STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING 00 B. WING	05/21/2024

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HOMEWOOD HEALTH CAMPUS	2494 N LEBANON ST LEBANON, IN 46052

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00417591, IN00417848, and IN00433378. This visit included a State Residential Licensure Survey. Complaint IN00417591 - Deficiencies related to the allegations are cited at F550, F677, and F679. Complaint IN00417848 - No deficiencies related to the allegations are cited. Complaint IN00433378 - Deficiencies related to the allegations are cited at F679. Survey dates: May 13, 14, 15, 16, 17, 20, and 21, 2024. Facility number: 002703 Provider number: 155680 AIM number: 200309250 Census Bed Type: SNF: 7 SNF/NF: 43 Residential: 29 Total: 79 Census Payor Type: Medicare: 4 Medicaid: 31 Other: 15 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amisha Shah	Executive Director	06/24/2024

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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	Quality review completed on June 5, 2024.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be			

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	free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident E) was treated with respect and dignity during a transfer observation, and failed to ensure a resident, (Resident B) was treated with respect and dignity during a treatment observation for 2 of 3 residents reviewed for dignity. Findings include: 1. On 5/17/24 at 11:25 a.m., the following was observed: Certified Nursing Aides (CNA) 14 and 15 entered Resident E's room to lay her roommate down. Resident E was observed sitting up in bed as she attempted to get out of bed. She was observed to have had an incontinent episode and stool was noted as it seeped from the edges of her brief. Resident E complained that her bottom was burning and itching very bad and she continued to attempt to get out of bed. CNA 14 indicated they would get Resident E cleaned up first since her roommate was comfortably asleep in her Broda chair. CNA 14 looked in the resident's closet, but indicated there were no pants so she left the room to go get Resident E a new pair of pants. After CNA 14 left, CNA 15 brought Resident E's wheelchair to the side of her bed. Without the application of a gait belt, CNA 15 grabbed the back of Resident E's saturated brief as she attempted to stand up. Resident E struggled to	F 0550	The submission of this plan of correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Homewood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Immediate actions taken for those residents identified: Both resident B and E were affected. No adverse effects noted. Floor staff was immediately in-serviced on Resident Rights Guidelines.	06/28/2024

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	support her own weight and hesitated to stand up all the way or pivot toward the seat of the chair. Resident E appeared to be anxious and confused. CNA 15 gave repeated instructions for the resident to put her right hand on her right arm rest, but Resident E kept putting her hand on the left arm rest during the transfer. CNA 15 let go of Resident E with one hand while maintaining her grasp on the back the resident's brief, as she attempted to move Resident E's hand from the left arm rest to the right. This appeared to startle Resident E, as the aides hand left Resident E's arm, Resident E reached out to grab CNA 15 for more support. CNA 15 pushed the resident's hips back to move her body away from Resident E's reach and with a sigh and eye roll CNA 15 scolded Resident E and indicated, "don't grab me, don't pinch me." Resident E continued to struggle to support her full weight, and was unable to complete the transfer from the edge of the bed. CNA 15 did not offer or attempt to raise the level of the bed, or apply a gait belt. As Resident E struggled, CNA 15's instructions became more clipped, her tone became more stern, and she sighed deeply many times. During one attempt, CNA 15 had the resident's left arm, and held onto the back of her brief which was pulled taunt against the resident's bottom which caused her stool to seep out from the edges more. Resident E was trying to straighten herself and stand, but CNA 15 indicated, "you're either going to have to turn and sit in the wheelchair, or sit back down on the bed, you're too heavy." Resident E sat back onto the bed and looked up at the aide and indicated, "Heavy? I'm not heavy, I'm usually told I'm so light." CNA 15 rolled her eyes.		2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes All staff were in-serviced on Resident Rights Policy and Procedure, all Clinical Staff were in-serviced on Transferring Residents/ADL Care Policy and Procedure. DHS/designee will complete observations to monitor staff providing ADL Care and Resident Transfers. Audits will be completed on 5 residents weekly x4 weeks, 3 res a week X 4 weeks, 3 resident every other week X 4 weeks, and then monthly X 6 months. 4) How the corrective actions will be monitored: The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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After Resident E sat for a few moments to rest, she was able to stand up and finally transferred to her wheelchair and was taken into the bathroom for incontinent care.

2. During an interview on 5/16/24 at 1:39 p.m., Resident B indicated she needed to be changed and requested her incontinent care to be observed to show the areas of irritation on her bottom and thighs which bothered her. She pressed her call light and within a few minutes Qualified Medication Aide (QMA) 7 and CNA 14 entered the room.

Resident B was rolled onto her right side where she faced QMA 7 who helped keep the resident in place with her hands on her hip and waist. When asked if Resident B was in any pain, or would she be able to tolerate some repositioning onto her side more often, before the resident could answer, QMA 7 rolled her head upward and rolled her eyes as she shook her head, "no." QMA 7 indicated out loud, but not to the resident, "no she doesn't, let us turn her, she never lets us reposition her." Resident B indicated, "Yes I would!"

After Resident B's incontinent care was complete, both QMA 7 and CNA 14 left her room without offering to reposition her.

Resident B indicated she would let them reposition her, but they are always in a rush and don't take their time. She indicated it made her feel like she was a burden and because it took too long to help get things just right for her, she didn't want to bother the staff.

During an interview on 5/21/24 at 9:44 a.m., the

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	Executive Director (ED) and Director of Nursing (DON) were informed of the above observations. The DON indicated usually Resident E was able to help with minimal assistance for her transfers, but if the aide realized she was struggling she should have used a gait belt and not the back of the brief which could tear. The DON indicated Resident B did often refuse all types of care, but the QMA should have asked if the resident would like to be repositioned when she said she would let them and document the results. The ED indicated all residents should be treated with respect and dignity, and not be made to feel bad about themselves or like a burden. On 5/20/24 at 12:20 p.m., the DON provided a copy of current facility policy titled, "Resident Rights Guidelines," revised, 5/11/17. The policy indicated, "Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus. The following is a list of rights recognized by staff at Trilogy Health Services: Our residents have the right to be treated with dignity and respect ... freedom to talk with staff and express concerns/grievances without fear of reprisal ... be treated fairly, courteously and with respect by all staff ...." This citation relates to Complaint IN00417591. 3.1-3(a)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS)	F 0641	Plan of correction not required.	06/28/2024

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	assessment was accurately coded for two residents with a serious mental health and/or developmental disorder for 2 of 4 residents reviewed for Pre-Admission Screen and Resident Review (PASRR) (Residents 207 and 209). Findings include: 1. On 5/17/24 at 12:51 p.m., Resident 207's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, delusional disorders, post-traumatic stress disorder (PTSD), and depression. She had a PASRR Level II, dated 4/23/23, which indicated she was considered to have a major mental illness and gave instruction to code her MDS assessment section 1500, "yes." Resident 207's admission MDS assessment, dated 5/19/24, section 1500 was incorrectly coded, "no." 2. On 5/17/24 at 1:02 p.m., Resident 209's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, Down syndrome and Obsessive-Compulsive Disorder (OCD). He had a PASRR Level II, dated 12/11/23, which indicated he was considered to have an intellectual/developmental disorder and gave instructions to code his MDS assessment, section 1500, "yes." Resident 209's admission MDS assessment, dated 12/20/23, section 1500 was incorrectly coded,			

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	"no." During an interview on 5/17/24 at 1:09 p.m., Resident 207 and 209's PASRR MDS coding was reviewed with the Regional MDS Support nurse. She indicated the admission MDS assessments for Residents 207 and 209 should have been coded "yes," to reflect their mental illness diagnoses which had been recognized by the state and approved for long-term care services without special services. She indicated she would put MDS correction assessments in for both residents.			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's			

