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	03/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF WHITESTOWN	5829 NEW HOPE BOULEVARD WHITESTOWN, IN 46075

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00428349, IN00424266, and IN00424140. Complaint IN0424266 - No deficiencies related to the allegations are cited. Complaint IN0428349 - No deficiencies related to the allegations are cited. Complaint IN0424140 - No deficiencies related to the allegations are cited. Survey dates: February 29, March 1, and 3, 2024. Facility number: 015004 Residential Census: 79 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 18, 2024.	R 0000	**R 0000** This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request consideration for paper compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heidi M Myers	Executive Director	03/29/2024

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.

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	admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure residents did not have medications in their rooms without a self-medication assessment for 2 of 5 residents reviewed for self-medication assessments (Resident D and M). Findings include: On 2/29/24 at 11:36 a.m., Resident D was observed in her room. Fluticasone (treats allergies) was observed on the table by her chair and 2 bottles of Milk of Magnesia (treats constipation) were observed on the floor. On 2/29/24 at 11:54 a.m., Resident M was observed in her room. Clobetasol propionate cream 0.05% (prescription topical cream for a variety of skin conditions), Monistat cream (treats yeast infections), 6 cranberry pills (may support urinary tract health) in blister pack, and a Funginail pen (treats toenail fungus) were observed on her bedside table. On 3/1/24 at 1:39 p.m., the DON indicated Resident D did not have orders or a self-administration assessment for the medications in her room, so she took the medications away. Resident M medications were removed from her room, except for her psoriasis medication cream because she did not have a self-administration assessment. For the psoriasis cream, she completed a self-administration assessment.	R 0216	**R 216** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A sweep of the rooms of residents D and M were conducted, and all medications not listed as self-administer were removed from the residents' room and secured in the med cart. Residents D and M were instructed to keep all medications secured in a locked cabinet. Medication orders were reviewed for both residents to ensure that all medications self-administered by the resident had physician orders in place and self-medications assessments were complete for those medications. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; All Assisted Living residents who do not self-administer their own medications have the potential to be affected by the alleged deficient practice. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not	04/17/2024

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	A current policy titled, "Medication Policy," with no date, was provided by the ED, on 3/1/24 at 12:08 p.m. A review of the policy indicated, " ...Self-Administration of Medications...Residents ...are solely responsible for dispensing and administering their own medication...and must meet the following requirements...Have written approval from their physician...Participant in an Evaluation for Self-Administration to determine whether the resident can safely manage his/her own medication ...Must keep medication(s) inaccessible to other individuals in a locked compartment within their apartment ...." A current policy titled, "Medication Policy," with no date, was provided by the ED, on 3/1/24 at 12:08 p.m. A review of the policy indicated, " ...Each resident has the right to self-administer his/her own medication unless determined that this practice is unsafe by the community, the resident/responsible party and/or physician ...PRN (As-needed) Medications ...these medication are normally managed in the same manner as routine prescription medications, however requirements for PRN medication administration vary according to the resident's cognitive ability and will be given in accordance with physician's orders and licensing requirements ... Over-the Counter Medications ...For your health and safety, and that of the other residents, all (OTC) medications must be locked and administered in the same manner as prescription medications ... OTC medications are required to have a Physician's Order with the same information as prescription medications ...."		recur; A) Nursing staff were retrained on the facility policy and ISDH regulations for self-administration of medications. Physicians' orders will be reviewed for all residents with self-medication orders to ensure that physicians orders are in place and a self-medication evaluation has been completed. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; DON or designee will complete a monthly review of all self-medication orders to ensure that a self-medication evaluation has been completed and physicians' orders are in place. Nursing staff will complete a monthly sweep of Assisted Living resident apartments to ensure that medications are secured in a locked cabinet. The date the systemic changes will be completed by; April 17, 2024.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff			

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	members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observations and interviews, the facility failed to review and obtain a signature from the residents for service plans for 4 of 8 residents reviewed for services plans (Resident G, B, F and D) and failed to update a service plan for 1 of 8 resident's reviewed (Resident E). Findings include: 1. On 3/1/24 at 9:30 a.m., a comprehensive medical record review was completed for Resident G. She had the following diagnosis which included but	R 0217	**R 217** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; Visits were scheduled for residents G, B, F, D and E, at which the service plans were reviewed and signed. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the	04/17/2024

