STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00429840, IN00431773, IN00432433, IN00432567, and IN00432537. Complaint IN00429840 - State deficiencies related to the allegations are cited at R116, R117, and R119. Complaint IN00431773 - State deficiencies related to the allegations are cited at R116, R117, and R119. Complaint IN00432433 - State deficiencies related to the allegations are cited at R116, R117, and R119. Complaint IN00432567 - State deficiencies related to the allegations are cited at R116, R117, and R119. Complaint IN00432537 - State deficiencies related to the allegations are cited at R90, R116, R117, R119, and R148. Survey dates: May 8, 9, and 10, 2024. Facility number: 013264 Residential Census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 20, 2024.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles Boswell	Executive Director	05/31/2024

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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R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in			

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	effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation, interview, and record review, the facility failed to adequately report an elopement to the Indiana Department of Health by omitting key elements of the accident including the resident's cognitive and behavioral status at the time of her elopement for 1 of 3 residents reviewed for elopement (Resident C). Findings include: On 3/1/24 the facility reported Incident #153 to the Indiana Department of Health which indicated, "[Resident C] left the community alone and was located by Hendricks County officer(s)." On 5/10/24 at 8:50 a.m., the Administrator (ADM) provided a copy of a police report corresponding Resident C's elopement. The report was dated 2/29/24 and indicated, " ...at approximately 6:51 p.m., officers responded to [Facility address] reference a missing person report. The complainant/executive director of the assisted living facility [name] advised that a patient had disappeared and is missing from the facility. The missing person was identified as [Resident C] who has been diagnosed with dementia ... [Resident C] exited the facility through a window on the west side of the building at approximately 5:01 p.m. wearing a gray long-sleeve jacket, jeans and maroon shoes. The security cameras last saw	R 0090	R 090 What corrective actions will be accomplished for those residents found to have been affected by the finding: No negative outcome identified for the resident that was affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents with reportable incidents had the potential to be affected. No other residents were adversely affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Assistant Vice President of Operations will educate Executive Director on IDOH incident reporting policy and reporting	07/01/2024

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	[Resident C] on foot running eastbound from the facility ... verified with [ED] that [Resident C] is diagnosed with dementia which she requires medication and care for. A Silver Alert requested and completed ... The Fire Department was contacted to assist with the search as well as the [Name of County] Blood Hound Unit ... received a call that [Resident C] was seen at approximately 6:00 p.m. walking ...received additional calls from sightings of [Resident C] at 7:00 p.m. and 7:25 p.m. ... After the Blood Hound Unit arrived on scene, they tracked around the area ... During the track, received a call at approximately 8:44 p.m., from [a local community resident] who advised that there was a disoriented female matching [Resident C's] description at his residence. Officers arrived on scene [at the local community residence] and identified [Resident C]. When asked if she was injured, she stated that she was just cold. Medics were requested to check her welfare. Medics arrived on scene and transported [Resident C] to the local hospital for further evaluation ...." A review of the archived weather conditions for the date and location of the elopement were included in the record which indicated, it had been 33 degrees Fahrenheit at the time of Resident C's elopement. On 5/9/24 at 9:50 a.m., Resident C's medical record was reviewed. She admitted to the facility on the Assisted Living side on 2/19/24, with a diagnosis which included, but was not limited to, memory deficits. Resident C's nursing progress notes were reviewed and demonstrated a pattern of increased confusion, persistent attempts to exit the facility, two successful exits from the facility and daily		procedures to include appropriate documentation to be included in the report. How the corrective action(s) will be monitored to ensure the finding will not recur: Executive Director, or designee, will audit reportable incidents for appropriate documentation twice weekly x 4 weeks, weekly x 4 weeks, monthly x 4 months, and randomly thereafter. By what date the systemic changes will be completed: 7/1/24	

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	redirection to the secured MC unit for safety. Resident C was seen at the request of nursing staff on 2/20/24 as a new admission, and on 2/27/24 she was seen for increased confusion, persistent attempts to leave the facility and daily wandering. On 2/29/24, Resident C was seen as an out-patient for a neurology consultation due to her increased memory deficits, wandering patterns and confusion. She was diagnosed with Alzheimer's dementia. During an interview on 5/9/24 at 10:35 a.m., the Memory Care Director (MCD) indicated, Resident C was originally admitted to the AL side of the building, but she had not adjusted very well. She wandered throughout the building and tried to get out several times. Resident C was brought over and "trialed" on the MC unit several days to keep her safe since she kept trying to get out. On the day of the incident, she had just come back from an appointment and the MCD thought since she had been able to go out with her daughter, she was anxious to go back out again. Resident C was able to get out of the window in room 102. The MCD indicated, at the time, staff did not know that the new windows slid fully open on both sides, so only one side had been secured, that way, she was able to open the other side all the way, she pushed the screen and climbed out. Incident #153 lacked accurate documentation to include Resident C's recent diagnosis and omitted key elements of her overall cognitive and psychosocial status. The incident report lacked documentation related to the resident exiting through a window on the secured memory care unit.			