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	needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to personalize resident care plans for advanced directives for 5 of 5 residents reviewed for advance directive care plans (Resident 11, 19, 32, 35, and 40). Findings include: 1. On 5/15/24 at 12:52 p.m., a record review was completed for Resident 11. She had the following diagnoses which included, but not limited to urinary tract infection, chest pain, chronic obstructive pulmonary disease (COPD), atrial fibrillation (A-Fib), hyperlipidemia, and dementia. Resident 11 had a care plan indicating she had chosen to have "the following advanced directive," but failed to indicate whether she was to have CPR (cardiopulmonary resuscitation) or DNR (do not resuscitate). She had an order, dated 6/16/23, for a DNR. 2. On 5/14/24 at 2:46 p.m., a record review was completed for Resident 19. He had the following diagnoses which included but were not limited to COPD, type II diabetes mellitus, morbid obesity, chest pain, heart failure, and major depression with psychotic symptoms. Resident 19 had an order for him to have CPR (Full Code). He lacked a care plan addressing his desire to have CPR.	F 0657	1) Immediate actions taken for those residents identified: Residents 11,19, 32, 35, and 40 were affected. Residents were assessed and no adverse effects noted. Resident care plans were immediately updated to reflect personalized advanced directives. 2) How the facility identified other residents: All residents have the potential to be affected. A house wide audit of all residents' code status care plans for accuracy of preferences. 3) Measures put into place/System changes IDT Team were re-educated on Code Status Care Planning Resident Preference. SSD/Designee will complete Code Status Care Plan Audit on 3 residents weekly x4 weeks, 3 res every other week X 4 weeks, 1 resident every other week X 4 weeks, one resident monthly X 3 months. 4) How the corrective actions will be monitored: The results of the audit observations will be reported, reviewed, and trended for	06/28/2024

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	3. On 5/14/24 at 2:12 p.m., a record review was completed for Resident 32. He had the following diagnoses which included but were not limited to urinary tract infection, swelling of left lower leg, bradycardia (a slow heartbeat), type 2 diabetes mellitus, and major depressive disorder. Resident 32 had an order for DNR dated 11/13/23., He lacked a care plan addressing his desire to be a DNR. 4. On 5/14/24 at 11:43 a.m., a record review was completed for Resident 35. She had the following diagnoses which included but were not limited to COPD, heart failure, type 2 diabetes, chronic kidney disease, depression, and chest pain. She had an order for full code dated 5/26/22. Her care plan, dated 6/8/22, lacked addressing her desire to be a full code. 5. On 5/14/24 at 2:34 p.m., a chart review was completed for Resident 40. He had the following diagnoses which included but were not limited to juvenile myoclonic epilepsy (an epilepsy syndrome characterized by myoclonic jerks (quick jerks of the arms or legs), generalized tonic-clonic seizures), dysphagia (difficulty swallowing), pain, major depressive disorder, and general anxiety disorder. He had an order, dated 4/10/24, for him to be a DNR. He lacked a care plan addressing his desire to be a DNR.		compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	A policy titled, "Comprehensive Care Plan Guideline" was provided by the Regional Nurse Support on 5/15/24 at 2:32 p.m. It indicated, " ...Comprehensive care plans need to remain accurate and current ....". 3.1-35(c)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADL) preferences were honored and implemented for a totally dependent resident for 1 of 3 residents reviewed for ADLs, (Resident B). Findings include: During a continuous observation and interview on 5/15/24 from 2:00 p.m., until 2:22 p.m., Resident B was observed in bed. She was lying flat on her back in her bed. She wore a hospital gown, and her hair was matted and tangled. Thick build up of eye drainage was observed caked in her eye lashes, and there were flakes of dandruff in her hair. A napkin from lunch remained on her chest, where bits of food crumbs had fallen, and there was food crust/stains around her mouth. Resident B indicated, no one had helped her get cleaned up after lunch. During a confidential interview during the survey, it was indicated that several complaints had been made and were ongoing related to Resident B's care. She went days or weeks without getting her	F 0677	1) Immediate actions taken for those residents identified: Resident B was affected. Resident B was assessed, and appropriate ADL care was provided. No adverse effects noted. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes All Clinical Staff were in-serviced on Transferring Residents/ADL Care Policy and Procedure. DHS/designee will complete observations to monitor staff providing ADL Care and Resident Transfers. Audits will be completed on 5 residents weekly x4 weeks, 3 res a week X 4 weeks, 3 resident every other	06/28/2024

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	teeth brushed, her hair was not washed with her special shampoo, and she was often left in soiled briefs. The following grievance documentation was provided for Resident B: a. an e-mail addressed to the Executive Director (ED) sent March 31, 2023 at 3:56:49 p.m., " ...She is also stating she is left for hours and not being changed ..." The ED replied and indicated she would speak to the nursing team. b. an e-mail addressed to the ED sent August 29, 2023 at 5:18 p.m., " ...she is stating it would be nice if her teeth were brushed more along with having her face washed and hair combed ..." The ED replied and indicated, the issue would be addressed and shared with the Director of Nursing Services (DNS). c. an e-mail addressed to the ED sent November 7, 2023 T 4:27:23 P.M., " ...She stated she had asked numerous staff members about getting her briefs changed after having a bowel movement and was simply "blown off" and told they were busy. She eventually fell asleep in the dirty briefs and this was not addressed for quite some time ..." The ED replied and indicated, it was not the facilities standard, and she would look into the issue. d. a text message screen shot sent to the ED on 1/29/24 at 6:10 p.m., " ...she is stating her teeth have not been brushed for several days, this seems to be an ongoing issue ..." The ED replied and indicated she had spoken to the Certified Nursing Aides (CNA). e. a text message screen shot sent to the ED on 2/17/24 at 5:10 p.m., " ...she states her teeth still		week X 4 weeks, and then monthly X 6 months. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	have not been brushed ... what can we do to assure this is done on a daily basis? It has been weeks per [Resident B] and this is not acceptable ... seems to be an ongoing issue. I bring it up, her teeth are brushed a couple of days and then they stop. It should be done everyday without my intervention ..." the ED replied the following day and indicated her teeth had been brushed that morning. f. a text message screen shot sent to the ED on 2/28/24 at 6:28 p.m., " ...any update on our conversation yesterday? She still has not have her teeth brushed yet, she would like a new toothbrush too ..." The ED replied that the clinical team was trying a new adaptive toothbrush. On 5/16/24 at 9:36 a.m., Resident B was observed as she remained in bed, and she indicated she had not had her teeth brushed yet that morning. Her hair remained tangled and there were flakes of dandruff in her hair. During a continuous observation on 5/16/24 from 1:39 p.m., until 2:27 p.m., Resident B received incontinent care. She had a large bowel movement and indicated she had not been changed since earlier in the morning. During the incontinent care, CNA 14 used a whole packet of wet wipes, and not a personal cleanser. On 5/17/24 at 9:04 a.m., Resident B was observed as she remained in bed, and she indicated she had not had her teeth brushed yet that morning. Her hair remained tangled and there were flakes of dandruff in her hair. During an interview on 5/20/24 at 1:28 p.m., Resident B was observed as she remained in bed, and she indicated she had not had her teeth			

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	brushed yet that morning. Her hair remained tangled and there were flakes of dandruff in her hair. During an interview on 5/21/24 at 1:38 p.m., Resident B was observed and appeared to have had a complete bed-bath. Her face was clean and free of debris, her hair had been neatly combed and Resident B indicated, "I think they are trying to butter me up, they came in here to see me and got me cleaned up and my hair and teeth brushed, I feel like a person again." On 5/15/24 at 2:24 p.m., Resident B's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, Parkinson's disease, hypertensive (high blood pressure), and heart disease with heart failure. She had a current physician's order to use a personal cleanser when completing incontinent care. She had a current physician's order for Ketoconazole shampoo to be used on her shower days. Her Shower days were Monday and Fridays for the morning/day shift and she preferred complete bed baths. Resident B's Medication Administration Record (MAR) was reviewed and revealed that her Ketoconazole shampoo was ordered on the for the evening shift, with several notes that the shampoo had not been applied as her scheduled showers were for the Day shift. Her Shower sheets were reviewed and revealed			

