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	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDALL RESIDENCE AT GATEWAY PARK	6338 WEST QUIET ROAD GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00451885, IN00452159, and IN00452589. Complaint IN00451885 -- Residential deficiencies related to the allegations are cited at R0241, R0247 and R0302. Complaint IN00452159 -- No deficiencies related to the allegations are cited. Complaint IN00452589 -- Residential deficiencies related to the allegations are cited at R0052 and R0090. Survey date: February 12, 13, and 14, 2025 Facility number: 015521 Residential Census: 38 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-5. Quality review completed on February 20, 2025.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense A. Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for abuse remained free from abuse related to being involuntarily secluded into their apartment by utilizing a chair to keep the door closed with the resident located inside the apartment. (Resident C)	R 0052	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Verified Resident C did not have a chair in front of the door and resident was free to come and go	03/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melanie Scott	RDHW	03/06/2025

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	B. Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for neglect received incontinence care, as identified in their service plan, that resulted in a resident not being provided with incontinence care for an entire shift and had an incontinence brief in place for at least 8 hours which was heavily saturated with urine and resulted in a reddened buttocks. (Resident B) Findings include: A. The clinical record of Resident C was reviewed on 2-12-25 at 11:30 a.m. His diagnoses included, but were not limited to, dementia with unspecified mood disturbance. It indicated he resided on the facility's secured memory care unit (MCU) for less than one year. During the facility's entrance conference on 2-12-25 at 9:35 a.m., with the Executive Director (ED), she was queried about knowledge of a male resident being secluded in his room by placing a chair against the door, by a staff member. The ED indicated she was aware of this, and she spoke to the Certified Nurse Aide (CNA) about this. She indicated she did not suspend the staff member or report this incident to the Indiana Department of Health's Long Term Care Division (IDOH-LTC). In an interview with the ED on 2-12-25 at 10:20 a.m., she shared she had spoken with a supervisor and would be suspending CNA 3, today, related to the issues with Resident C. The ED emphasized the aide was unsure of the date or time of the occurrence or with whom the aide was working when this happened. She clarified at the time of the event, the aide shared the resident was going in and out of other resident's rooms and she felt		in his apartment at his leisure. Verified Resident B has an updated service plan that includes incontinence care. In addition, skin assessment was completed and shows no skin breakdown at this time. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** Clinical staff in-serviced on Abuse and Neglect and Exploitation Policy and Basic care policy to include mandatory reporting, changing residents timely and not barricading residents in their rooms on 2/19/2024. Remaining staff were educated 1:1 as needed. Clinical staff voiced no other incidents of abuse and/or neglect has occurred to their knowledge. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;*** Compliance with documentation of the ADL assistance for residents is tracked by the electronic health record and reviewed by the Health and Wellness Director during HWD Morning Routine. Executive Director and Health and Wellness Director will be educated on EHR	

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	this, being secluded in his room, would limit his ability to continue this. She added the aide told her she had left him like this in his room for only a short period of time, time span unknown, and checked on him and then allowed him to leave as he desired. She indicated the aide told her the resident was in bed when she went back to remove the chair. The ED indicated she educated the aide in regards to not restraining a resident for anything at any time and indicated the aide shared she had never done this prior to, or since this incident. On 2-12-25 at 10:20 a.m., the ED provided a copy of a document, dated 2-7-25, which was signed by the ED. The document indicated the ED had "spoke [sic] with [name of CNA 3] and asked about an incident where she placed a chair in front of a [un-named] resident's door. The employee stated she did just for a few minutes because he was wandering in and out of other residents' apartments. She stated she never do [sic] this before and will never do this again. Employee did not know the exact date and time of incident. ED inserviced employee about restraining a resident at anytime for any reason. Let her know to reach out to her nurse on duty and have them help with a situation like this." In an interview with the ED on 2-12-25 at 12:45 p.m., she indicated she was unable to recall when or who informed her of the situation with Resident C. The ED recalled she had been on the MCU, and someone asked her if she was aware of CNA 3 placing a chair up against Resident C's door to keep him in his room. The ED indicated it would have been within the last week, or so, because she spoke with CNA 3 on 2-7-25. It was several days before the ED had the opportunity to speak with CNA 3, after learning of the chair being placed in		reports and overseeing compliance. Rounding of Memory Care will occur daily by a department director and documented on the audit form to verify residents can enter and exit their apartments freely for 60 days. After 60 days, if compliant, will discontinue the use of the audit form. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** Executive Director will review care tracking reports at least quarterly during Quality Assurance meetings. The Daily Rounding of Memory Care Audit Form will be reviewed also while in 60 day audit period.	