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	not limited to HTN (hypertension), depression, overactive bladder, anemia, HLD (hyperlipidemia), GERD (gastro-esophageal reflux disease) constipation and muscle weakness. During an interview with Resident G on 3/1/24 at 1:10 p.m., she indicated a nurse came by on 2/29/24 and had her sign it per the DON's (director of nursing) request. A copy of her service plan 5/5/23 was provided and signed by the resident without a date. 2. On 2/29/24 at 10:45 a.m., a comprehensive medical record review was completed for resident B. She had the following diagnoses which included but not limited to anxiety, depression, dysphagia (difficulty swallowing), acute kidney failure, embolism (blood clot), HLD (hyperlipidemia), anemia, and urinary retention. She had a service plan dated 12/19/23. The facility was unable to provide a copy of the resident's signed service plan. 3. On 2/29/24 at 11:30 a.m., a medical record review was conducted for Resident F. She had the following diagnoses which included but not limited to dementia, hypothyroidism, anxiety, major depression, and abnormal weight loss. She had a service plan dated 10/17/23. The facility was unable to provide a copy of the resident's signed service plan. 4. On 2/29/24 at 11:00 a.m., a comprehensive medical record review was completed for Resident D. She had the following diagnoses which included but were not limited to schizoaffective disorder, chronic kidney disease, osteoarthritis,		corrective action that will be taken; All Assisted Living residents have the potential to be affected by the alleged deficient practice. All service plans without signatures of resident and/or family, will be updated and a visit scheduled to review and sign the service plan. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur; B) The DON and licensed staff were trained on the facility policy and ISDH regulations for evaluations and service plans. An audit will be completed for all residents to determine any service plans not signed by family and/or resident and visits will be scheduled for those residents and the service plan will be reviewed and signed. DON or designee will be responsible for ensuring service plans are updated and signed by resident/family. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; C) A tracking tool will be utilized by the DON or designee, who will audit service plans weekly x 3 weeks, then bi-weekly x 3 weeks and then monthly x 3 months to ensure that updates are completed timely. Visits with residents and family will be scheduled to review the updated service plans.	

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	HLD (hyperlipidemia), type 2 diabetes, and edema (swelling of the arms or legs). She had a service plan dated 7/6/23. The facility was unable to provide a copy of the resident's signed service plan. 5. On 3/1/24 at 10:00 a.m., an interview was completed with Resident E and his spouse. Medications were observed on a dresser. They include prostate medication, Tylenol, and ibuprofen. His wife indicated the other medications were hers. She indicated she would lock up all medications. She also indicated that since the resident returned from the hospital, the staff have been doing his medications for him. Resident E had a service plan dated 9/8/23 with a goal indicating he would be supported to take all medications safely and as ordered. An intervention indicated he was responsible for taking medications correctly without assistance. A policy titled "Assistance/Service Plan" was provided by the ED (executive director) on 3/4/24 at 9:15 a.m. It indicated, " ...The Resident Services Coordinator and Resident Assistant will visit with the resident and family to complete the plan ....".		The date the systemic changes will be completed by; April 17, 2024.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record	R 0241	**R 241**	04/17/2024

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	review, the facility failed to ensure medications were administered without error for 3 of 5 residents observed for medication administration (Resident D, M, N, P). Findings include: 1. On 2/29/24 at 11:36 a.m., Resident D was observed to provide a glucometer reading to Qualified Medication Aide (QMA) 6. Without observing the reading herself, she took the resident's word for the blood sugar level and administered insulin according to an existing sliding scale physician's order. QMA 6 indicated Resident D received 10 units of scheduled Humalog insulin and additional Humalog insulin per the sliding scale. Resident D would receive a total of 11 units. QMA 6 did not wash or gel her hands before putting on gloves. She added a needle to the Humalog insulin pen. There was no open date on the insulin pen. She did not prime the needle and administered the Humalog. She did not wash or gel her hands after removing the gloves. Since the needle was not primed the resident may have only received 9 units of insulin. 2. On 2/29/24 at 11:54 a.m., QMA 6 did not wash or gel her hands between residents. She was observed to remove Resident M's glucometer from Medication Cart 1. She unzipped the pouch and removed it. She did not clean it before checking Resident M's BS. Her BS was 148. QMA 6 did not clean the glucometer before returning it to the glucometer pouch. She removed the Novolog pen and added a needle. She did not prime the needle. She dialed in 4 units and administered it. Since the needle was not primed the resident may have only received 2 units of insulin. QMA 6 gave 2 injections, instead of one for Resident M's scheduled insulin and sliding		The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; Immediately following the ISDH survey, the QMA was suspended pending investigation and subsequently terminated. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; All residents who have medications administered by nursing staff have the potential to be affected by the alleged deficient practice. D) Licensed nurses and qualified medication aides have been retrained regarding the ISDH regulations and facility policies for medication administration, labeling/dating, insulin administration, glucometer cleaning and hand hygiene between residents. A med cart audit was completed by DON to ensure that all medications were labeled/dated, and any expired medications were immediately removed. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur; DON or designee will monitor insulin administration, use of gloves, glucometer testing and medication administration for QMA's on staff to ensure that	