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	the following: a. at the time of the record review, Resident B had only received one complete bed bath for the month on 5/13/24. b. In April she did not receive her bed bath on the 8th, 12th, 22nd, or the 26th. c. In March she did not receive her bed bath on the 8th, 11th, 22nd, or the 29th. Her Resident Profile, dated 5/14/24, indicated the following approaches for care which included, but were not limited to: a. incontinent care and foley catheter [which did not specify the use of a personal cleanser] b. assist with oral care as needed [but did not specify resident's preference for time of day or frequency i.e. daily, twice a day ... ect.] c. see shower schedule [which did not specify the type/frequency of bathing]. d. skin- incontinent care protective ointment as needed [did not specify the use of a personal cleanser]. Resident B's care plans were reviewed: One care plan indicated, "Resident demonstrates non-compliance/refusals with physician orders and/or plan of care as evidenced by: Refusing therapy, meals, care, turning, and weekly weight at times." The care plan was last reviewed on 7/7/24, however all the interventions were dated 1/3/22 and no new interventions had been put into place to address or encourage or educate Resident B against refusals. Her care plans lacked revision to include the special shampoo she required and the days,			

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	frequency and/or preference she had for bathing and lacked revision to specify the frequency or preferences she had for brushing her teeth. During an interview on 5/21/24 at 3:00 p.m., the Regional Clinical Support Nurse (RCS) indicated Resident's preferences for all ADLS should be honored and care planned as detailed as possible. She indicated the facility followed the Indiana code for ADL morning and evening routine care, and at that time provided a copy of Indiana Code as she indicated, there was no facility policy for ADL care and that Residents should be treated with respect and dignity regarding their ADL preferences. On 5/20/24 at 12:20 p.m., the DON provided a copy of current facility policy titled, "Resident Rights Guidelines," revised, 5/11/17. The policy indicated, "Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus. The following is a list of rights recognized by staff at Trilogy Health Services: Our residents have the right to be treated with dignity and respect ... freedom to talk with staff and express concerns/grievances without fear of reprisal ... be treated fairly, courteously and with respect by all staff ... be consulted and encouraged to have input into their care plan which guides the services delivered to the resident ...." This citation relates to Complaint IN00417591. 3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based			

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	on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review, the facility failed to ensure a person-centered and meaningful activity program was implemented for a resident (Resident B) to maintain and/or enhance her quality of life for 1 of 3 residents reviewed for activities. Findings include: During a continuous observation and interview on 5/15/24 from 2:00 p.m., until 2:22 p.m., Resident B was observed in bed. The lights were off, there were personal items stacked in front of her TV which was off. Resident B was alert and oriented and engaged in conversation. Resident B indicated she did not get invited to activities, and any activity she wanted to try, staff did not have her up and ready in time. She required a Hoyer lift for transfers which was painful, especially when staff often rushed through the task and did not take their time to help make sure she was comfortable, "it was too much trouble." During the interview, activity staff was heard in the hallway inviting other residents to activities. Resident B asked who was in the hall and what they were doing. When explained, Resident B indicated, "they won't come ask me, and I do not have a calendar to see for myself."	F 0679	1) Immediate actions taken for those residents identified: Resident B was affected. No adverse effects noted. Care plans were reviewed and 1:1 interaction updated to reflect preferences. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes Life enrichment staff educated on Resident Choice Policy and Procedure. The LED/designee will audit residents for participation, documentation of participation, and to ensure preferences match care plan and assessment data. Audit to consist of 5 residents weekly x4 weeks, then twice monthly x2 months, then monthly x3 months. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for	06/28/2024

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	An activity calendar was observed on top of a pile of incontinent briefs which were stacked on top of her visitors chair. The calendar was out of Resident B's line of sight, and out of her reach. On 5/15/24 at 2:55 p.m., Activity Staff was observed as they invited several residents to an upcoming activity. Resident B was not invited. During a confidential interview, it was indicated, Resident B was no longer receiving one-on-one (1:1) activities. They used to talk with her about genealogy and helped her with research which she had loved, but they stopped doing that. There was a "Silly Safari" activity a while back that Resident B didn't even know about, it was a family member that saw it on the Facilities Facebook page. Resident B used to attend Silly Safari when it was held at the local library, and she would have loved to have been a part of it. The activity calendar was brought to the room, but it got thrown away or misplaced where Resident B could not see it. There had been an autumn Farm Tractor show and she really wanted to see what that was about, but no one came to help get her up in time or try to involve her. It was hard for Resident B to get out of bed and she did not like the use of the Hoyer lift, so they used to come to her room for the 1:1s. She enjoyed conversations, looking things up on the internet, genealogy research, bird identification etc. She used to like to read, but required glasses, which had been lost, and she could no longer hold the books due to contractures in her hands and weakness. On 5/16/24 at 9:36 a.m., Resident B was observed as she remained in bed. Resident B indicated she had not been invited to any activities so far that morning, and she did not know what was on the calendar for the day. She indicated she would like		compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	someone to read the calendar to her to discuss what was going on, and she enjoyed it when staff read the Daily Chronicle to her. Resident B indicated they were supposed to read the chronicle to her since she was unable to read it well enough herself. On 5/16/24 at 10:13 a.m., the Activity Director (AD) entered Resident B's room with the Daily Chronicle. She exited the room a minute later at 10:14 a.m. The Chronicle was not read to Resident B. During a continuous observation on 5/16/24 from 1:39 p.m., until 2:27 p.m., Activity Staff invited residents to upcoming activities. Resident B was not invited/encouraged. On 5/17/24 at 9:04 a.m., Activity Staff were observed as they invited and assisted several residents out for a Scenic Tour travel on the bus. Resident B was not invited. On 5/20/24 at 9:21 a.m., an Activity Assistant entered Resident B's room to pass out the Daily Chronicle. He exited the room, moments later at 9:23 a.m. The Chronicle was not read to Resident B and she was not invited/encouraged for upcoming activities. On 5/20/24 at 10:43 a.m., an Activity Assistant was observed in the main lounge with several residents. She indicated, she was doing "Mindful Moments," which was a colorful sensory puzzle game where the residents talked about the shapes as they matched the pieces. Resident B was not invited. During an interview on 5/20/24 at 1:28 p.m., Resident B indicated, someone had come to ask			

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	her about her glasses and some other things but everything they said, "it seemed they got it wrong." On 5/15/24 at 2:24 p.m., Resident B's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, Parkinson's disease and hypertensive (high blood pressure) heart disease with heart failure. Her Resident Profile, dated 5/14/24, indicated the following approaches for care: a. incontinent care and foley catheter b. regular diet with plate guard per family request and built up silverware as needed. c. glasses d. assist with oral care as needed e. bed rail assessed as enabler f. Hoyer, wheelchair, bedbound g. see shower schedule h. skin- incontinent care protective ointment as needed i. transfers with Hoyer, and head of bed elevated Her profile lacked revision to include invitations or encouragement to activities, and/or the requirement of 1:1 activity. Resident B's comprehensive care plans were reviewed, which included, but were not limited to the following: a. Resident demonstrated visual losses, Last reviewed/revised 3/18/24, with the Goal of the Resident would continue to participate in his/her activities of daily living despite significant visual loss/legal blindness. Interventions included, but were not limited to, provide visual-aid appliances such as Braille reading materials and talking books.			