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	Cross Reference R148. This citation relates to Complaint IN00432537.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interviews and record reviews, the facility failed to ensure appropriate and specific policies/procedures were written and implemented to screen prospective employees which resulted in the hiring of an unlicensed staff member when appropriate inquiries were not completed prior to hire for 1 of 5 employee records reviewed. This deficient practice had the potential to affect 76 of 76 residents who resided in the facility. Findings include: On 5/8/24 at 9:22 a.m., an Entrance Conference was conducted with the Administrator (ADM) present. At that time, Employee 66's full record and applications were requested. On 5/8/24 at 12:00 p.m., the ADM provided Employee 66's file which was reviewed at that time and revealed the following: a. A criminal background and reference check authorization had been filled out on 1/25/24/. Employee 66 listed his current name and a "Maiden" name.	R 0116	***R 116*** ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcomes identified. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No residents were adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Community updated new hire procedure to include business office manager is responsible for	07/01/2024

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	b. Employee 66 provided a copy of his government issued Driver's License and Social Security Card as proof of identification (ID) however, neither listed his "Maiden" name. The record lacked documentation to verify Employee 66's name discrepancies. During an interview on 5/8/24 at 12:15 p.m., the Director of Nursing (DON) indicated Employee 66 had been cleared via the Business Office Manager's (BOM) process. That meant the next step in the process was to interview with the DON. During her interview with Employee 66 the DON indicated she searched for his nursing license using his given name and the name that was listed on his government issued IDs. There was no result. The DON recalled she joked with Employee 66 about an expired liquor license, but there was no nursing license under his current name. Employee 66 asked her to run the search again but to use his "Maiden" name which generated an active License Practical Nurse (LPN) name. The DON noted this license was out of Fort Wayne, IN, and not Indianapolis, IN as all his application and government issued IDs indicated. The DON indicated she had not requested proof of his name change. During an interview on 5/8/24 at 12:25 p.m., with the DON present, the BOM indicated, background checks were based off the names and date of birth provided on an employee's application. Although Employee 66 listed a "Maiden" name, the BOM indicated she had not requested verification of the name, and because his background check came back with no issues, he was moved forward in the process.		obtaining verification of name change discrepancies prior to obtaining background check and license verification. The Executive Director will in-service BOM on updated procedure. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Business office manager, or designee, will audit all new hires for name change discrepancies twice weekly x 4 weeks, weekly x 4 weeks, monthly x 4 months, and randomly thereafter. ***By what date the systemic changes will be completed:*** 7/1/24	

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	During an interview on 5/8/24 at 12:45 p.m., Employee 66's employment reference (R1) indicated he had worked with Employee 66 in July of 2021 for an unnamed ambulance service where he helped pack supplies and various janitorial duties but did not practice any nursing skills as he was not certified. R1 indicated, Employee 66 did not have any nursing license, which was why he was surprised to be asked as a reference for a nursing facility but thought it must have been for a different department. R1 indicated no one from the facility called him for his reference, so he thought Employee 66 had not applied for or gotten the job. During an interview on 5/8/24 at 12:50 p.m., Receptionist 13 indicated she helped conduct new hire reference checks and called when she worked during the weekdays. When asked if she remembered the reference calls for Employee 66, she indicated she did not remember. During an interview on 5/9/24 at 9:23 a.m., Employee 66's employment reference (R2) indicated she had agreed to be listed as a reference for Employee 66 because they were good friends from high school. When asked if she had ever been his co-worker in a formal or professional position, she indicated they had never worked together and only knew each other from high school. Employee 66 helped take care of R2's grandfather when he was sick so she though he was kind and would be a good entry level caregiver. When asked if he was a certified aide, or licensed nurse, R2 indicated, not at the time, but he had talked about going to nursing school. When asked if she had received a reference call from the facility she indicated, "no," but would check her call log. R2 reviewed her call log for 1/29/24 (indicated on the reference check form)			

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	and did not have a call from the facility on that day, or any other day. During an interview on 5/9/24 at 1:40 p.m., the ADM indicated, there was no formal/written policy or procedure for new-hire employee screening, so he had typed up the process the facility currently implemented. The typed procedure for New Hire was dated 5/9/24 and indicated, " ...2. BOM runs background and pulls license if new hire is a licensed/certified professional ... 9. On the day of onboarding, BOM takes copies of ID and SSN or Birth Certificate. 10. BOM goes over the paperwork ...." The procedure lacked specification of who was responsible for obtaining verification of name change discrepancies. Cross Reference R117. This citation relates to Complaints IN00429840, IN00431773, IN00432433, IN00432567 and IN00432537.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility			

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	regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a new hire was a licensed nurse prior to his employment and contact with residents resulting in medications and treatments not being administered as ordered by their physicians, an unlicensed employee performing nursing duties without a license, and there was no qualified staff to respond in the case of a medical emergency which had the potential to affect 76 of 76 residents who resided in the facility at the time of his employment (Residents B, C, D, E, F, G, H, J, K, L, M, and N). Findings include: On 5/8/24 at 9:22 a.m., an Entrance Conference was conducted with the Administrator (ADM) present. At that time, Employee 66's full record and applications were requested. On 5/8/24 at 12:00 p.m., the ADM provided Employee 66's file which was reviewed at that time and revealed the following: a. A criminal background and reference check authorization had been filled out on 1/25/24/.	R 0117	***R 117*** ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcomes were identified. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No residents were found to be adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Community updated new hire procedure to include business office manager is responsible for obtaining verification of name change discrepancies prior to	07/01/2024

