medications on the days it should have been held and they indicated they did hold the medication but did not document it. A policy for medication errors was not provided at the time of exit.		residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No residents were found to be affected. All resident with parameters were reviewed by Wellness Director. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: All QMA'S and LPN's will be re-educated on proper documentation and holding medications when appropriate, that include parameters. How the corrective action(s) will be monitored to ensure the finding will not recur: QMA's and LPN's were educated on proper documentation and proper medication administration. Medication parameters will be randomly monitored 1x per week for 3 weeks and then 1x monthly for 3 months by Wellness Director or designee. By what date the systematic changes will be completed: 04/05/2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
	local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure all foods were labeled, dated, and sealed, emergency food supplies were available, and trash cans were closed with a lid for 1 of 1 kitchen observation. This deficiency had the potential to affect 120 of 120 residents served from the kitchen. Findings include: On 3/26/24 at 9:45 a.m., the Dietary Manager (DM) indicated the kitchen served 120 assisted living (AL) residents and was currently SafeServe certified. Observation during the kitchen tour included: Inside the walk-in freezer, open plastic bags of food were observed with no label or open and expiration dates. These items were tater tots, French fries, garlic toast, hand chicken tenders. Sealed in plastic wrap were 5 chicken patties with no label or opening and expiration date. The DM indicated she did not have the emergency food separated from the daily food supplies. She indicated she was responsible for the ordering and maintaining of the emergency food supply for the residents. She indicated the emergency food supply should have included 30 pounds (lbs) of canned tuna and they only had one 4 lb. can. She should have had bottled water as another emergency supply on hand. She indicated the bottled water expired at the end of last year and it was thrown out and not replaced. Two swing-top trash cans were observed to be open with trash all the way to the top of the container in the front serving area and the back	R 0273	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. R0273-Food and Nutritional Services What corrective actions will be accomplished for those residents found to have been affected by the finding: No residents were found to be affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No residents were found to be affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Swing top trash cans have been replaced. Emergency food supply will be improved and located in a separate area and labeled as 'emergency food and water supply'. Dining staff will receive inservice on proper storage and labeling of food. How the corrective action(s) will be	04/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
	prep area. She indicated since it was the swing-top trash can, once you put something in it, it usually stayed open. She needed to buy different types of trash cans, without a swing-top, to replace the current trash cans in the kitchen. The cook observed starting food for lunch. On 3/26/24 at 10:25 a.m., the DM indicated all the foods in the kitchen should have been labeled with the date received and opened foods should have been labeled and open dated with an expiration date. She indicated she should have had more tuna and water for the on-hand emergency food supplies and the trash can should have been closed. A current policy, titled, "Dating and Labeling Food," dated 6/14, was provided by the Executive Director (ED), on 3/27/24 at 11:37 a.m. A review of the policy indicated, " ...All food in all Traditions Managed Facilities must be clearly labeled and dated ...All foods should have an Open date clearly written on them ...All containers must be labeled with the contents and date food was placed in storage ...." A current policy, titled, "Traditions Management Policy and Procedure," dated 10-22, was provided by the ED, on 3/27/24 at 11:02 a.m. A review of the policy indicated, " ...Traditions Senior Living shall maintain at all times for the resident a 3-day supply of staple foods and a two-day supply of perishable foods. The amount of such supplies shall be based on three meals per day, through its admission policies and resident agreements, we have chosen to provide three meals daily ...." A current policy, titled, "Kitchen Facility," dated 6/13, was provided by the ED, on 3/27/24 at 11:02 a.m. A review of the policy indicated, "		monitored to ensure the finding will not recur: Culinary Director or designee will provide inservice to all staff on proper storage and labeling of food per company policy. Culinary Director or designee will audit food for proper storage and labeling 3x/week for one month and 2x monthly ongoing. By what date the systematic changes will be completed: 04/19/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
	...Traditions Senior Living shall procure, store, prepare, distribute, and serve all food in a manner that protects it against contamination and spoilage ...Place food scraps and trash in garbage can with tightfitting lids and bag liners and shall empty garbage cans daily, or more often if needed ...."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.			
	Based on observation, interview, and record review, the facility failed to ensure medication open dates were correct, medications were not expired, and resident medication only had one pharmacy generated label on it for 3 of 13 resident medications reviewed (Resident 11, 13, 16, and 18) Findings include: On 3/27/24 at 10:13 a.m., Medication Cart 1 was reviewed with Qualified Medical Aide (QMA) 9: Resident 11's pataday eye drops (for eye allergies) was labeled as opened on 2/31/24. QMA 9 indicated since this date did not exist, she did not know when they were opened. The medication storage room was reviewed with QMA 9: Resident 13's paroxentine hcl (treats depression) 40 mg bottle was expired on 12/19/23. Resident 16's humalog (insulin) had a pharmacy	R 0300	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. R0300-Pharmaceutical Services What corrective actions will be accomplished for those residents found to have been affected by the finding: No residents were found to be affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No residents were found to be affected. What measures will be put in	04/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET INDIANAPOLIS, IN 46260

(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
	label on it for her, but also had another pharmacy label attached too, for Resident 18. On 3/27/24 at 12:38 p.m., QMA 9 indicated Resident 11's pataday expired 30 days after opening and the paroxetine was expired for Resident 13. A current policy, titled, "Medication Storage in Centralized Medication Storage," with no date, was provided by the Director of Nursing (DON), on 3/27/24 at 1:07 p.m. A review of this policy indicated, "...Medication are stored safely, securely, and properly, following manufacturers' recommendations of those of the supplier, and in accordance with federal and state laws and regulations. The medication supply is accessible only to authorized personnel...Medications for different resident are clearly separated...Medications that are...expired...are immediately removed from the locked medication storage area and disposed of in accordance with Community policies and procedures...."		place or what systemic changes the facility will make to ensure that the deficient practice does not recur: QMA’s and LPN’s will be educated on proper dating/labeling of medications immediately. Wellness Director or designee will monitor medication labeling 1x weekly for 4 weeks, 1x monthly for 3 months and randomly ongoing. How the corrective action(s) will be monitored to ensure the finding will not recur: Wellness Director or designee will monitor medication labeling 1x weekly for 4 weeks, 1x monthly for 3 months and randomly ongoing. By what date the systematic changes will be completed: 04/19/2024	