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	b. "My ability to make decisions regarding my daily activity engagement may be altered due to my diagnosis of Parkinson's and dementia. I have a history of enjoying pets, animals, and religious services." Last reviewed/revised 3/18/24 with the goal of positively responding and actively participating in one-on-one visits at least 1 time per week. Interventions included, but were not limited to provide in-room sensory related supplies as appropriate and try smaller groups. c. "My faith is important to me and it is important that I continue to engage in religious services or practices. Please help me do this by providing me opportunities to watch services on TV." Last reviewed/revised 3/18/24. Interventions included but were not limited to the following approaches: It was important for the resident to be able to go outside and get fresh air when the weather was good. Provide the resident with opportunities to go outside. Invite the resident to visit the courtyards when the weather was nice. It was important to the resident to do things with groups of people. Invite and or engage the resident to the following group activities that were meaningful to her, such as crochet, reading about plants, gardening, watching/listening to the TV. It was important to the resident to keep up with the news. It was important to me to be around animals. The resident enjoy being around dogs and cats. Please invite the resident to see animals when they were at the campus. Please invite and assist the resident, as needed, to activities of her interest where she may exercise her strengths and ability to participate. d. "Resident demonstrates non-compliance/refusals with physician orders and/or plan of care as evidenced by: Refusing			

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	therapy, meals, care, turning, and weekly weight at times." The care plan was last reviewed on 7/7/24, however all the interventions were dated 1/3/22 and no new interventions had been put into place to address or encourage or educate Resident B against refusals. An Annual Life Enrichment assessment, dated,12/15/23 indicated, provided resources would include: reading materials, plant activities and religious needs. "I am most successful in a 1:1 setting. Provide me with individual interventions," with the goal of attending religious programs, outings, brunch and/or happy hour. A Quarterly Life Enrichment assessment, dated 3/15/24 indicated independent activities of interest in which the Resident Participated was: Watching TV and Other: reading and visitors. The question of if the Resident had interest in changing her activity pursuits or trying new activities was answered yes, that she would like to try to get up more. The record lacked documentation of attempts and/or encouragement to get Resident B up more. Resident B's Activity Participation Log was reviewed. On 5/4/24 an activity note indicated, "resident was playing games on phone," however she did not have a phone with games on it. On 5/16/24 she was coded as having participated in the Mindful Moments activity. However, she had not been invited to the activity and the activity had not been provided in her room. On 5/16/24 she was coded as having "declined"			

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	the Scenic Tour activity. Resident B had not been invited. On 5/18/24 and 5/19/24 she was coded as "reading," but Resident B did not have reading material other than the Daily Chronicle, which she could not read because she did not have glasses. On 5/20/24 at 12:20 p.m., the Director of Nursing Services (DNS) provided a copy of current facility policy titled, "Life Enrichment Program Components/Standards," revised 6/3/17. The policy indicated, "the Life Enrichment Department designs programs which are meaningful, diverse, stimulating, and consistent with the needs, preferences, and abilities of each individual resident/patient ... individual or independent pursuits: provide opportunities for residents/patients to participate in structured and unstructured programs ...." This citation relates to Complaints IN00433378 and IN00417591. 3.1-33(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent the potential	F 0689	1) Immediate actions taken for those residents identified:	06/28/2024

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	for accidents during a resident's transfer, ensuring the implementation of routine monitoring for an electronic wheelchair seatbelt and by ensuring a new mattress was appropriately measured and fitted to the bed frame for 3 of 3 residents reviewed for accidents (Residents E, 8 and C). Findings include: 1. On 5/17/24 at 11:25 a.m., the following was observed. Certified Nursing Aides (CNA) 14 and 15 entered Resident E's room to lay her roommate down. Resident E was observed sitting up in bed as she attempted to get out of bed. She was observed to have had an incontinent episode and stool was noted as it seeped from the edges of her brief. Resident E complained that her bottom was burning and itching very bad and she continued to attempt to get out of bed. CNA 14 indicated they would get Resident E cleaned up first since her roommate was comfortable asleep in her broad chair. CNA 14 looked in the resident's closet, but indicated there were no pants so she left the room to go get Resident E a new pair of pants. After CNA 14 left, CNA 15 brought Resident E's wheelchair to the side of her bed. Without the application of a gait belt, CNA 15 grabbed the back of Resident E's saturated brief as she attempted to stand up. Resident E struggled to support her own weight and hesitated to stand up all the way or pivot toward the seat of the chair. CNA 15 let go of Resident E with one hand while maintaining her grasp on the back the resident's brief, as she attempted to move Resident E's hand from the left arm rest to the right. This appeared to		Resident E,8,C were affected with no adverse reactions noted, all nursing staff were reeducated by DHS designee on proper transfer of residents, ensure proper assessments were completed for resident seat belts, and corrected the gap between the mattress and headboard of the resident bed. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes All nursing staff were in-serviced on Transferring Residents Policy, Enabler Use Policy, and Guidelines for Bed Frame Fitting. DHS/designee will complete audits for Enabler Use, Bed Frames, and observations will be completed for Resident Transfers. Audits will be completed on 5 residents weekly x4 weeks, 3 res a week X 4 weeks, 3 resident every other week X 4 weeks, and then monthly X 6 months. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for	

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	startle Resident E, as the aide's hand left Resident E's arm, Resident E reached out to grab CNA 15 for more support. CNA 15 pushed her hips back to move her body away from Resident E's reach and with a sigh and eye roll, CNA 15 scolded Resident E and indicated, "don't grab me, don't pinch me." Resident E continued to struggle to support her full weight and was unable to complete the transfer from the edge of the bed. CNA 15 did not offer or attempt to raise the level of the bed or apply a gait belt. During an interview on 5/21/24 at 9:44 a.m., the Executive Director (ED) and Director of Nursing (DON) were informed of the above observations. The DON indicated, usually Resident E was able to help with minimal assistance for her transfers, but if the aide realized she was struggling she should have used a gait belt and not the back of the brief which could tear. On 5/20/24 at 10:28 a.m., Resident E's medical record was reviewed. She was a long-term care resident with diagnoses which include, but were not limited to, Alzheimer's disease (a degenerative brain disease which affects short and long-term memory), a history of falling, lack of coordination, unsteadiness on feet and muscle weakness. Resident E had a comprehensive care plan, initiated 1/31/23, which indicated she had functional impairment related to bed mobility, transfers toileting and eating. Interventions for this plan of care included, but were not limited to, assistance with transfers "keeping in mind that ADL's could fluctuate frequently." On 5/17/24 at 1:55 p.m., the Minimum Data Set (MDS) Support nurse provided a copy of current		a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	facility policy titled, "Resident Transfers," revised 5/11/16. The policy indicated, "To ensure the safety of residents and staff when performing mobility/transfers tasks." On 5/21/24 at 3:13 p.m. the Regional Clinical Support (RCS) provided a copy of the Indiana State Department of Health Nurse Aide Curriculum, revised 3/21/14. The curriculum indicated, " ...do not cause the resident pain or injury, be gentle, do not rush ... proper transfer: planning and safety ... using transfer/gait belt, secure belt around resident's waist and over their clothes ... Role of the Nurse Aide, provide for privacy and encourage the resident to help as much as possible to promotes independence ... be patient and give the resident time to adjust to change in position ... observe resident for signs of discomfort or fatigue ...." 2. On 5/15/24 at 9:59 a.m., Resident 8 was observed. He was seated in an electronic wheelchair. A blue seat belt strap was observed secured across his waist. When asked about his belt, Resident 8 indicated, "this is for safety, so I don't go flying out of my chair if I go too fast." Resident 8's hands were observed to be malformed, crooked and Resident 8 indicated he had "bad" rheumatoid arthritis and he was not able to use his hands very well. During an interview on 5/17/24 at 12:09 p.m., the Therapy Director (TD) indicated Resident 8 was initially evaluated for the electric wheelchair and the safety seat belt. After his discharge from therapy, she did not know if there was any further ongoing nursing assessments for changes in his ability to use the seat belt. The chair and seat belt should be care planned so nursing knew to check for placement, safety and appropriateness.			

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	During an interview on 5/17/24 at 12:15 p.m., the Director of Health Services (DHS) indicated she was not sure if there was any ongoing monitoring of the seat belt, but there should be a physician's order and care plan for the device. During an interview on 5/20/24 at 1:41 p.m., the Regional Clinical Consultant (RCS) indicated the care plan had not been revised as it should be, and ongoing assessment for safety should be put in place. On 5/16/24 at 9:47 a.m., Resident 8's medical record was reviewed. He was a long-term care resident with a diagnosis which included, but was not limited to, rheumatoid arthritis (RA- chronic inflammatory disorder usually affecting small joints in the hands and feet causing pain and deformity). The record lacked a physician's order for the use of a seat belt. Resident 8 had a comprehensive care plan, dated 1/16/2020, indicated he used an electric wheelchair to self-propel throughout the facility. He had been screened by therapy and deemed safe to operate the wheelchair, but the care plan lacked revision to include the use of a safety belt. Resident 8 had a comprehensive care plan, initiated 4/10/19, indicated he had limited range of motion of both his hand and fingers related to RA. Interventions for the plan of care included, but was not limited to, observe for and report any increased stiffness in joints and follow therapy recommendations. On 5/21/24 at 9:32 a.m., Resident 8 was observed.			