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	Employee 66 listed his current name and a "Maiden" name. b. Employee 66 provided a copy of his government issued Driver's License and Social Security Card as proof of identification (ID) however, neither listed his "Maiden" name. c. A criminal background check was conducted and completed on 1/26/24 which did not reveal a "limited criminal record." d. Two "co-worker" reference checks: one completed on 1/29/24 and the second completed on 1/31/24. His record lacked a job-specific new hire orientation checklist to confirm/verify his abilities/skills. Employee 66's file contained 4 Disciplinary Action Forms and one Interview/Investigation Record as follows: a. An Interview/Investigation Record, dated 2/12/24, after his first weekend working unsupervised as the Charge Nurse, the following complaint was lodged against Employee 66. "[Employee 66] was told multiple complaints from weekend Feb. 10th and 11th. Interviewed all residents that would get med [medications] from [Employee 66] ...Resident E, did not apply cream to legs ... Resident D, very upset ...." The record lacked documentation these concerns had been discussed and or reviewed with Employee 66. b. A Disciplinary Action Form, dated 2/20/24, indicated Employee 66 received a verbal warning.		obtaining background check and license verification. The Executive Director will in-service BOM on name change discrepancies. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Business office manager, or designee, will audit all new hires for name change discrepancies prior to license verification twice weekly x 4 weeks, weekly x 4 weeks, monthly x 4 months, and randomly thereafter ***By what date the systemic changes will be completed:*** 7/1/24	

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	" ...discussed with Employee 66 to slow down, get to know his residents, listen to them when they ask him to check for medication accuracy, be available on A.L. [Assisted Living] side, don't go in offices, don't harass [Receptionist 28] ...." The document was not signed by Employee 66 and did not indicate the employee's receipt of acknowledgement of the concerns against him. c. A Disciplinary Action Form, dated 2/21/24, indicated Employee 66 received a verbal warning. " ...talked with Employee 66 about call light system and not answering lights on night shift of 2/21/24 ..." The document was not signed by the Supervisor. The document was not signed by Employee 66 and did not indicate the employee's receipt of acknowledgement of the concerns against him. d. A Disciplinary Action Form, dated 2/26/24, indicated Employee 66 received a final written warning. " ...Residents are not getting their medication, being signed for but still in med cart ..." The following was listed: Resident F - did not get insulin Sunday Resident G - no blood sugars (B.S.) since Friday and sensor not put on. Resident H - no nasal spray or inhalers all weekend. Resident J - no B.S. checks Resident K - meds in cart from Sunday, signed for on MAR Resident L - no meds given Friday, Saturday and Sunday. e. A Disciplinary Action Form, dated 2/27/24, indicated Employee 66 was terminated. "			

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	...Medication error discovered by 2nd shift nurse, went to count narcotics and discovered that Employee 66 had not put Duragessic [transdermal narcotic pain medication] patches on [Resident M] x 3 but signed that they were placed. [Resident M] gets patches qod [every other day] ... [Resident N] no temazepam [a controlled substance used to treat insomnia] 23rd, 24th and 25th ..." The document was not signed by Employee 66. On 5/8/24 at 12:00 p.m., the ADM provided a copy of Employee 66's actual worked schedule which indicated the following: a. On February 3rd and 4th, he was listed on the schedule as, "Orientation" from 6:00 a.m., until 10:00 p.m. The record lacked documentation of his orientation, to include but not limited to; who oriented him, what he was oriented on and if he was competent in the skills/requirements reviewed. b. He worked on the following days: February 10th, 11th, 17th, 18th, 20th, 21st, 23rd, 24th and 25th, 2024. During an interview on 5/8/24 at 12:15 p.m., the Director of Nursing (DON) indicated Employee 66 had been cleared via the Business Office Manager's (BOM) process, which meant the next step in the process was to interview with the DON. During her interview with Employee 66, the DON searched for his nursing license using his given name. There was no result. Employee 66 asked her to run the search again but to use his "Maiden" name which generated an active			

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		A. BUILDING 00 B. WING	05/10/2024

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	License Practical Nurse (LPN) name. The DON noted this license was out of Fort Wayne, IN and not Indianapolis, IN as all his application and government issued IDs indicated. The DON indicated she had not requested proof of his name change. The DON indicated they did not know he wasn't a nurse until after he was fired. Her was fired after it had become evident that he had not administered medications and treatments as ordered, but had simply checked off on the Electronic Medical Record (E-MAR) that the tasks had been completed. During an interview on 5/8/24 at 12:25 p.m., with the DON present, the BOM indicated, background checks were based off the names and date of birth provided on an employee's application. Although Employee 66 listed a "Maiden" name, the BOM indicated she had not requested verification of the name, and because his background check came back with no issues, he was moved forward in the process. When asked if there was a record of his job-specific orientation, the DON and BOM indicated there was not. Employee 66 must have kept it and not returned the document. During an interview on 5/9/24 at 10:08 a.m., Resident B's family member indicated, she remembered a conversation with Employee 66 about a decline in the resident's condition. Resident B had been on Hospice for a long time but had started to transition. The family member indicated, Employee 66 was a new "weekend-guy" and had not been there long. The morning of Resident B's death, the family member had called the facility to get an update on Resident B. Employee 66 told the family member Resident B's vital signs had been "going down," but a lot of time Hospice patients could "yo-yo" and he thought her vital signs might come back up. The			