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	front of the door, because CNA 3 was not working every day. The ED indicated it did not cross her mind to suspend CNA 3, do a more thorough investigation, or report the incident to IDOH-LTC. The ED indicated Resident C tends to pace and walk around a lot and sometimes staff report intrusive behaviors of going into other residents' rooms. In a telephone interview on 2-12-25 at 1:30 p.m., with CNA 3, she indicated she was unable to recall the exact date of occurrence when she put a chair in front of Resident C's door to keep him in his room, but thought it may have been sometime in December 2024, during a 6:00 p.m. to 6:00 a.m. shift. She explained it was a common event for this resident to wander the halls and have intrusive wandering into other resident's rooms, but indicated on this shift, it seemed worse than other times, especially during the evening shift, with the resident pacing and intrusive wandering for an extended period of time. She shared she was busy with resident care with other residents on the MCU, as well as trying to complete laundry for other residents. She recalled hearing other residents occasionally yell out, as well as receiving calls from some family members that Resident C was in their room and the affected residents were "scared and wanting him out of their room." CNA 3 indicated, somewhere between 11:00 p.m. and midnight, she again had removed him from a peer's room and took him back to his room and tried to help toilet him and get him to lie down. "I know it was bad, but I was very upset about the whole situation and the other residents being upset with him." She indicated she left him in his room and pushed a chair up against his door to keep him from leaving his room and left him like that for about 30 minutes. She continued, when she went to check on him, he was in bed			

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	and slept the rest of the night, so she removed the chair at the end of the 30 minutes. CNA 3 indicated the nurse on duty on the MCU, that shift, was Registered Nurse (RN) 4. She (RN 4) was aware of this and reported her (CNA 3) to the ED, but was uncertain when she was reported by RN 4 to the ED. She recalled RN 4 did not address this with her that shift or since the incident occurred. CNA 3 clarified several days after the event; the ED spoke with her about the seclusion. "I told [name of the ED] that I knew that it was a bad thing to do, but I didn't know what else to do...All of the nurses know that [name of Resident C] wanders in and out of other people's rooms, some nights it's worse than others and it was really bad that night. It really upset the other residents." CNA 3 indicated in her conversation with the ED, she was told not to do that again and added the ED had contacted her earlier today and suspended her, pending the results of the investigation regarding the involuntary seclusion of Resident C. In a confidential interview, it was indicated they had heard, but not witnessed, that CNA 3 had placed a chair in front of Resident C's door to keep him from coming out of his room. It was unknown when this took place, but it was told the ED was aware of the situation. They shared they had no idea what type of discipline, if any, was conducted, but were aware CNA 3 had been allowed to continue to work. In an interview on 2-13-25 at 8:50 a.m., with a member of the contracted management team, she indicated the ED, was suspended last evening, pending an investigation related to not following the facility's abuse prohibition policy, including untimely reporting of an allegation of abuse.			

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	An interview with RN 4 was unable to take place during the survey, despite requesting contact information from the administrative team several times during the survey. On 2-14-25 at 2:40 p.m., during the Exit Conference with a member of the contracted management team, he indicated he had not received confirmation from the ED of a reportable event being filed in regards to involuntary seclusion and was in contact with IDOH-LTC staff to gain access to the IDOH electronic pathway to submit the report late. A review of Resident C's most recent "Custom Level of Care Assessment," dated 9-27-24, indicated he displayed "Frequent socially inappropriate behaviors (i.e., yelling, verbally inappropriate, spitting, aggressive behavior, sexually inappropriate). Disoriented of all spheres at all time. [Handwritten entry of] Peeing on walls and other inappropriate areas. Does not wander." It indicated he ambulated independently and was dependent on staff for continence management and may resist incontinence care. Resident C's most recent associated Service Plan, dated 9-27-24, indicated a goal of maintaining independent mobility with staff to "encourage resident to use proper assistive device...if needed." Under the "Focus" of "Cognition and Behavior," it indicated the "Goal," to be "Confusion, not always cooperative," with interventions identified as, "Staff to offer resident support and redirection." A second "Focus" of "Cognition and Behavior," indicated the "Goal," of "Resident exhibits unpredictable and frequent socially inappropriate behaviors," with interventions identified as, "Staff to offer			