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	He was seated in his wheelchair with his seat belt secured. When asked if he could demonstrate releasing and re-applying the belt, Resident 8 was able to unsnap the buckle, but did not have the strength or dexterity to loosen the strip of Velcro, and he did not have the strength or dexterity to re-snap the buckle. On 5/20/24 at 11:05 a.m., the Executive Director (ED) provided a copy of current facility policy titled, "Guidelines for Restraints/Enabler Use," revised 10/9/17. The policy indicated, "to ensure completion of observation and evaluation for appropriate and safe use of restraints/enablers for each resident ... An order shall be obtained that specifies the type of restraint/enabler and reason for use ...a comprehensive plan of care shall be developed that ... addressed safety issues because of restraint/enabler use ... identifies measured to minimize the risk of resident decline and maintain strength and mobility ... is reviewed as necessary, at least quarterly ...." 3. On 5/20/24 at 9:36 a.m., Resident C was observed. She laid in her bed which had a Low-Air-Loss (LAL) mattress in place. The head of her bed (HOB) was elevated so she could eat her breakfast, however she appeared to have slid down and leaned to the right, almost against the side rail. There was an over-bed triangular trapeze. Resident C complained that she was happy to have the new mattress, but it seemed like no one knew how to help get her comfortable. Additionally, Resident C complained that when she laid the HOB down to reposition herself and use her trapeze, there was a gap between the mattress and the headboard. She was not used to the new LAL mattress so she slid faster than she was used to and her head would fall over the edge			

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	of the mattress. Resident C requested to be repositioned and Certified Nursing Aides (CNA) 14 and 16 came to help her get repositioned. When the HOB of her bed was laid down, Resident C grabbed her trapeze bar, and was able to hoist herself up the length of the mattress. There was a large gap between the edge of the mattress and the head of the bed so that Resident C's head could hang off the edge. CNA 16 indicated she would let the Maintenance Director know. During an interview on 5/20/24 at 10:53 a.m., the Therapy Director (TD) indicated if a resident got a new mattress and utilized mobility devices such as side rails and/or a trapeze, she would expect a referral to therapy for an evaluation to ensure proper positioning and safety precautions. On 5/20/24 at 11:11 a.m., Resident C's mattress and bed frame was observed with the Director of Nursing Services (DNS). The DNS indicated the gap was too large and she would work with Maintenance on adjusting the frame or getting a wedge at the foot of the bed to close the gap. On 5/20/24 at 10:40 a.m., Resident C's medical record was reviewed. She was a long-term care resident who had diagnoses which included, but were not limited to, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with (acute) exacerbation, chronic pain syndrome and chronic respiratory failure. She had physician's orders for Lorazepam, (a sedative medication which can cause drowsiness), Percocet (a narcotic pain medication which can cause drowsiness), and morphine, (an opioid pain			

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	medication which can cause drowsiness). Resident C had a physician's order for the utilization of a Trapeze bar for bed mobility. The record lacked an order for the LAL mattress. The record lacked documentation of a therapy referral to evaluate the new mattress. On 5/20/24 at 11:05 a.m., the RCS indicated, there was no policy related to the LAL mattress and bedframe, but the facility would follow mobility devices and bed rail policy to ensure resident safety. At this time the RCC provided a copy of current facility policy titled, "Guidelines for the Use of Bed Rails," revised, 10/9/17. The policy indicated, "Accident hazards: the resident could attempt to climb over, around, between or through the rails or over the foot board. A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress ...." 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record	F 0695	1) Immediate actions taken for	06/28/2024

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	review, the facility failed to ensure respiratory equipment was stored according to the facility policy for 1 of 1 residents reviewed for respiratory equipment (Resident 44). Findings include: On 5/14/24 at 1:48 p.m., Resident 44's continuous positive airway pressure (CPAP) facial equipment was observed uncovered on the resident's bedside table. On 5/17/24 at 11:14 a.m., Resident 44's CPAP facial equipment was observed uncovered on the resident's bedside table. On 5/17/24 at 2:09 p.m., Resident 44's record was reviewed. He was admitted on 10/20/23. His diagnoses included, but were not limited to, obstructive sleep apnea (OSA) (difficulty breathing while sleeping), dementia (progressive loss of intellectual functioning), chronic obstructive pulmonary disease (COPD) (lung disease including constriction of the airways), hypotension (low blood pressure), altered mental status (AMS), asthma (chronic disease of bronchial airways causing difficulty breathing). Physician orders included, but were not limited to, fluticasone propionate salmeterol aerosol powder breath activate inhaler for shortness of breath and albuterol sulfate inhaler as needed for shortness of breath. A care plan, dated 10/20/23, indicated Resident 44 had impaired cognition and impaired communication with associated short term memory impairment and risk short term memory impairment and risk for confusion, disorientation,		those residents identified: Resident 44 was affected. No adverse effects noted. DHS immediately inspected the CPAP equipment and placed it in its designated bag. 2) How the facility identified other residents: All residents who require the use of oxygen equipment have potential to be affected. 3) Measures put into place/System changes All Clinical Staff were re-educated on Respiratory Equipment SOP. DHS/designee will complete audits for Oxygen Storage. Audits will be completed on 5 residents weekly x4 weeks, 3 res a week X 4 weeks, 3 resident every other week X 4 weeks, and then monthly X 6 months. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met	

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	altered mood, impaired or reduced safety awareness related to diagnosis of dementia. A care plan, dated 10/20/23, indicated Resident 44 had potential for shortness of breath while lying flat related to COPD, OSA, and asthma. A care plan, dated 10/20/23, indicated Resident 44 had a potential for complications, functional and cognitive status decline related to respiratory disease related to COPD, OSA, and asthma. A care plan, dated 5/17/24, indicated Resident 44 demonstrated non-compliance with physician orders and/or plan of care as evidence by family non-compliant in plan of care in regards to care ...bagging of tubing. The goal indicated the resident's preferences will be honored to the extent that non-compliance with physician orders will not result in injury to self or others. The nursing approached included to assess for need for a guardian or other legal oversight as needed, educate the resident regarding physician orders and risk and benefits of compliance, encourage the resident to actively participate in care plan and decision making by offering choices and discussion of advance directives and monitor the resident's ability to give informed consent and fluctuations in decision making. During an interview, on 5/20/24 at 11:46 a.m., Regional Clinical Support (RCS) indicated CPAP's should have been covered when not in use. She indicated the policy said the nebulizer circuits should be covered which included the CPAP's used by the residents. A current policy, titled, "Respiratory Equipment," dated 12/31/23, was provided by the Administrator, on 5/20/24 at 11:03 a.m. A review of			

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	the policy indicated, " ...Overview ...To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment and to prevent transmission of infections to resident and staff ...Medication Nebulizers/Continuous Aerosol ...Store circuit in plastic bag, marked with date and resident's name, between uses ...." 3.1-47(a)(6)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all			

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	controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to properly dispose of medications belonging to residents for 1 of 6 resident reviewed for medication disposition (Resident 204, 205 and 50). Findings include: 1. On 5/20/24 at 11:36 a.m., a record review was completed for Resident 204. He has the following diagnoses which included but were not limited to hypertension, hyperlipidemia, hypothyroidism, insomnia, and pain. He was discharged from the facility on 3/30/24. He had the following medications unaccounted for after being discharged from the facility. a.) Amlodipine 5 milligrams (mg) b.) Aspirin 81 mg c.) Atorvastatin 80 mg d.) Cholecalciferol 1,250 micrograms (mcg) (50,000 unit) e.) Ipratropium-albuterol 0.5 mg - 3 mg (2.5mg/3ml) f.) Levothyroxine 112 mcg g.) Melatonin 5 mg h.) Ondansetron 4 mg i.) Tylenol 325 mg 2. On 5/20/24 at 11:47 a.m., a record review was completed for Resident 205. She had the following diagnoses which included but were not limited to hypertension, heart failure, diabetes	F 0755	1) Immediate actions taken for those residents identified: Residents 204, 205, and 50 were affected. All medications were disposed of with no adverse effects noted. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes All Nurses were re-educated on Medication Destruction Policy and Procedure. As a measure of ongoing compliance, the DHS and/or designee will conduct Medication Destruction Audits on 3 discharged residents weekly x4 weeks, 1 discharge res a week X 4 weeks, 1 discharge resident every other week X 4 weeks, and then monthly X 6 months. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be	06/28/2024

