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	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF BLOOMINGTON	3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401

(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 the Investigation of Complaint IN00388860. Complaint IN00388860 - Substantiated. State deficiencies related to the allegations are cited at R64. Survey dates: September 1 and 2, 2022 Facility number: 012706 Residential Census: 35 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed September 9, 2022.	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on record review and interview, the facility failed to exercise reasonable care for the protection of residents property from loss and theft for 2 of 5 residents reviewed for misappropriation of property. (Residents D, Resident E) Finding includes: During a review of the facility self reported	R 0064	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: all residents, including those residents found to have been affected y the deficient practice, will have their medications more frequently. Executive Director or designated person will continue to do	10/23/2022

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

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	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF BLOOMINGTON	3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401

(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
	incident, on date and time, the facility found the medication count was incorrect for Resident D. The investigation found that Resident F's Norco 5 mg (milligram)/325 mg was 23 tablets off. Resident D's Hydrocodone 5 mg/325 mg had been replaced with Tylenol. During a review of all resident's narcotics, the NP (Nurse Practitioner) observed that Resident B and Resident E's morphine appeared diluted. During an interview with the NP on 9/1/22 at 2:00 p.m., she indicated she ordered another bottle of morphine, went and picked it up from the pharmacy, and compared the color of the medication in the bottles and found them to be 2 different colors, appearing diluted. During an interview with the ED (Executive Director), 9/1/22 at 2:00 p.m., she indicated she tried to contact the agency QMA (Qualified Medication Assistant) to come in and submit to a drug screen. The agency QMA would not return messages or calls from the ED. The ED indicated that while all the narcotic counts appeared to be correct, upon further inspection the morphine had been diluted and the pills had been replaced with Tylenol. On 9/1/22 at 12:00 p.m., the ED provided the facility policy for Medication Administration Policy and Procedures updated February 24, 2022, and indicated this policy was the one the facility followed. It indicated "a licensed nurse or other designated staff ... and witness should document via a count-down sheet when a narcotic is counted and verified. This State tag relates to Complaint IN00388860.		medication audits with DON on at least a weekly basis for 2 months followed by a monthly medication audit for 2 months. Each affected resident's primary medical provider will be notified of any possible medication errors including those resulting from not receiving prescribed medication. -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: all residents, including those residents found to have been affected by the deficient practice, will have their medications monitored more frequently. Executive Director or designated person will continue to do medication audits with DON on at least a weekly basis for 2 months followed by a monthly medication audit for 2 months. Each affected resident's primary medical provider will be notified of any possible medication errors including those resulting from not receiving prescribed medication. -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: ongoing nursing in-services will occur to inform all staff of our medication policies and procedures. Executive Director, Nurse Practitioner, DON & support	

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	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF BLOOMINGTON	3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401

(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
			will work hand-in-hand to ensure medication counts, audits and education are continual. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Corrective actions will be monitored using the attached spreadsheet that shows that medication audits have been completed on the set forth schedule. Systematically, this will include any QMA/Nurse, DON, Executive Director and clinical support at the community. -By what date the systemic changes will be completed: The audit tools will remain in place for at least 4 months. Weekly for 2 months and monthly for 2 additional months. If discrepancies are found, additional education will be provided.	