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	family member indicated she told Employee 66 she would come in to visit, but they were not able to make it in time before Resident B passed away. During an interview on 5/9/24 at 10:40 a.m., Resident B's Hospice Nurse (HN) indicated, she remembered Employee 66 was new, but that she had visited Resident B on several occasions and spoken with Employee 66 about the resident's comfort measure and pain management. The HN indicated, Employee 66 had taken vital signs and administered medication although Resident B started to have swallowing difficulties at the end so they talked about her liquid morphine (a narcotic pain medication). During a confidential interview, it was indicated a resident reported he had not received insulin and he complained. The complaint was brought to the attention of the DON. During a confidential interview, it was indicated, a nurse who helped orient Employee 66 observed him take vital signs, complete nursing assessments and give medications. When the nurse who helped orient Employee 66 returned to work a week later, it was noted that several medications which should have been administered were still in the medication cart. It was indicated, a nurse that helped provide orientation for Employee 66 had not been provided an Orientation Checklist to keep track of what/when skills were completed. During an interview on 5/9/24 at 1:40 p.m., the ADM indicated there was no formal/written policy or procedure for new-hire employee screening, so he had typed up the process the facility currently implemented. The ADM indicated he was not the ADM at the time Employee 66 was hired, but it			

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	was his expectation that at the time of hire, all names and/or name changes should be verified. The typed procedure for New Hire was dated 5/9/24 and indicated, " ...BOM runs background and pulls license if new hire is a licensed/certified professional ... Receptionist prepares reference check sheets and calls references ... On the day of onboarding, BOM takes copies of ID and SSN or Birth Certificate ... BOM goes over paperwork ...." The procedure lacked instructions for name change verification. Cross reference R116 and R119. This citation relates to Complaints IN00429840, IN00431773, IN00432433, IN00432567, and IN00432537.			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies;			

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	(C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure a new hire nursing staff member was provided appropriate job-specific orientation and training to verify his level of competencies and skills, and failed to ensure the supervisor (or designee) maintained a copy of the employee's job-specific orientation for 1 of 5 employee records reviewed. This deficient practice had the potential to affect 76 of 76 residents who resided in the facility. Findings include: On 5/8/24 at 9:22 a.m., an Entrance Conference was conducted with the Administrator (ADM) present. At that time, Employee 66's full record and applications were requested. On 5/8/24 at 12:00 p.m., the ADM provided Employee 66's file which was reviewed at that time. His record lacked a job-specific new hire	R 0119	***R 119*** ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcomes were identified. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No residents were found to be adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Community updated new hire	07/01/2024

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	orientation checklist to confirm/verify his abilities/skills. On 5/8/24 at 12:00 p.m., the ADM provided a copy of Employee 66's actual worked schedule which indicated he completed orientation on February 3rd and 4th, 2024. The record lacked documentation of his orientation, to include but not limited to; who oriented him, what he was oriented on, and if he was competent in the skills/requirements reviewed. The schedule indicated he worked the following days unsupervised: February 10th, 11th, 17th, 18th, 20th, 21st, 23rd, 24th and 25th, 2024. During a confidential interview, it was indicated, a nurse who helped orient Employee 66 observed him take vital signs, complete nursing assessments and give medications. When the nurse who helped orient Employee 66 returned to work a week later, it was noted that several medications which should have been administered were still in the medication cart. It was indicated, a nurse that helped provide orientation for Employee 66 had not been provided an Orientation Checklist to keep track of what/when skills were completed. During an interview on 5/9/24 at 1:40 p.m., the ADM indicated, there was no formal/written policy or procedure for new-hire employee screening so he had typed up the process the facility currently implemented. The ADM indicated he was not the ADM at the time Employee 66 was hired, but it was his expectation that whoever completed the employee's job-specific orientation maintained a copy for the		procedure to include responsibilities for job specific orientation. The employee's direct supervisor is responsible for ensuring completion of job specific orientation and the business office manager is responsible for adding to the employee file. The Executive Director will in-service BOM and department directors on job specific orientation responsibilities. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Business office manager, or designee, will audit all new hires for name job specific orientation completion twice weekly x 4 weeks, weekly x 4 weeks, monthly x 4 months, and randomly thereafter. ***By what date the systemic changes will be completed:*** 7/1/24	

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	employee's record. The typed procedure for New Hire was dated 5/9/24 and indicated, " ...8. BOM [Business Office Manager] adds onboarding appointment to Outlook and adds reminders to call new hire on the day before ... 12. BOM takes new hires to their supervisors to get training schedules ...14. BOM adds job-specific to supervisor's mailbox ...." The procedure lacked specification of who was responsible for maintaining documentation of the job-specific orientation and/or and when it should be added to the employee's file. Cross Reference R117. This citation relates to Complaints IN00429840, IN00431773, IN00432433, IN00432567 and IN00432537.			
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 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			