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	mellitus type 2, and depression. She was discharged from the facility on 1/20/24. She had the following medication unaccounted for after being discharged from the facility. a.) Furosemide 20 mg b.) Humalog U-100 insulin pen c.) Coreg 12.5 mg d.) Lantus U-100 insulin pen e.) Sertraline 50 mg daily f.) Tylenol 500 mg g.) Glucagon emergency kit 1mg 3. On 5/16/24 at 2:32 p.m., a comprehensive record review was completed for Resident 50. She had the following diagnoses which included but were not limited to hypertension, hyperlipidemia, and constipation. She discharged from the facility on 3/6/23. She had the following medications unaccounted for after being discharged from the facility. a.) Miralax 3350 17 gram (gm) powder b.) Oxycodone 5 mg c.) Potassium chloride 20 milliequivalents (meq) d.) Protonix 40 mg e.) Aspirin 81 mg f.) Atorvastatin 80 mg g.) Plavix 75 mg h.) Furosemide 40 mg i.) Lorazepam 0.5 mg j.) Magnesium oxide 400 mg k.) Metoprolol 25 mg On 5/20/24 at 10:46 a.m., the Regional Support Nurse indicated it was difficult to account for medications disposed of because they got individual pill packs for a week at a time for		reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met	

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	residents. She indicated they put controlled substances into a "secured box" for pharmacy to pick up and destroy. On 5/20/24 at 11:30 a.m., Pharmacy indicated they were unable to find medication disposition logs on for the residents listed above. They indicated controlled substances should be destroyed at the facility level. If the facility put controlled substances in the secured box, the medications went to a DEA facility for proper destruction. A policy titled, "PackEdge SOP for Medication Changes, Discontinued Medications, and Medication Destruction," was provided by the Director of Nursing Services (DNS) on 5/20/24 at 10:46 a.m. It indicated, " ...The facility should destroy any controlled narcotic medications from the multi-dose packaging system for any unneeded, discontinued medications within the medication destruction disposal solution. The facility shall return to the pharmacy any non-controlled medications for resident's medications that are discontinued, expired and/or discharged ...." 3.1-25(a) 3.1-25(b)(1) 3.1-25(c)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to indicate the rationale for the use of medications for residents reviewed for medication use for 2 of 2 residents (Resident 33 and 19). Findings include: 1. On 5/15/24 at 2:55 p.m., a record review was completed for Resident 33. She had the following diagnoses which included but were not limited to type 2 diabetes mellitus, depression, major depression, and heart disease. She had the following medication orders that lacked an indication for use. a. Atorvastin (medication typically used for hyperlipidemia) 80 milligrams (mg) at bedtime for an indication of use of not applicable (N/A). b. Basaglar kwikpen U-100 insulin (medication typically used for diabetes mellitus) 20 units at bedtime. The medication order lacked an indication for use. c. Clonidine (medication typically used for	F 0757	1) Immediate actions taken for those residents identified: Residents 33 and 19 were affected with no adverse effects noted. The prescribing physician was contacted for Resident 33 and 19 for medication rationale for their medications. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes All Nurses re-educated on Guidelines for Medication Orders. DHS and/or designee audit using the medication order audit tool. The DHS/designee will audit 5 residents weekly x 4 weeks to	06/28/2024

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HOMEWOOD HEALTH CAMPUS	2494 N LEBANON ST LEBANON, IN 46052

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	hypertension and heart failure) 0.2 mg give with 0.3 mg to equal 0.5 mg daily with an indication for use of N/A. d. Ferrous sulfate (medication typically used for anemia) 325 mg two times daily for an indication of use of N/A. e. Levothyroxine (medication typically used for hypothyroidism) 25 micrograms (mcg) daily for an indication of use of N/A. f. Megace (medication typically used to increase appetite in the elderly) 40 mg two times daily for an indication of use of N/A. g. Metoprolol (medication typically used for hypertension)100 mg daily for an indication of use of N/A. 2. On 5/15/24 at 1:57 p.m., a record review was completed for Resident 19. He had the following diagnoses which included but were not limited to COPD, type II diabetes mellitus, morbid obesity, chest pain, heart failure, and major depression with psychotic symptoms. He had the following medication orders that lacked an indication for use. a. Isosorbide mononitrate (medication typically used for hypertension) 60 mg daily for an indication of use of N/A. b. Docusate sodium (medication typically used for constipation) 100 mg two times daily for an indication of use of N/A. c. Crestor (medication typically used for hyperlipidemia)10 mg at bedtime for an indication of use of N/A d. Cyanobalamin (medication typically used for vitamin B12 deficiency) once daily. The order lacked an indication for use. e. Ferrous Sulfatae (medication typically used for anemia) 325 mg 1 tablet daily. This order lacked		ensure proper ADL care has been provided then 3 residents a week X 4 weeks, 1 resident a week X 4 weeks, 1 resident a week every other week and then monthly X 3 months. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met	

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	an indication for use. f. Finasteride (medication typically used for enlarged prostate) 5 mg daily. This order lacked an indication for use. g. Potassium chloride (medication typically used for potassium deficiency) 10 meq daily. This order lacked an indication for use. h. Miralax (medication typically used for constipation) 17 grams daily as needed for an indication of use of N/A. i. Pregabalin (medication typically used for nerve pain) 50 mg capsule three times daily for an indication of use of N/A. j. Protonix (medication typically used for gastro-esophageal reflux disease) 40mg daily for an indication of use of N/A. k. Ranolazine (medication typically used for chest pain) 1000 mg two times daily for an indication of use of N/A. l. Tamsulosin (medication typically used for enlarged prostate) 0.4mg daily for an indication of use of N/A. m. Toprol XL medication typically used for hypertension) 50 mg daily for an indication of use of N/A. A policy titled, "Guidelines for Medication Orders," was provided by the Regional Clinical Support on 5/15/24 at 2:32 p.m. It indicated, " ...When recording medication orders specify: the type, route, dosage, frequency, strength of the medication and reason for order (i.e. "Dilantin 100mg three times daily for seizure disorder) ....". 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)			

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F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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 when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to date and/or label insulin pens, eye drops, and inhalers when opened, and remove expired insulin pens and lorazepam from the cart when expired for 2 of 3 medication carts and 1 of 1 medication storage room reviewed for medication storage. Findings include: 1. The following medications were in the 100-hall	F 0761	1) Immediate actions taken for those residents identified: Residents 14, 29, 33, 5, 42, 4, 26 and 21 were affected with no adverse reactions noted. Ensured all Residents medication were labeled and stored properly. 2) How the facility identified other residents: All residents have the potential to	06/28/2024