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	redirection/difficult to redirect. Give prn [as needed] medication with documentation. Call MD [medical doctor] and family." The assessment and service plan did not reflect any concerns with wandering or intrusive wandering in the MCU. B. The clinical record of Resident B was reviewed on 2-12-25 at 11:50 a.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety, and depression. It indicated she resided on the facility's secured memory care unit (MCU) for less than one year. A review of Resident B's "Level of Care Tool," dated 1-20-25, but unsigned by any staff person or family member, indicated she required "maximum assist" with toileting, displayed moderate confusion, but was cooperative without negative behaviors. Her most recent associated Service Plan, dated 9-29-24, indicated a focus of "Continence Management," with a goal to maintain proper continence care with assistance from staff, with interventions identified as, "Res [Resident] to be toileted in the am, before lunch, before nap, after nap, before dinner and before bed. Staff to give proper incontinence care with each episode." In an interview with the Executive Director (ED) on 2-12-25 at 2:20 p.m., she indicated she had been informed "in the last month or so" that Resident B had been found "very wet" by the evening shift staff on the MCU. She recalled CNA 8 commenting, during an interview, that she may have lost track of time and did not change Resident B for 10-12 hours. When the evening shift staff changed Resident B, the resident's brief was saturated and literally just fell apart. The ED indicated CNA 8 was given a written warning regarding job performance and neglect but was allowed to continue to work. She added CNA 8 ended up giving a written resignation, on 1-31-25,			

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	which provided two weeks notice with an effective last day of 2-14-25 but only worked the following day and never returned to work. A document entitled, "Employee Disciplinary Report," dated 1-29-25, but unsigned by any staff, indicated CNA 8 was given "Disciplinary Action," related to "Mistreated co-worker or client," related to taking care of Resident B "and did not toilet/change Resident [B] during her entire shift...Resident [B] was changed at approximately 5pm [5:00 p.m.] when her brief was saturated in urine and Resident [B] had a red bottom." A written statement from CNA 8, dated 1-28-25, indicated when she "arrived in Memory Care Jan.27th, 2025. Received report from co-worker. Was told that [Resident B] was changed at 5:20 a.m. and was dry. Approx. [approximately] 6:20 [a.m.], I went into [Resident B's room] ...I checked her brief again and she was still dry...Throughout the shift I was busy and sometimes could not find co-worker to help. I lost track of time and did not change [Resident B] before my shift ended." In a written statement from Home Health Aide (HHA) 5, dated 1-28-25, she indicated, on 1-27-25 around 5:15 p.m., a family member of Resident B requested she be checked and changed for urinary incontinence. It indicated that during the process of incontinence care, the brief that had been in place, "fell apart and the gel into/with the pad came off also...her back [buttocks] was red." It indicated she immediately notified the ED of the situation by text message. In a written statement from Licensed Practical Nurse (LPN) 9, dated 1-28-25, she indicated, "Unbeknownst to me, resident [Resident B] was not changed from 5am until 5pm". LPN 9 indicated			

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	after dinner, on 1-27-25 around 5:00 p.m., Resident B's family requested "she be changed due to her soiling her clothes," with the two evening shift aides going to provide incontinence care. LPN 9 indicated she was not made aware of the issue until receiving a call from the ED. In an interview on 2-13-25 at 10:13 a.m., with a family member of Resident B, she indicated it was the resident's family who requested incontinence care for Resident B, early into the evening shift, due to the resident becoming "fidgety." In a second interview on 2-13-25 at 10:40 a.m., she indicated once she became aware of the lack of incontinence care, she reported it immediately to the ED and the facility's owner via email. "She did not respond until last week about the incident with [name of Resident B] being left wet for an extended period of time, but even then, she did not specifically address the issue at hand...I do know that she did conduct an investigation, but did not speak with [name of Resident B's spouse] who was present for it." On 2-12-25 at 10:20 a.m., the ED provided a copy of an undated policy entitled, "Abuse Prohibition." This policy indicated, "We will not tolerate any form of abuse, neglect, or exploitation [via] Maintain a ZERO tolerance for ANY form of abuse, neglect, or exploitation. Maintain a work and living environment...free from threat of and/or occurrence of harassment, abuse (verbal, physical, mental, psychological, or sexual), neglect...involuntary seclusion...Protect residents from abuse, neglect, or exploitation by anyone, including but not limited to: staff...Ensure that staff uses caring, ethical, and professional behavior in all relationships with residents. Definitions. Abuse-Any willful infliction of...unreasonable confinement...or punishment			

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	with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being...Involuntary Separation or Seclusion-Separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative...Neglect-The failure to provide good and services necessary to avoid physical harm or mental anguish. Neglect is the provide the necessary treatment, rehabilitation, care, attention...supervision, or medical services by a caregiver...Actions [to be taken by the facility to prevent abuse include, but are not limited to,] Screening of Staff...Training of Staff...Prevention of Abuse...Identification [of allegation of abuse and safeguard the resident from further abuse]...Investigation [of the allegation of abuse]...Reporting of Abuse..." On 2-12-25 at 10:35 a.m., the ED provided a copy of the "Resident's Admission Packet," which included information on the State of Indiana's Resident Rights, which includes, but is not limited to, "Residents have the right to a dignified existence...without restraint; interference...Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality...Residents have the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Residents have the right to be free from...physical abuse, mental abuse...neglect; and involuntary seclusion."			