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	systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure a safe and secure environment for a resident (Resident C), who had a history of and exhibited increased behaviors of wandering after her admission, to prevent her elopement from the facility for 1 of 3 residents reviewed for Elopement. This deficiency had the potential to affect 20 of 20 residents residing in the secure Memory Care Unit. Findings include: On 5/8/24 at 10:05 a.m., during a general tour of the secured Memory Care Unit (MC) Resident C was observed. She ambulated independently without any assistive devices. She was observed to go in and out of her room several times, with various personal times and asked passing staff, visitor and other residents about how to get out, and when she could go home. On 3/1/24 the facility reported Incident #153 which indicated, "[Resident C] left the community alone and was located by Hendricks county officer(s)." On 5/9/24 at 9:50 a.m., Resident C's medical record was reviewed. She admitted to the facility on the Assisted Living side on 2/19/24, with a diagnosis which included, but was not limited to, memory deficits. A pre-admission physician evaluation, dated 1/15/24, indicated Resident C was evaluated for establishment of care. " ...She would forget whether she had eaten, and sometimes got lost ...." She was diagnosed with "memory deficits," and a referral to neurology was recommended "for further management for her dementia ... Her	R 0148	***R 148*** ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcomes were identified. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All memory care residents had the potential to be affected. No additional residents were identified to be affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Maintenance Director has initiated routine checks to ensure memory care unit remains secure. These checks include monitoring the window locking mechanisms for correct placement and functionality. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Maintenance Director, or designee, will audit routine MC checks twice weekly x 4 weeks, weekly x 4 weeks, monthly x 4 months, and randomly thereafter ***By what date the systemic***	07/01/2024

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	Minin-Mental [MMSE, a screening tool used to determine an individual's cognitive functioning], score is 12 which is incredibly low and primarily related to her memory." A pre-admission nursing evaluation, dated 2/8/24, indicated Resident C had memory deficits, but did not wander, " ...but family says if she goes out for a walk she is not able to find her way back ...." Resident C's nursing progress notes were reviewed and revealed the following: On 2/19/24 at 4:04 p.m., indicated Resident C admitted to the facility accompanied by her daughter. On 2/19/24 at 10:56 p.m., (approximately 7 hours after her admission), indicated Resident C had settled in her apartment during the day, but around 9:00 p.m., she packed up some of her things and stated she had to deliver the items to someone and made several attempts to exit the building. She was taken to the secured MC unit to spend the night there for safety. On 2/21/24 at 10:30 a.m., Resident C required an escort from breakfast due to confusion and she got turned about in the building. On 2/21/24 at 2:12 p.m., Resident C was seen carrying several pictures in her hands and stated she was going to donate the photos and was seen walking outside. She even opened an unlocked car door and looked inside. Resident C believed she was in a hotel and her daughter would be coming to stay with her. Her daughter was notified, and Resident C was sent to the secured MC unit for a few hours.		***changes will be completed:*** 7/1/24	

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	On 2/22/24 at 8:47 p.m., Resident C was on admission follow up and noted to be wandering after dinner. She was confused and voiced, "I am looking for my husband, I don't know if he is safe." She went to the exit door but was unable to open it. She was taken back to her room and her TV was turned on. On 2/23/24 at 11:59 a.m., Resident C was found crying and screaming in the hallway near another room. She said she heard a loud noise. Other residents alerted staff that she was screaming. She was assisted to her room to calm down and call her daughter. Resident C was taken to the secured MC unit for lunch and activities. On 2/23/24 at 11:02 p.m., Resident C was brought back from MC for bedtime, but remained awake in her room. On 2/24/24 at 9:02 p.m., Resident C continued to exhibit increased behaviors and was noted with her shoes and coat on and tried to leave via the front door. She stated she needed to go to the hotel next door and get a room since there was no longer a room for her. Resident C was taken to the MC unit. On 2/25/24 at 3:53 p.m., Resident C woke up late that morning, had lunch and activities on the MC unit. She had increased confusion and tried to leave the MC unit with another resident's family member, so she remained in the MC unit for the night. On 2/27/24 at 8:06 a.m., Resident C went down the stairwell and once exited from the stairs started walking towards the front door with a basket and her coat on her. She stated she needed to put the basket in the car.			