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	medication cart: a. Resident 14 had a bottle of lorazepam 2mg/ml in the refrigerator. It expired on 1/8/24. b. Resident 29 had basaglar insulin dated 2/15/24. It was expired. c. Resident 33 had basaglar insulin with no date to indicate when it was opened. She also had lantus insulin with a date opened of 4/8/24. It was expired. She had a bottle of refresh eye drops in the cart. The drops lacked a label. d. Resident 5 had an albuterol inhaler HFA 90mcg per actuation. It lacked a date to indicate when it was opened. She had an inhaler trelegy ellipta 100mcg/62.5mcg/25mcg in the cart. It lacked a date to indicate when it was opened. e. Resident 42 had an albuterol inhaler HFA 90mcg per actuation. It lacked a date to indicate when it was opened. He had a bottle of genteal tear solution sent from the pharmacy on 12/23/23. It lacked a date to indicate when it was opened. f. Resident 4 had a bottle of latanoprost and genteal tears solution. Both lacked dates to indicate when they were opened. g. Resident 26 had a bottle of latanoprost sol 0.005% solution in the medication cart. It lacked a date to indicate when it was opened. h. Resident 21 had a bottle of carboxymethyl solution 0.5% in the medication cart that lacked a date to indicate when it was opened. 2.)The following was observed on the 300 hall medication cart:		be affected. 3) Measures put into place/System changes All Nurses and QMA's will be re-educated on Medication Storage/Proper Labeling Policy and Procedure. DHS/designee will audit 3 carts weekly for proper medication storage of all medication x 8 weeks and 2 carts weekly for proper medication storage of all medications x 12 weeks. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met	

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	a. Resident 6 had novolog insulin indicating it was opened on 3/1/24. On 5/14/24 at 12:20 p.m., RN 6 was present during the observation and confirmed findings. A current policy, titled, "Medication Storage in the Facility," dated 11/18, was provided by the Regional Clinical Support (RCS), on 5/22/24 at 9:55 a.m. A review of the policy indicated, " ...Medications and biologicals are stored safely ...Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications ...are permitted to access medications ...Certain medications ...such as ...multiple dose injectable vials, ophthalmics ...once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency ...." 3.1-25(j) 3.1-25(m) 3.1-25(n)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility			

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	gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure hand hygiene was completed between residents during meal service for 1 of 1 observation of dining (Residents 26, 18, and1) Findings include: On 5/14/24 at 11:43 a.m., 37 residents were observed during a lunch service. Dietary Aide (DA) 12 was observed to serve milk to Resident 26, then moved his wheelchair into a better position in front of the lunch table. He was observed to hold the handles of his wheelchair with his bare hands. DA 12 did not use hand washing and hand sanitizer before providing a drink to Resident 18. After a short conversation with Resident 18, he went to a cabinet, used his bare hand to open it and retrieved a clothing protector and placed it on the resident. DA 12 did not do any hand hygiene and provided a drink for an unidentified resident. DA 12's bare hands were observed on the Resident's 1 wheelchair handles as he brought her into the lunch room. He did not do any hand hygiene, then went to a cabinet area and opened a drawer with his bare hand. He removed a plate and retrieved a Styrofoam cup with liquid inside to provide to Resident 1.	F 0812	1) Immediate actions taken for those residents identified: Residents 26, 18, and 1 were affected with no adverse reaction noted. All Staff immediately re-educated on proper hand hygiene. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes. All Staff Re-educated on Hand Hygiene Policy and Procedure with checkoff completed. The DHS/ designee will complete Hand Hygiene audits on 10 employees 3 times weekly x 8 weeks, 5 employees weekly x 8 weeks to ensure hand hygiene is being completed corrected. 4) How the corrective actions will be monitored: As a Quality measure, the results	06/28/2024

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	On 5/16/24 at 11:00 a.m., the Infection Preventionist (IP) indicated her expectation was for staff who provide resident transportation to the dining room for meals should have used hand washing or hand sanitizer before provided the resident with drinks or food after touching their wheelchair handles with their bare hands and between residents after providing items for lunch service. She indicated every Friday, she was the meal manager and observed hand hygiene during meals. Sometimes, she would observed meals unexpectedly. A current policy, titled, "Guideline for Handwashing/Hand Hygiene," dated 12/31/23, was provided by the Regional Clinical Support, on 5/17/24 at 11:40 a.m. A review of the policy indicated, " ...Handwashing is the single most important factor in preventing transmission of infections ...All healthcare workers shall utilize hand hygiene frequently and appropriately ...Health Care Workers (HCW) shall use hand hygiene at time such as ...Before/after preparing/serving meals ...." 3.1-21(i)(3)		of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met	
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza			

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	immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education			

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	regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to ensure the infection control program objectives were followed regarding the influenza vaccinations for residents in a timely manner for 5 of 22 residents reviewed for 2023/2024 flu season (Resident 8, 22, 23, 38, and 46). This deficiency was corrected on 4/26/24 prior to the start of the survey and was therefore Past noncompliance. Finding include: On 5/16/23 at 12:04 p.m., Resident 46's immunizations were reviewed. The last flu vaccination for her was provided on 1/27/23. On 5/16/24 at 3:30 p.m., the Regional Clinical Support (RCS) indicated the facility did not offer Resident 46 a flu vaccination for the 2023/24 flu season. She indicated when the Director of Health Services (DHS) started at the facility in 2/12/24, she updated everyone with tuberculous (TB) screenings, and was working on updates for flu vaccinations. On 5/16/24 at 11:20 a.m., the Infection Preventionist (IP) indicated flu shots were mandatory at this facility. Resident should have been provided flu vaccination annually, every October. During an interview, on 5/20/24 at 10:31 a.m., the Director of Health Services (DHS) indicated the resident influenza (flu) vaccinations were a priority due to it still being flu season when she	F 0883	Received past non-compliance, no plan of correction required.	05/21/2024

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	started working at the facility on 2/12/24. She provided the, "Department Action Plan Update." It indicated the action plan starting date was 3/21/24 and the expected ending date was 7/21/24. The goal was to have an infection control binder that was current and have all vaccines and tuberculous (TB) screening caught-up per policy. The Root Cause analysis was the facility had, "no infection control nurse designated to follow program." The Plan of Action was to assign the Infection Control program to the Assistant Director of Health Services (ADHS). The Systemic Monitoring included monitoring the infection control binder and auditing vaccines. The Progress Comments indicated, on 4/26/24, the resident TB screenings and the IC binder were up-to-date. On 5/20/24 at 10:35 a.m., the DHS indicated there was no working IP when she came here in February. The Assistance Director of Health Services (ADHS) was hired on 3/12/24, and she became the IP. On 5/20/24 at 11:48 a.m., the RCS indicated and provided documentation of a former employee who became the IP on 2/14/23 while also working as the MDS Coordinator (MDSC) 13. She left the facility employ on 3/14/24. She indicated the facility did not have a gap in IP coverage. The previous MDSC 13 did not have enough time to complete the MDSC job and do IP for the build effectively. On 5/20/24 at 1:30 p.m., the RCS provided the facility's Preventive Health Care Report, dated 2/1/24 to 5/20/24. It indicated the residents who did not have flu vaccinations for the 2023/24 flu season. a Resident 23 was admitted on 6/15/23, he did not			

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	get the flu vaccine until 3/13/24. b. Resident 8 was admitted on 3/19/19, he did not get the flu vaccine until 3/13/24. c. Resident 22 was admitted on 12/21/18, she did not get the flu vaccine until 3/13/24. d. Resident 38 was admitted on 3/15/23, he did not get the flu vaccine until 3/15/23. A current policy, titled, "Guidelines for Influenza, Pneumococcal, & Covid-19 Immunizations," dated 12/31/23, was provided after the entrance conference. A review of the policy indicated, " ...Purpose ...to establish an immunization program that facilitates providing education to residents ...allowing them to make an informed decision regarding immunization and to follow through per their decision to received or not to receive immunization ...Each resident ...will be provided annually with information regarding the risk and benefits of influenza vaccine and receive the immunization per their request ...." A current policy, titled, "Infection Prevention and Control Program (IPCP)," dated 12/31/23, was provided after the entrance conference. A review of the policy indicated, " ...to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections ...The campus shall designate a member of the clinical team to monitor the campus IPCP program ...Monitors compliance with infection control practices and procedure ...." 3.1-18(b)(5)			
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	R 0000 This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00417591, IN00417848, and IN00433378. Complaint IN00417591 - Deficiencies related to the allegations are cited at F550, F677, and F679. Complaint IN00417848 - No deficiencies related to the allegations are cited. Complaint IN00433378 - Deficiencies related to the allegations are cited at F679. Survey dates: May 13, 14, 15, 16, 17, 20, and 21, 2024. Facility number: 002703 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 5, 2024.			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power			