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	On 2-14-25 at 12:15 p.m., a member of the contracted management team provided a copy of an undated policy and/or procedure entitled, "Bowel and Bladder Care." It indicated, "Assist residents with elimination, as needed, in a dignified and personal way...Encourage residents to use the bathroom frequently throughout the day. Escort residents with bowel and bladder control problems to the bathroom frequently, such as every two to three hours." On 2-14-25 at 12:15 p.m., a member of the contracted management team provided a copy of an undated policy and/or procedure entitled, "Incontinence Care." It indicated, "If residents are unavoidably incontinent, help them care for themselves in a dignified and respectful manner...Incontinent residents are at a greater risk for skin breakdown...Take special care to clean the resident's skin when changing undergarments...Respond to a resident's requests for toileting promptly. Check on incontinent residents frequently..." This Residential tag relates to Complaint IN00452589. 2.5-1.2(b) 2.5-1.2(c)(1) 2.5-1.2(c)(2) 2.5-1.2(d) 2.5-1.2(u) 2.5-1.2(v)(5) 2.5-1.2(v)(6)			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on interview and record review, the facility	R 0090	***What corrective action(s) will be accomplished for those***	03/04/2025

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	failed to ensure reports of unusual occurrences that may directly adversely affect a resident's health or safety, specific to abuse and/or neglect, were promptly reported to the Indiana Department of Health's (IDOH) Long Term Care Division (LTC) within 24 hours of becoming aware of the unusual occurrence, for 2 of 3 residents reviewed for abuse and/or neglect. (Residents B and C) Findings include: 1. During the facility's entrance conference on 2-12-25 at 9:35 a.m., with the Executive Director (ED), she was queried about knowledge of a male resident being secluded in his room by placing a chair against the door, by a staff member. The ED indicated she was aware of this, and she spoke to the Certified Nurse Aide (CNA) about this. She indicated she did not suspend the staff member or report this incident to the Indiana Department of Health's Long Term Care Division (IDOH-LTC). In an interview on 2-12-25 at 10:20 a.m., with the ED, she shared she had spoken with a supervisor and would be suspending CNA 3, today, related to the issues with Resident C. The ED emphasized the aide was unsure of the date or time of the occurrence or with whom she was working when this happened. She clarified at the time of the event, the aide shared the resident was going in and out of other resident's rooms and she felt this, being secluded in his room, would limit his ability to continue this. She added the aide told her she had left him like this in his room for only a short period of time, time span unknown, and checked on him and then allowed him to leave as he desired. She indicated the aide told her the resident was in bed when she went back to remove the chair. The ED indicated she educated the aide in regards to not restraining a resident for		***residents found to have been affected by the deficient practice;*** An incident report was completed for resident C and resident B and was reported to IDOH electronically 2/20/2025. Physicians and families notified. Residents assessed at time of visit and no adverse effects identified. No new orders from physicians received. Administrator educated on Abuse and Neglect, state reporting requirements, and mandatory reporting. Administrator voiced no further concerns with Abuse and/or Neglect that have been reported to her. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** Administrator educated on Abuse and Neglect, state reporting requirements, and mandatory reporting. Administrator voiced no further concerns with Abuse and/or Neglect that have been reported to her. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;*** Administrator is no longer	

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	anything at any time and indicated the aide shared she had never done this prior to, or since this incident. On 2-12-25 at 10:20 a.m., the ED provided a copy of a document, dated 2-7-25, which was signed by the ED. The document indicated the ED had "spoke [sic] with [name of CNA 3] and asked about an incident where she placed a chair in front of a [un-named] resident's door. The employee stated she did just for a few minutes because he was wandering in and out of other residents apartments. She stated she never do [sic] this before and will never do this again. Employee did not know the exact date and time of incident. ED inserviced employee about restraining a resident at anytime for any reason. Let her know to reach out to her nurse on duty and have them help with a situation like this." In an interview with the ED on 2-12-25 at 12:45 p.m., she indicated she was unable to recall when or who informed her of the situation with Resident C. The ED recalled she had been on the MCU, and someone asked her if she was aware of CNA 3 placing a chair up against Resident C's door to keep him in his room. The ED indicated it would have been within the last week, or so, because she spoke with CNA 3 on 2-7-25. It was several days before the ED had the opportunity to speak with CNA 3, after learning of the chair being placed in front of the door, because CNA 3 was not working every day. The ED indicated it did not cross her mind to suspend CNA 3, do a more thorough investigation, or report the incident to IDOH-LTC. The ED indicated Resident C tends to pace and walk around a lot and sometimes staff report intrusive behaviors of going into other residents' rooms.		employed by community. New Administrator will be educated and trained on state required reporting, process for reporting and verify they have access to the IDOH-LTC electronic pathway reporting site for future reporting if needed. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** Abuse and/or Neglect reportables will be audited in the Quality Assurance Meetings to verify proper reporting. Administrator will print out the report as evidence of proper reporting.	