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	scale insulin. QMA 6 put on disposable gloves and checked the Novolog pen. She indicated it did not have enough insulin in the pen for the second injection. She removed the gloves and did not wash or gel her hands. In the medication room, QMA 6 and the Director of Nursing (DON) were unable to find another Novolog pen for Resident M. The DON indicated she did not know why there were no prescription box or prescription label for the Novolog vial found in the refrigerator marked with Resident M's room number. There was no resident name on the vial. There was no open date. QMA 6 indicated the manufacturer's expiration date was 6/24/24. QMA 6 drew up 36 units of Novolog in a disposable syringe and needle. She carried it to Resident M's room. At 12:23 p.m., Resident D was found stable, but nearly falling. QMA 6 dropped the disposable syringe with Resident M's Novolog on the floor. Resident M's carpet was observed to be very dirty. QMA 6 assisted Resident M to the floor, where Resident M was able to use the bed to get herself up. QMA 6 indicated she tried to put the insulin syringe in her pocket but missed and it fell to the floor. QMA 6 was observed to pick up the insulin syringe from the floor and administer it to the resident. Since the needle was not primed, the resident may have only received 34 units of insulin. 3. On 2/29/24 at 12:32 p.m., QMA 6 knocked on Resident N's door. Resident P answered the door, but kept it mostly closed. QMA 6 removed benzonatate 200 mg for Resident N and gave the medications to Resident P. Then, she removed fish oil 1200 mg for Resident N, placed it in a separate medication cup, and gave it to Resident P. QMA 6 gave the medications to the wrong resident and did not observe the correct resident receiving the medications or ingesting them.		facility policy is being followed. The medication cart will be audited weekly for unlabeled, expired or medication with no open dates. D) All staff administering medication will be retrained on glucometer cleaning, medication administration, use of gloves between residents and insulin administration. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; E) DON or designee will monitor medication administration daily 5 days a week x 3 weeks, then twice a week x 3 weeks and then weekly x 3 weeks or until it is deemed that the alleged deficient practice has been resolved. The medication cart will be audited weekly for unlabeled, expired or medication with no open dates. D) All staff administering medication will be retrained on glucometer cleaning, medication administration, hand hygiene between residents and insulin administration per facility policy. The date the systemic changes will be completed by: April 17th, 2024.	

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	On 2/29/24 at 1:12 p.m., the DON indicated a QMA should have asked to look the resident's glucometer reading before giving insulin. She could have looked on the resident's phone or her Dexcom (device that sends blood sugar levels to a smart device). If that did not work, she should have used a glucometer to get a reading herself. Medications that were open should have had an open and expiration date. Staff should hand wash or gel between resident's during medication administration. Glucometers should have been cleaned before use on the resident and cleaned afterward before putting it away. Residents with medications in their rooms should have a self-medication assessment and those medications should be stored in a locked container in the resident's closet. The DON indicated medications in a syringe, if dropped on the floor, should have been disposed of, and new medication drawn up. Medications should not be placed in a staff person's pocket. When giving injectable medications the needle should have been primed for accurate dosages. On 3/1/24 at 2:05 p.m., the DON indicated QMA 6 needed more training. She should have given the medication to the resident it was intended for and not the person answering the door. She should have watched him take the medication. A current document, titled, "The 5 Rights of Medication Administration," dated 5/19/2016, was provided by the Executive Director (ED), on 3/4/24 at 9:15 a.m. A review of the document indicated, " ...The Right Medication ...First, and foremost, when we go to administer any kind of medication, we should all take a second to double, triple, even quadruple check to ensure that we're getting the medication that has been prescribed for the			