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	sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observations, interviews and record reviews, the facility failed to ensure resident's environments remained free from the potential for accidents when bedrails were applied but not monitored or maintained to ensure continued safe operating condition for 2 of 2 residents reviewed for bedrails, (Resident 1 and 17). Findings include: 1. On 5/22/24 at 11:24 a.m., Resident 1's room observed in the secured memory care unit. One half side rail was observed installed to the open side of her bed. The rail was loose and wobbled. On 5/22/24 at 11:40 a.m., Resident 1's medical record was reviewed. She was an Assisted Living Resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, dementia and repeated falls. The record lacked documentation of the bed rail installation, evaluation, and/or ongoing monitoring for continued safety checks. 2. On 5/22/24 at 11:55 a.m., Resident 17's room was observed in the secured memory care unit. A square bedrail was observed on the open side of his bed. There were arms that went under the mattress and two legs that rested on the floor.	R 0148	The submission of this plan of correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Homewood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1) Immediate actions taken for those residents identified: Residents 1 and 17 were affected with no adverse reaction noted. Bed Rails were immediately	06/28/2024

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	155680	A. BUILDING 00 B. WING	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOMEWOOD HEALTH CAMPUS	2494 N LEBANON ST LEBANON, IN 46052

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	There was a large gap between the mattress and the rail. On 5/22/24 at 12:05 p.m., Resident 17;s medical record was reviewed. He was an Assisted Living Resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, dementia. The record lacked documentation of the bed rail installation, evaluation, and/or ongoing monitoring for continued safety checks. During an interview on 5/22/24 at 12:15 p.m., the Regional Clinical Support Nurse (RCS) indicated, unless the Resident's beds belonged to the facility, there were no safety checks on bed rails. Because it was Assisted Living and the Resident's had the right to a homelike environment, bed rails were not required to monitored by the facility. When asked about residents with dementia who would not be able to assess or communicate that their rails may need repairs/tightening, the RCS indicated nursing staff should monitor. The RCS indicated there was no AL bed rail or mobility device policy, but they would follow the Resident's rights policy, and for safety purposes she indicated monitoring the bedrails should be completed to ensure gaps and disrepair could not cause a hazard to the resident.		assessed by DPO to ensure proper function. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes. DPO/Environmental/Clinical Staff Re-educated on ensuring all Resident Equipment is working properly. The DHS/ designee will complete Safety Inspection audits on 3 residents' equipment weekly x 8 weeks, 3 resident's equipment every other week x 8 weeks to ensure equipment is functioning properly. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met	
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			

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	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 Apisol solution (for tuberculous screening) had no open date and was given to a resident (Resident 11), and open medications in the medication storage room had no open date for 4 of 6 medications observed for open dating (Resident 9, 18, and 26). Findings include: On 5/21/24 at 1:21 p.m., the Assisted Living (AL) Medication Storage room was observed with the AL Director (ALD). a Apisol (tuberculous screening) solution was observed with no open date. The ALD indicated she used the bottle to provide a tuberculous screening for Resident 11 yesterday, on 5/20/24. She indicated she did not know how long the Apisol solution was good for once it was opened. b. Resident 25's lorazepam intensol liquid 2 mg/mL. Give 0.25 mL by mouth for anxiety. It did not have an open date on it. c. Resident 9's lorazepam intensol liquid 2 mg/mL. Give 0.25 mL by mouth for agitation and restlessness. It did not have an open date on it. d. Resident 18's lorazepam intensol liquid 2 mg/mL. Give 0.25 mL by mouth for agitation and restlessness. It did not have an open date on it. On 5/21/24 at 1:31 p.m., the ALD indicated the lorazepam medications should have had open dates on them. Once they were opened, they would have been good for 90 days. On 5/21/24 at 1:35 p.m., the Director of Health Services (DHS) indicated the open date should have been on the medications.	R 0300	1) Immediate actions taken for those residents identified: Residents 11,25, and 9 were affected with no adverse reactions noted. Ensured all Residents medication were labeled and stored properly. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes All Nurses and QMA's will be re-educated on Medication Storage/Proper Labeling Policy and Procedure. DHS/designee will audit medication carts weekly for proper medication storage of all medication x 8 weeks and medication carts every other week for proper medication storage of all medications x 12 weeks. 4) How the corrective actions will be monitored: As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is	06/28/2024

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	On 5/21/24 at 1:41 p.m., the Infection Preventionist (IP) indicated the Apisol was good for 30 days after it was opened. On 5/21/24 at 1:43 p.m., the ALD indicated she would throw away the Apisol. A current policy, titled, "Medication Storage in the Facility," dated 11/18, was provided by the Regional Clinical Support (RCS), on 5/22/24 at 9:55 a.m. A review of the policy indicated, " ...Medications and biologicals are stored safely ...Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications ...are permitted to access medications ...Certain medications ...such as ...multiple dose injectable vials, ophthalmics ...once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency ...."		met	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug.			

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	(9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to properly dispose of medications belonging to residents for 2 of 2 resident reviewed for medication disposition (Resident 31 and 32). Findings include: 1.On 5/2 2/24 at 10:27 a.m., a record review was completed for Resident 31. She had the following diagnoses which included but were not limited to major depressive disorder and dementia in other diseases. Resident 31 had discharged from the facility. These medications were not properly disposed of. a.) Levothyroxine 75mcg daily. b.) Acetaminophen 325mg 2 tablets every 6 hours as needed. c.) Prozac 20mg daily. d.) Galantamine 4mg two times daily. e.) Namenda 5mg two times daily. 2. On 5/22/24 at 11:05 a.m., a record review was completed for Resident 32. She had no diagnoses recorded in her record. Resident 32 had discharged from the facility. These medications were not properly disposed of. a.) Buspirone 7.5mg two times daily. b.) Fluticasone propionate 50mcg two times daily. c.) Gabapentin 300mg at bedtime. d.) Guaifenesin 200mg three times daily. e.) Melatonin 3mg at bedtime. f.) Oxycodone 5mg every 6 hours as needed. g.) Pantoprazole 40mg two times daily before meals.	R 0306	1) Immediate actions taken for those residents identified: Residents 31 and 32 were affected. All medications were disposed of with no adverse effects noted. The prescribing physician was contacted for Resident 33 and 19 for medication rationale for their medications. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/System changes All Nurses were re-educated on Medication Destruction and Medication Order Policy and Procedure. As a measure of ongoing compliance, the DHS and/or designee will conduct Medication Destruction Audits and Medication Order Audits on 3 discharged residents and 3 active residents weekly x4 weeks, 1 discharge res and 1 active res a week X 4 weeks, 1 discharge resident and 1 active res every other week X 4 weeks, and then monthly X 6 months. 4) How the corrective actions will be monitored:	06/28/2024

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	h.) Simethicone 80mg every 4 hours as needed. i.) Tizanidine 4mg daily. j.) Tylenol 500mg 2 tablets three times daily. k.) Methocarbamol 500mg daily. l.) Mirtazapine 15mg daily. m.) Hydroxyzine 25mg four times daily as needed. On 5/20/24 at 10:46 a.m., the Regional Support Nurse indicated it was difficult to account for medications disposed of because they get individual pill packs for a week at a time for residents. She indicated they put controlled substances into a "secured box" for pharmacy to pick up and destroy. On 5/20/24 at 11:30 a.m., Pharmacy indicated they were unable to find medication disposition logs on for the residents listed above. They indicated controlled substances should be destroyed at the facility level. If the facility put controlled substances in the secured box, the medications went to a DEA facility for proper destruction. A policy titled "PackEdge SOP for Medication Changes, Discontinued Medications, and Medication Destruction," was provided by the Director of Nursing Services (DNS) on 5/20/24 at 10:46 a.m. It indicated, " ...The facility should destroy any controlled narcotic medications from the multi-dose packaging system for any unneeded, discontinued medications within the medication destruction disposal solution. The facility shall return to the pharmacy any non-controlled medications for resident's medications that are discontinued, expired and/or discharged ....".		As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met	