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	In a telephone interview on 2-12-25 at 1:30 p.m., with CNA 3, she indicated she was unable to recall the exact date of occurrence when she put a chair in front of Resident C's door to keep him in his room, but thought it may have been sometime in December 2024, during a 6:00 p.m. to 6:00 a.m. shift. CNA 3 indicated the nurse on duty in the MCU that shift was Registered Nurse (RN) 4 and she was aware of this and reported her (CNA 3) to the ED, but was uncertain when she was reported by RN 4 to the ED. She recalled RN 4 did not address this with her that shift or since. CNA 3 clarified several days after the event; the ED spoke with her about the seclusion. CNA 3 indicated in her conversation with the ED, she was told not to do that again and added the ED had contacted her earlier today and suspended her, pending the results of the investigation regarding the involuntary seclusion of Resident C. In a confidential interview, it was indicated they had heard, but not witnessed, that CNA 3 had placed a chair in front of Resident C's door to keep him from coming out of his room. It was unknown when this took place, but was told the ED was aware of the situation. They shared they had no idea what type of discipline, if any, was conducted, but were aware CNA 3 had been allowed to continue to work. In an interview on 2-13-25 at 8:50 a.m., with a member of the contracted management team, she indicated the ED, was suspended last evening, pending an investigation related to not following the facility's abuse prohibition policy, including untimely reporting of an allegation of abuse. On 2-14-25 at 2:40 p.m., during the Exit Conference with a member of the contracted management company team, he indicated he had not received			

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	confirmation from the ED of a reportable event being filed in regards to involuntary seclusion and was in contact with IDOH-LTC staff to gain access to the IDOH electronic pathway to submit the report late. 2. In an interview with the ED on 2-12-25 at 2:20 p.m., she indicated she had been informed "in the last month or so" that Resident B had been found "very wet" by the evening shift staff on the memory care unit (MCU). She recalled CNA 8, "admitted during an interview that she may have lost track of time and did not change the resident for 10-12 hours". When the evening shift staff changed Resident B, the resident's brief was saturated and literally just fell apart. The ED did not indicate she had reported this unusual event to the IDOH-LTC, nor did she provide any documentation of such a report. A document entitled, "Employee Disciplinary Report," dated 1-29-25, but unsigned by any staff, indicated CNA 8 was given "Disciplinary Action," related to "Mistreated co-worker or client," related to taking care of Resident B "and did not toilet/change Resident [B] during her entire shift...Resident [B] was changed at approximately 5pm [5:00 p.m.] when her brief was saturated in urine and Resident [B] had a red bottom." A written statement from CNA 8, dated 1-28-25, indicated when she "arrived in Memory Care Jan. 27th, 2025. Received report from co-worker. Was told that [Resident B] was changed at 5:20 a.m. and was dry. Approx. 6:20 [a.m.], I went into [Resident B's room] ...I checked her brief again and she was still dry...Throughout the shift I was busy and sometimes could not find co-worker to help. I lost track of time and did not change [Resident B] before my shift ended."			

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	In a written statement from Home Health Aide (HHA) 5, dated 1-28-25, she indicated, on 1-27-25 around 5:15 p.m., a family member of Resident B requested she be checked and changed for urinary incontinence. It indicated that during the process of incontinence care, the brief that had been in place, "fell apart and the gel into/with the pad came off also...her back [buttocks] was red." It indicated she immediately notified the ED of the situation by text message. In an interview on 2-13-25 at 10:13 a.m., with a family member of Resident B, she indicated it was the resident's family who requested incontinence care for Resident B, early into the evening shift, due to the resident becoming "fidgety." In a second interview on 2-13-25 at 10:40 a.m., she indicated once she became aware of the lack of incontinence care, she reported it immediately to the ED and the facility's owner via email. "She did not respond until last week about the incident with [name of Resident B] being left wet for an extended period of time, but even then, she did not specifically address the issue at hand... I do know that she did conduct an investigation, but did not speak with [name of Resident B's spouse] who was present for it." On 2-12-25 at 10:20 a.m., the ED provided a copy of an undated policy entitled, "Abuse Prohibition." This policy indicated, "We will not tolerate any form of abuse, neglect, or exploitation [via] Maintain a ZERO tolerance for ANY form of abuse, neglect, or exploitation. Maintain a work and living environment...free from threat of and/or occurrence of harassment, abuse (verbal, physical, mental, psychological, or sexual), neglect...involuntary seclusion...Protect residents from abuse, neglect, or exploitation by anyone,			