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	patient ...The Right Patient ...The second, and also very obvious, right is to ensure that the medication is being administered to the right patient ...The Right Dose ...A single wrong dosage could have devastating consequences, including severe conditions or even death. Be absolutely certain that the dosage you're going to administer matches what is listed in the physician's order ...The Right Time ...ensure that doses have been given the proper time-interval ...The Right Route ...Staying accurate in using the prescribed route, or method of administration is vital ...." A current policy, titled, "Medication Policy," with no date, was provided by the Executive Director (ED), on 3/1/24 at 12:08 p.m. A review of the policy indicated, " ...Injections ...Community staff will store injectables in the same manner as other prescription medications ...." A current policy, titled, "Injectable Medication Administration Procedures," with no date, was provided by the DON, on 2/29/24 at 3:30 p.m. A review of the procedure indicated, " ...Observe the 5 rights of medication administration ...Hands are to be washed before preparing injectable ...gloves are to be used during administration ...Gloves disposed of in waste receptable ...Hands are to be washed ...." A current policy, titled, "Cleaning and Disinfecting Blood Glucose Meter Policy & Guidelines," with no date, was provided by the DON, on 2/29/24 at 3:30 p.m. A review of the policy indicated, " ...Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe ...."			

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	A, "Job Description," for a, "Certified Medication Technician," dated 9/28/2020, was provided by the ED, on 2/29/24 at 2:30 p.m. A review of the document indicated, " ...Primary Job Functions ...the primary purposed of the Certified Medication Technicians [sic] to provide personal care to residents in a manner conducive to their safety and comfort consistent with policies and procedures while complying with state federal and all other applicable health care standards ...Dispenses medication to residents as per physicians' order, quality assurance standards and state regulations ...Washes hands before and after performing any service for the resident and follow infection control guidelines and universal precautions ..."			
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 local sanitation and safe food handling standards, including 410 IAC 7-24. Based on interview, and record review, the facility failed to provide pasteurized eggs for residents requesting partially cooked eggs for 1 of 1 observation of eggs. This had the potential to effect any residents who consumed eggs that were not completely cooked through. Findings include: On 2/29/24 at 10:45 a.m., the Dietary Manager (DM) provided an invoice from a local food supplier. Eggs were observed to be ordered. The invoice did not indicate the eggs were pasteurized. On 3/1/24 at 2:17 p.m., the DM indicated the eggs	R 0273	**R 273** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; All unpasteurized eggs were disposed of immediately and an order placed for pasteurized eggs on 3/4/2024. Until the order pasteurized eggs were delivered, all egg orders were cooked either scrambled or fried. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the	04/17/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF WHITESTOWN	5829 NEW HOPE BOULEVARD WHITESTOWN, IN 46075

(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
	in the kitchen refrigerator were not pasteurized. The cooks had been serving the residents their choice of egg preparation. He told all the cooks, until the new order came in with pasteurized eggs, to cook all resident eggs hard fried or scrambled. On 3/4/24 at 10:30 a.m., the DM indicated the kitchen staff had been preparing over-easy eggs for residents with unpasteurized eggs. On 3/4/24 at 9:43 a.m., the ED provided an order summary. It indicated Large Grade A Eggs, large and pasteurized, were ordered on 3/4/24. On 3/4/24, at the time of exit, no policy was provided for use of pasteurized eggs.		corrective action that will be taken; All residents requesting eggs cooked over-easy or partially cooked had the potential to be affected by the alleged deficient practice. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur; The dietary manager will purchase pasteurized eggs from the vendor and no longer utilize unpasteurized eggs. The dietary manager and cooks were trained that unpasteurized eggs are not to be purchased for use at the community. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; Dietary manager will review each order placed from the vendor to ensure that the eggs received are pasteurized and upon arrival, the DM will check to ensure the eggs are marked “pasteurized”. The date the systemic changes will be completed by: April 17th, 2024.	
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.			