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	On 2/27/24 at 10:12 a.m., Resident C went down the stairs and stated she was going shopping. She was immediately taken to the secured MC unit for safety concerns. A physician progress note, dated 2/20/24, indicated, " ...patient is alert to self only. She believes she is still in Montana, where she previously lived ... She is in the facility due to her inability to take care of herself at home, and getting lost. Nursing staff notes that patient is attempting to elope from facility multiple times, once making it out of the door and sitting in an empty car ... patient is high elopement risk. She is spending approximately 2-4 hours daily on the secured MC unit ...." A physician progress note, dated 2/27/24, indicated, " ...patient is being seen today for elopement and wandering. Nursing staff has reported that patient has attempted elopement multiple times, exiting down stairwell or attempting to follow other residents out of the doors. Patient believes she has a car that she needs to get to, or refers to the assisted living facility as a hotel she is ready to leave ... patient is high risk for elopement, she is ambulatory and persistent in attempts to leave the building. Patient to go to secure memory care unit as needed to prevent elopement .... Neurologist consultation pending ...." Resident C had a Neurology Out-Patient Consultation conducted on 2/29/24 at 3:30 p.m. The Consultation progress noted indicated, Resident C who was accompanied by her daughter, was seen for clinical evaluation of her memory concerns. Her daughter was concerned for her mother's worsening memory and increased			

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	wandering. At the conclusion of the evaluation, Resident C was diagnosed with Alzheimer's Dementia. " ...likely patient has Alzheimer's dementia, possible behavioral variant versus frontotemporal dementia. Vascular dementia possible ... trouble with visual-spatial, delayed recall, mathematics, naming and orientation ...." Upon Resident C's return to the facility, after her out-patient consultation, the record lacked documentation of her new diagnosis, and/or physician notification of the consultation findings. A nursing progress note, dated 2/29/24 at 6:30 p.m., indicated, "Nursing staff called the Wellness Director [DON] to report inability to locate resident. Staff directed to initiate search. Executive Director notified, family notified, MD notified, 911 notified, corporate VPs and regional nurse consultant notified. Department leaders did search by foot and by car until fire department took over search." On 5/10/24 at 8:50 a.m., the Administrator (ADM) provided a copy of a police report corresponding Resident C's elopement. The report was dated 2/29/24 and indicated, " ...at approximately 6:51 p.m., officers responded to [Facility address] reference a missing person report. The complainant/executive director of the assisted living facility [name] advised that a patient had disappeared and is missing from the facility. The missing person was identified as [Resident C] who has been diagnosed with dementia ... [Resident C] exited the facility through a window on the west side of the building at approximately 5:01 p.m. wearing a gray long-sleeve jacket, jeans and maroon shoes. The security cameras last saw [Resident C] on foot running eastbound from the			

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	facility ... verified with [ED] that [Resident C] is diagnosed with dementia which she requires medication and care for. A Silver Alert requested and completed ... The Fire Department was contacted to assist with the search as well as the [Name of County] Blood Hound Unit ... received a call that [Resident C] was seen at approximately 6:00 p.m. walking ...received additional calls from sightings of [Resident C] at 7:00 p.m. and 7:25 p.m. ... After the Blood Hound Unit arrived on scene, they tracked around the area ... During the track, received a call at approximately 8:44 p.m., from [a local community resident] who advised that there was a disoriented female matching [Resident C's] description at his residence. Officers arrived on scene [at the local community residence] and identified [Resident C]. When asked if she was injured, she stated that she was just cold. Medics were requested to check her welfare. Medics arrived on scene and transported [Resident C] to the local hospital for further evaluation ...." A review of the archived weather conditions for the date and location of the elopement were included in the record which indicated, it had been 33 degrees Fahrenheit at the time of Resident C's elopement. During an interview on 5/9/24 at 10:35 a.m., the Memory Care Director (MCD) indicated, Resident C was originally admitted to the AL side of the building, but she had not adjusted very well. She wandered throughout the building and tried to get out several times. Resident C was brought over and "trialed" on the MC unit several days to keep her safe since she kept trying to get out. On the day of the incident, she had just come back from an appointment and the MCD thought since she had been able to go out with her daughter, she was anxious to go back out again. Resident C was			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

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	able to get out of the window in room 102. The MCD indicated, at the time, staff did not know that the new windows slid fully open on both sides, so only one side had been secured, that way, she was able to open the other side all the way, she pushed the screen and climbed out. During an interview on 5/9/24 at 10:48 a.m., the Maintenance Director indicated he had not been employed at the time Resident C eloped, but he had been told about the incident. After he was told, he started a hand-written log of safety checks for the MC windows since they had not previously been routinely inspected. The only routine safety inspections at the time he was hired were for security camera functioning, secured door and alarms. On 5/9/24 at 11:15 a.m., with the ADM, Regional Nurse Consultant (RNC), MCD and the Former Maintenance Director present, the window in room 102 was observed. The Former Maintenance Director indicated he had personally helped install the new windows in the MC unit when they were purchased. The Former Maintenance Director demonstrated how the windows were secured and explained how the window had been opened at the time of Resident C's elopement. The windows purchased to the MC unit were "double sliders," but at the time of the installation, the facility was not aware. The only security intervention installed at the time of the instillation was for the right pane of the window, which consisted of a "bump-stop" drilled into the top of the windowsill to prevent it from sliding more than 4 inches open. The Former Maintenance Director indicated the left side of the windowpane was also able to be slid open by pushing a release button to lock the right side, so the left side could slide over. After Resident C eloped, and the problem was identified, he and			