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	including but not limited to: staff...Ensure that staff uses caring, ethical, and professional behavior in all relationships with residents...Reporting of Abuse. Report any incident to the Executive Director or designee immediately. Report the incident to the State Regulatory Agency within 3 days of the occurrence when: There is a specific written or verbal allegation of abuse, neglect...There is a reasonable suspicion of abuse, neglect...There is actual knowledge of resident abuse, neglect...Document, log and track incidents of suspected or actual abuse, neglect..." This Residential tag relates to Complaint IN00452589. 2.5-1.3(g)(1)			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered by the physician for 2 of 3 residents observed for medication receipt during 2 of 2 medication pass observations with two nursing staff and three residents. (Resident B and Resident F) Findings include: 1. During a medication pass observation with Qualified Medication Aide (QMA) 12, on 2-13-25 at 9:35 a.m., for Resident B, she was observed to prepare the following medications for administration and then administered the following medications:	R 0241	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Pharmacy consultant completed a full MAR to cart audit on 2/21/2025 to verify all orders on MAR match the physicians orders and the medication labels are accurate. Verified medications were accurate. QMA's educated on the requirement to follow physician orders on meds required prior to breakfast (on empty stomach), such as Levothyroxine. Also, to notify the Health and Wellness Director if patches	03/21/2025

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	-levothyroxine (Synthroid) (thyroid medication) 75 micrograms (mcg), 1 tablet. -Prednisone (a steroid) 10 milligrams (mg), 1 tablet. -amlodipine (an anti-hypertensive medication) 10 mg, 1 tablet. -Bifidophilus Flora Force Probiotic Blend (a probiotic and over the counter medication), 1 tablet. A review of the clinical record for Resident B's levothyroxine/Synthroid orders indicated the labeled instructions were to administer 75 mcg daily on an empty stomach. The written physician's order, dated 9-26-24, indicated the same. The medication administration record (MAR) indicated to administer this medication before breakfast. QMA 12 acknowledged Resident B normally received this medication at 7:00 a.m., but she could not awaken her at that time and was now administering the medication, after she ate breakfast. A review of the clinical record for Resident B's Prednisone orders indicated the labeled instructions were to administer 10 mg daily. The written physician's order, dated 1-28-25, indicated to administer Prednisone 1.5 tablets of the 10 mg tablets (to provide 15 mg total) daily for 30 days. The MAR indicated the dosage had increased, on 1-28-25, from 10 mg daily to 15 mg daily via a handwritten notation. A review of the clinical record for Resident B's amlodipine orders indicated the labeled instructions were to administer 10 mg daily. The written physician's order, dated 9-25-24, indicated to administer 5 mg daily. The MAR indicated to administer 5 mg daily. A review of the clinical record for Resident B's		weren't removed, prior to placing a new patch. Med Error Incident Reports were completed and physicians/ families notified. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** Pharmacy consultant completed a full MAR to cart on 2/21/2025 to ensure all orders on MAR matched the physicians orders and the medication labels. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;*** Health and Wellness Director or designee will complete at least weekly med cart audits to ensure all medications on MAR match labels and are properly stored. Any medications noted on audit not properly labeled or stored will be reported to the Executive Director and corrected. Med Error Incident Reports will be completed as appropriate. New Electronic Medication Administration Record is being implemented to allow for more accurate med administration and will be completed by 3/18/2025. Medication orders will be implemented by pharmacy. Pass Med Report will be reviewed	

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	orders indicated physician orders, dated 11-7-24, were to administer, "Probiotic 10 billion cell capsule" once daily. The MAR instructions were to administer, "Culturelle Capsule, take 1 capsule by mouth once daily." The manufacturer's labeled instructions for the "Bifidophilus Flora Force Probiotic Blend," indicated to take 2 capsules daily and to keep the medication refrigerated. The medication bottle was housed in the unrefrigerated medication cart. When the bottle was touched, the bottle was not cold. In an interview with QMA 12 at this time, she indicated she was unaware to keep the medication refrigerated. 2. During a medication pass observation with QMA 6, on 2-14-25 at 7:40 a.m., for Resident F, she was observed to prepare a Lidocaine 5% patch (for pain relief) for application. When she was ready to place the patch on Resident F's back, she indicated the previous patch was still in place. The previous patch had a handwritten date of 2-13-25, on it. QMA 6 was observed to remove the previous patch prior to placing the current patch, with a handwritten date of 2-14-25, onto the resident's lower back. QMA 6, indicated the Lidocaine patches were to be removed after 12 hours and to be off of the resident for 12 hours. A review of the clinical record for Resident F's Lidocaine orders indicated the labeled instructions were to apply one patch daily but had no instructions for removal. The written physician's order, dated 1-2-25, indicated to apply topically a lidocaine 5% film to the affected area daily. A review of the website, "medlineplus.gov," retrieved on 2-18-25, indicated lidocaine 5% patches should only be left in place for a maximum		daily to verify meds required to be given on empty stomach are documented as being passed prior to breakfast, and medication administration documentation is appropriate. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** Executive Director will review med cart audits at least quarterly during Quality Assurance Meetings. Pass Med Report will also be reviewed at Quality Assurance Meetings.	