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	Based on observation, interview, and record review, the facility failed to ensure medications were labeled with resident names and/or medication open dates for 3 of 3 medications observed without medication labels (Residents M, and S). Findings include: 1. On 2/29/24 at 11:54 a.m., QMA 6 put on disposable gloves and checked Resident M's Novolog pen. She indicated it did not have enough insulin in the pen for the second injection. She removed the gloves and did not wash or gel her hands. In the medication room, QMA 6 and the Director of Nursing (DON) were unable to find another Novolog pen for Resident M. The DON indicated she did not know why there were no prescription box or prescription label for the Novolog vial found in the refrigerator marked with Resident M's room number. There was no resident name on the vial. There was no open date. QMA 6 indicated the manufacturer's expiration date was 6/24/24. 2. On 2/29/24 at 12:44 p.m., the medication storage was observed with QMA 6, Licensed Practical Nurse (LPN) 12 was in the room. Two bottles of apisol (for diagnosis of tuberculosis) was observed with a blank open date sticker on it. LPN 12 indicated they should have had an opened date on them. 3. On 2/29/24 at 12:49 p.m., Resident S's medication was observed. There were 2 vials of Novolog in a prescription box labeled for one vial. One vial was opened with no open date or expiration on it, the other vial was not opened but had a manufacturer's expiration date of 1/31/24.	R 0300	**R 300** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; The DON pulled the insulin for residents S and M which were missing labels/not dated and the two bottles of tuberculin that were not dated. These medications were disposed of and replaced with insulin pens/vials that were labeled/dated. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; All AL residents receiving medication administration have the potential to be affected by the alleged deficient practice. The DON or designee completed a med cart audit to ensure that no expired meds remained on the cart and all meds had intact labels and dates. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur; All licensed nursing staff were trained on the facility medication policy and ISDH regulations for labeling and dating medication. Night shift nursing staff will complete weekly med cart audits to ensure that all medications have labels, are dated and there are no expired	04/17/2024

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	A current policy titled, "Assisting with Medication Example Follow Manufacturer's Directions for Medication System," with no date, was provided by the ED, on 3/4/24 at 9:15 a.m. The ED indicated this was the medication storage policy. This policy did not address medications stored in the medication room or the medication refrigerator. A current policy, titled, "Medication Policy," with no date, was provided by the ED, on 3/1/24 at 12:08 p.m. A review of the policy indicated, "... Over-the Counter Medications ...For your health and safety, and that of the other residents, all (OTC) medications must be locked and administered in the same manner as prescription medications ... OTC medications are required to have a Physician's Order with the same information as prescription medications ...."		medications on the cart. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; F) DON or designee will complete a medication cart audit weekly x 3 weeks, then bi-weekly x 3 weeks, then monthly x 3 months. DON or designee will log results of the medication cart audit and re-train of nursing staff, as needed. The date the systemic changes will be completed by; April 17, 2024.	
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interviews, the facility failed develop a mental health care plan in cooperation with a mental health agency for a resident reviewed for mental health needs for 1 of 8 residents reviewed (Resident D). Findings include: On 2/29/24 at 11:00 a.m., a comprehensive medical record review was completed for Resident D. She had the following diagnoses which included but were not limited to schizoaffective disorder, chronic kidney disease, osteoarthritis, HLD (hyperlipidemia), type 2 diabetes, and edema	R 0382	**R 382** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A mental health care plan was created for resident D. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; All residents with a major mental health diagnosis have the potential	04/17/2024

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	(swelling of the arms or legs). During an interview on 2/29/24 at 11:10 a.m., Resident D indicated she had a psychiatrist. On 3/1/24 at 10:00 a.m., a request was made to see Resident D's mental health service plan. The DON (Director of Nursing) indicated she would call the mental health provider and request a copy. On 3/4/24 at 9:30 a.m., requested a copy of Resident's service plan for mental health. The DON indicated she would find out where the service plan was located. No mental health service plan was provided by the survey exit. A policy titled "Health Counseling" was provided by the ED (Executive Director) on 3/4/24 at 11:20 a.m. The policy was not specific for mental health counseling.		to be affected by the alleged deficient practice. A list of residents with major mental health diagnoses will be reviewed and a mental health care plan completed in cooperation with a mental health agency. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur; DON will review care plans for all residents with a major mental health diagnosis to ensure that a mental health care plan is included in cooperation with a mental health agency. The DON was trained on the ISDH rule for mental health screening. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; G) DON or designee will utilize the tracking tool to ensure that all new residents with a major mental health diagnosis will have a comprehensive care plan developed within 30 days of admission. The date the systemic changes will be completed by: April 17th, 2024.	