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	had installed a second security measure on the base of the windowsill but screwing in a 90-degree angled bracket to prevent the left side pane from opening more than 4 inches. During an interview on 5/9/25 at 1:20 p.m., the ADM indicated he was unable to locate any as needed or routine window safety checks for the MC unit windows after instillation. On 5/9/24 at 11:32 p.m., the Maintenance Director provided a copy of a print-out of routine "Security Checks" which only required inspection of security cameras to make sure all are in working order and inspection of doors and lock and alarms, but did not specific, which lock, and/or frequency of safety inspections. On 5/9/24 at 1:30 p.m., the ADM provided a copy of the invoice and instillation record, dated 9/11/23, for the new windows. The windows were listed as "Double Sliders with Flat Colonial Grids." On 5/9/24 at 1:30 p.m., the RNC indicated, there was no policy for the Dementia Care Services and/or Secured Memory Care Management, but the facility utilized the Varietas Memory Care Program. At that time the RNC provided a Varietas program manual which was reviewed at this time and indicated the following. "Traditions has a specialized program for individuals suffering from Alzheimer's and other age-related dementias. The Program is called Varietas, and it is proven to maximize quality of life for residents. The Varietas program is based on 4 principles: Therapeutic Environment, Social Engagement, Individualized Care and Family Support ... General Caregiver Guidance: Changes in behavior can be very distressing for caregivers			

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	and family members. Residents may experience depression, anxiety, irritability and repetitive behaviors. As the disease progresses, other changes may occur, including sleep changes, physical and verbal outbursts, and wandering ...." This citation relates to Complaint IN00432537.			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview, and record review, the facility failed to ensure medications were secure for a resident who self-administered their own medications for 1 of 1 resident reviewed for self-adminstration (Resident 70) Finding include: On 5/8/24 at 11:39 a.m., a review of Resident 70's self-administered medication was conducted with Resident 70. He indicated he kept some of his medications in a locked container and some medications on his bedside table. He indicated he did not lock his apartment when he left. The unsecured medications observed on his bedside table were: a Tizanidine 2 milligrams (mg) used for muscle relaxant. b. Lisinopril to prevent protein from leaking out of the kidneys. c. Loperamide as an antidiarrheal. d. Senna S as a stool softener. e. R lipoic acid supplement for energy. f. Acetaminophen 500 mg one tab for pain as needed.	R 0295	***R 295*** ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcomes identified. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No residents were adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Residents that self-administer medication will be re-educated regarding storage of medication in apartment. Nursing staff will be re-educated on proper storage of	07/01/2024

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	On 5/10/24 at 9:59 a.m., the Administrator indicated residents who self-administer their own medications have the ability to do so independently. A current policy, titled, "Self Administration of Medications," dated 12/22, was provided by the Administrator, on 5/10/24 at 10:44 a.m. A review of the policy indicated, " ...Storage of self-administered medications will comply with state and federal regulations. All bedside medications will be maintained in a secured non visible location in the resident's room ...."		medication for residents that self-administer their medication. Locking storage containers will be provided for residents that self-administer medications. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director, or designee, will audit apartments of residents that self-administer medications twice weekly x 4 weeks, weekly x 4 weeks, monthly x 4 months, and randomly thereafter. ***By what date the systemic changes will be completed:*** 7/1/24	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and interview, the facility failed to appropriately store and label prescription medications and over the counter (OTC) medications for 7 of 13 residents reviewed for medication storage (Residents 209, 204, 202, 207, 206, 224, and 221). Findings include: 1 Resident 209 had a bottle of olopatadine 0.2% eye drops in the Memory Care medication cart with no date to indicate when they were opened. 2. Resident 204 had a bottle of woman's probiotic,	R 0300	***R 300*** ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcomes identified. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to	07/01/2024

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	calcium 600 milligrams (mg), cranberry 650 mg, and D-Mannose 500 mg in the memory care (MC) medication cart without proper labeling. 3. Resident 202 had a Humalog insulin pen in the MC medication cart that was expired. It had a date opened of 4/9/24. 4. Resident 207 had a Lantus insulin pen in the MC medication cart that was expired. It had a date opened of 3/29/24. 5. Resident 206 had a bottle of stool softener 8.6 mg, AREDS 2 vitamin, and vitamin D in the MC medication cart without proper labeling. 6. Resident 224 had a bottle of centrum and aspirin 81mg (ASA) on the MC cart without proper labeling. 7. Resident 221 had a bottle of vitamin D3 on the MC medication cart without proper labeling. A policy titled, "Medication Storage and Labeling Procedure," was provided by the Administrator on 5/9/24 at 8:10 a.m. It indicated, " ...Every container of medication and drugs prescribed for a resident for self-administration or assistance by non-licensed health care personnel, shall be clearly labeled with the resident's names, the proprietary or generic name of the medication dispensed, it strength, the name and address of dispensing pharmacy, the name or initials of the dispensing pharmacist, the prescription number, the date dispensed, the name of the prescribing physician or individual authorized under state law to prescribe medications, and the instruction for use including any caution which may be required by federal or state law. Container too small to bear a complete prescription label shall be labeled		be affected. No residents were adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Education provided by Wellness Director to all LPN's and QMA's regarding labeling and storage of medications. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director, or designee, will audit medication carts for proper labeling and storage of medications twice weekly x 4 weeks, weekly x 4 weeks, monthly x 4 months, and randomly thereafter. ***By what date the systemic changes will be completed:*** 7/1/24	