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	of 12 hours, unless the physician orders specify differently. On 2-14-25 at 12:15 p.m., a member of the contracted management team provided an undated copy of a policy and/or procedure entitled, "Medication Administration." This policy and/or procedure indicated, "Licensed nurse certification is required to administer medications in Ohio and Illinois. Caregivers are allowed to administer medication in Michigan. Those administering medications may do any of the following to administer and remind the resident: Remind/administer medications to a resident and watch to ensure that the resident complies with the directions on the medication administration record (MAR)...Check medication for correct resident's name (positive identification can be made from photo), correct medication and dose, correct day and time...All residents who are on the medication administration system must be observed taking their medication...Report any concerns to the Wellness Coordinator, the resident's physician, and family members when necessary." This Residential tag relates to Complaint IN00451885. 2.5-4(e)(1)			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure any errors in medication administration were documented in the clinical record and the physician was notified of the medication errors. (Residents B and F)	R 0247	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Med Error Incident Reports were	03/21/2025

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	Findings include: 1. During a medication pass observation with Qualified Medication Aide (QMA) 12, on 2-13-25 at 9:35 a.m., for Resident B, she was observed to prepare the following medications for administration and then administered the following medications: -levothyroxine (Synthroid) (thyroid medication) 75 micrograms (mcg), 1 tablet. -Prednisone (a steroid) 10 milligrams (mg), 1 tablet. -amlodipine (an anti-hypertensive medication) 10 mg, 1 tablet. -Bifidophilus Flora Force Probiotic Blend (a probiotic and over the counter medication), 1 tablet. A review of the clinical record for Resident B's levothyroxine/Synthroid orders indicated the labeled instructions were to administer 75 mcg daily on an empty stomach. The written physician's order, dated 9-26-24, indicated the same. The medication administration record (MAR) indicated to administer this medication before breakfast. QMA 12 acknowledged Resident B normally received this medication at 7:00 a.m., but she could not awaken her at that time and was now administering the medication, after she ate breakfast. A review of the clinical record for Resident B's Prednisone orders indicated the labeled instructions were to administer 10 mg daily. The written physician's order, dated 1-28-25, indicated to administer Prednisone 1.5 tablets of the 10 mg tablets (to provide 15 mg total) daily for 30 days. The MAR indicated the dosage had increased, on 1-28-25, from 10 mg daily to 15 mg daily via a		completed and physicians/ families notified. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken*** QMA and LPN in-serviced on medication administration policy on 2/21/2025. Health and Wellness director or designee will complete competency evaluation for all QMAs and LPNs. Pharmacy consultant completed a full MAR to cart on 2/21/2025 to ensure all orders on MAR matched the physicians orders and the medication labels. Any additional medication errors identified had a Med Error Incident Report completed and physicians/ families notified. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur***; All QMA and LPN will have medication administration competency verification completed upon hire and at least yearly to reduce the risk of medication errors occuring. Ongoing medication administration in-services will be completed as needed. QMA's and LPN's educated on the need for Med	

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	handwritten notation. A review of the clinical record for Resident B's amlodipine orders indicated the labeled instructions were to administer 10 mg daily. The written physician's order, dated 9-25-24, indicated to administer 5 mg daily. The MAR indicated to administer 5 mg daily. A review of the clinical record for Resident B's orders indicated physician orders, dated 11-7-24, were to administer, "Probiotic 10 billion cell capsule" once daily. The MAR instructions were to administer, "Culturelle Capsule, take 1 capsule by mouth once daily." The manufacturer's labeled instructions for the "Bifidophilus Flora Force Probiotic Blend," indicated to take 2 capsules daily and to keep the medication refrigerated. The medication bottle was housed in the unrefrigerated medication cart. When the bottle was touched, the bottle was not cold. In an interview with QMA 12 at this time, she indicated she was unaware to keep the medication refrigerated. 2. During a medication pass observation with QMA 6, on 2-14-25 at 7:40 a.m., for Resident F, she was observed to prepare a Lidocaine 5% patch (for pain relief) for application. When she was ready to place the patch on Resident F's back, she indicated the previous patch was still in place. The previous patch had a handwritten date of 2-13-25, on it. QMA 6 was observed to remove the previous patch prior to placing the current patch, with a handwritten date of 2-14-25, onto the resident's lower back. QMA 6, indicated the Lidocaine patches were to be removed after 12 hours and to be off of the resident for 12 hours. A review of the clinical record for Resident F's		Error Incident Reports needing completed when errors are made, including notification to physician and families. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** Executive Director will review competencies quarterly during Quality Assurance meetings and review Incident Reports, including Medication Error Incident Reports for documentation of proper notifications and for improving the quality of med administration. ***By what date the systemic changes will be completed.*** In-service and competency evaluations to be completed for all LPNs and QMAs by 3/21/2025.	

