STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altenheim Health & Living Community	3525 E Hanna Ave Indianapolis, IN 46237

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assured the accurate receiving and dispensing of drugs) to meet the needs of residents for 2 of 3 residents reviewed for pharmacy services (Resident B and Resident C).Findings include:During an interview on 7/29/25 at 11:45 a.m., the Director of Nursing (DON) indicated Resident B was erroneously discharged home with Resident C's Novalog (insulin) pen and the nurse should have verified the name on the medication. During an interview on 7/29/25 at 2:48 p.m., LPN 1 indicated she was the nurse who discharged the Resident B home. She removed the insulin pens which were labeled with the resident's identification sticker on the outside of the bag, and she did not check the labels on the medication itself. She indicated she should have checked inside of the bags for the labels on the actual insulin pens. On 7/29/25 at 12:13 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to diabetes mellitus and dependence on renal dialysis.A 7/7/25 order indicated the resident was prescribed 5 units of Novolog via FlexPen 3 times a day, and 20 units of Lantus via insulin pen once a day.During an interview on 7/30/25 at 12:23 p.m., the DON indicated she did not know if the medication came packaged incorrectly from the pharmacy or if a staff member placed the insulin pen in the incorrect bag. On 7/30/25 at 12:45 p.m., the DON provided the facility policy, Discharge Planning, dated 6/4/19, and indicated it was the policy currently being used. A review of the policy did not indicate the need for staff to confirm medication labels when residents' received discharge medications for home. This deficient practice was corrected on 7/14/25 after the facility implemented a systemic plan of correction that included the following actions: staff was educated on ensuring residents who discharged with insulin had the correct medications, with ongoing monitoring and audits.This citation relates to Complaint 2562216.3.1-25(p)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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