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	with at least the prescription number and the dispensing date, and shall be dispensed in a container bearing a complete prescription label ...."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to indicate the reason for medications usage/diagnosis for 3 of 3 residents reviewed for medication usage/diagnosis (Residents 78, 201, and 77). Findings include: 1. On 5/8/24 at 10:45 a.m. a record review was completed for Resident 78. She had the following diagnoses to include but not limited to atrial fibrillation (an irregular heart rhythm), hyperlipidemia (high cholesterol), coronary artery disease (a condition that affects the heart), hypertension (high blood pressure), and cellulitis of the foot (swelling and infection). Resident 78 had the following orders for medications. The medication lacked an indication/diagnosis for use. a.) Atorvastin 20 milligrams (mg) at bedtime. This medication is used for hyperlipidemia (HLD).	R 0349	***R 349*** ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcomes identified. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No residents were adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Wellness Director will educate all licensed nursing staff on	07/01/2024

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	b.) Budesonide enteric coated (EC) 3 mg take 3 capsules in the morning. This medication is used to treat Chron's disease (an inflammatory bowel disease that causes chronic inflammation of the GI tract, which extends from your stomach all the way down to your anus). c.) Eliquis 5 mg tablet every 12 hours. This medication is used to treat atrial fibrillation and blood clots. d.) Gabapentin 100 mg capsule three times daily. This medication is used to treat epilepsy. e.) Hydrocodone-acetaminophen tablet 10/325 mg three times daily. This medication is used to treat pain. f.) Lisinopril 5 mg once daily. This medication is used to treat hypertension. 2. On 5/9/24 at 10:32 a.m. a record review was completed for Resident 201. She had the following diagnoses which included but were not limited to asthma (difficulty in breathing), hypertension (high blood pressure), osteoporosis (a bone disease), schizophrenia (A disorder that affects a person's ability to think, feel, and behave clearly), depression, hyperlipidemia (high cholesterol), anxiety, dementia, and pain. She had the following medication orders. These medications lacked an indication/diagnosis for use. a.) Advair HFA 45-21mcg inhaler two times daily. This medication is used for asthma and other breathing disorders. b.) Fentanyl patch 72 hour 25 mcg/hr apply 1 patch every 3 days. This medication is used for pain. c.) Hydroxyzine HCL 10 mg two times daily. This medication is used to treat anxiety. d.) Lorazepam 1mg tablet three times daily. This		physican's order policy, to include the need to have a diagnosis listed for medications. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director, or designee, will audit all medication orders for proper diagnosis. Wellness Director, or designee, will then audit all new medication orders for appropriate diagnosis twice weekly x 4 weeks, weekly x 4 weeks, monthly x 4 months, and randomly thereafter. ***By what date the systemic changes will be completed:*** 7/1/24	

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	medication is used to treat anxiety. e.) Namenda 10 mg two times daily. This medication is used to treat dementia. f.) Polyethylene glycol 3350 take 1 capful daily. This is used to treat constipation. g.) Risperdal 0.25 mg take 1 tablet daily at bedtime. This medication treats schizophrenia, bipolar disorder, and autism spectrum disorder. h.) Risperdal 2 mg tablet take 1 tablet daily at bedtime. i.) Sertraline HCl 100 mg tablet at bedtime. This medication is used to treat depression. j.) Tramadol HCl 50 mg tablet three times daily. This medication is used to treat pain. 3. On 5/8/24 at 1:10 p.m., a comprehensive record review was completed for Resident 77. She had the following diagnoses which included but was not limited to dementia, gastro-esophageal reflux disease (GERD), hyperlipidemia, hypertension, osteoarthritis (OA) and osteoporosis (OP). She had the following medication orders. These medications lacked an indication for use/diagnosis. a.) Amlodipine besylate 5 mg daily in the morning. This medication is used to treat hypertension. b.) Atenolol 100 mg tablet daily in the morning. This medication is used to treat hypertension and abnormal heartbeats. c.) Celecoxib 200 mg daily in the evening. This medication is used to treat arthritis. d.) Haloperidol lac 2 mg/ml con take 0.5 mg two times daily. This medication is used to treat nervous, emotional, and mental conditions (eg, schizophrenia). She also had an order for haloperidol 2 mg/ml con take 0.5 ml every 6 hours as needed without an indication for use.			

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	e.) Losartan potassium 100 mg once daily in the morning. This medication is used to treat hypertension. f.) Morphine sulfate (concentrate) oral solution 100 mg/5 ml take 0.5 ml every 6 hours. This medication is used to treat pain. During an interview with the Assistant Director of Nursing (ADON) on 5/10/24 at 9:29 a.m., she indicated, "The doctor writes the script and he/she may place the diagnosis with the medication. The pharmacist will often add the diagnosis if the physician has assigned one. Other than that, they typically do not add the diagnosis." A policy titled, "Physician's Orders Procedure" was provided by the Administrator on 5/9/24 at 8:10 a.m. It indicated, "Traditions management shall keep an updated list written list of all medication prescribed for each resident and shall make a good-faith effect to keep list current ...."			