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	Lidocaine orders indicated the labeled instructions were to apply one patch daily but had no instructions for removal. The written physician's order, dated 1-2-25, indicated to apply topically a lidocaine 5% film to the affected area daily. A review of the website, "medlineplus.gov," retrieved on 2-18-25, indicated lidocaine 5% patches should only be left in place for a maximum of 12 hours, unless the physician orders specify differently. On 2-14-25 at 12:15 p.m., a member of the contracted management team provided an undated copy of a policy and/or procedure entitled, "Medication Administration." This policy and/or procedure indicated, "Licensed nurse certification is required to administer medications in Ohio and Illinois. Caregivers are allowed to administer medication in Michigan. Those administering medications may do any of the following to administer and remind the resident: Remind/administer medications to a resident and watch to ensure that the resident complies with the directions on the medication administration record (MAR)...Check medication for correct resident's name (positive identification can be made from photo), correct medication and dose, correct day and time...All residents who are on the medication administration system must be observed taking their medication...Report any concerns to the Wellness Coordinator, the resident's physician, and family members when necessary." This Residential tag relates to Complaint IN00451885. 2.5-4(e)(1)			

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	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure over-the-counter (OTC) medications were labeled within acceptable standards for 1 of 3 residents observed during 1 of 2 medication pass observations with 1 of 2 nursing staff and three residents. (Resident B) Findings include: During a medication pass observation with Qualified Medication Aide (QMA) 12, on 2-13-25 at 9:35 a.m., for Resident B, the following OTC medications were observed to be prepared for administration: -Bifidophilus Flora Force Probiotic Blend (a probiotic). -Fexofenadine (an antihistamine) 180 milligrams. An observation of the Bifidophilus Flora Force Probiotic Blend bottle during the medication pass observation time indicated the bottle failed to have the resident's name, the physician's name, an expiration date or drug strength present on the label, and the directions for use indicated by the manufacturer differed from the prescriber's directions for use. A review of the clinical record for Resident B's orders indicated physician orders, dated 11-7-24, were to administer, "Probiotic 10 billion cell capsule" once daily. The MAR instructions were to administer, "Culturelle Capsule, take 1 capsule by mouth once daily." The manufacturer's labeled instructions for the "Bifidophilus Flora Force	R 0302	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Audit was completed for Resident B and proper labels were applied per regulatory requirement. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** Clinical specialist or designee with complete med cart audits to verify OTC medications are labeled appropriately. Any OTC medications that are identified not having an appropriate label will be labeled and reported to Executive director. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;*** QMA's and LPN's were educated on the label requirements for OTC medications via inservice on 2/19/2025. ***How the corrective action(s) will be monitored to ensure the deficient practice will***	03/18/2025

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	Probiotic Blend," indicated to take 2 capsules daily and to keep the medication refrigerated. The medication bottle was housed in the unrefrigerated medication cart. When the bottle was touched, the bottle was not cold. In an interview with QMA 12, at the time of the medication pass observation time, she indicated she was unfamiliar with the "guidelines" for the labeling of over-the-counter medications. An observation of the fexofenadine container, at the time of the medication pass observation, indicated the container failed to have the physician's name present. This Residential tag relates to Complaint IN00451885. 2.5-6(c)(6)(A) 2.5-6(c)(6)(B) 2.5-6(c)(6)(C) 2.5-6(c)(6)(D) 2.5-6(c)(6)(E)		***not recur, i.e., what quality assurance program will be put into place;*** Health and Wellness Director or designee will complete cart audits weekly to include over the counter medications are labeled with residents name, physician name, date of expiration, and name of drug and strength. Weekly med cart audits are a standard of practice with new management company. Executive Director will review med cart audits at least quarterly during quality assurance meetings. ***By what date the systemic changes will be completed.*** Audit to be completed by 3/18/2025 and ongoing.	