STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155361	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amber Manor Care Center	801 E Illinois St Petersburg, IN 47567

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 39130 Based on observation, interview, and record review, the facility failed to adequately monitor signs and symptoms of adverse reactions to newly prescribed pain medications for 1 of 3 residents reviewed for pain. No routine monitoring of adverse reactions were documented in the resident's record while the resident displayed signs of decreased alertness and increased difficulty with mobilization and eating following an increase in the resident's pain medication regimen. (Resident D) Finding includes: During an observation on 1/14/25 at 11:15 A.M., Resident D was sitting up in a recliner in her room. Resident D did not respond when spoken to and appeared to be asleep. Resident D was holding a television remote control in her right hand, pushing the controller to cause the television channel menu to scroll continuously. During an observation on 1/14/25 at 11:42 A.M., Resident D was sitting in the same position in her recliner while the television channel menu continued to scroll. During record review on 1/14/25 at 12:00 P.M., Resident D's diagnoses included but were not limited to, migraines, chronic pain, convulsions, gout, opiod dependence, pain in left hand, and Parkinson's disease. Resident D's most recent Significant Change Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident was cognitively intact, had unclear speech, was able to make self understood, and required partial to moderate assistance with eating. Resident D's quarterly MDS assessment, dated 11/6/24, indicated the resident was cognitively intact, had clear speech, was able to make self understood, and required supervision with eating. Resident D's care plan included, but was not limited to, Resident is at risk for pain due to decreased mobility, oseoarthritis, migraines, and chronic pain (initiated 9/22/22). Interventions included, but were not limited to, administer medications as ordered and notify physician for any side effects observed. (continued on next page)

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

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident D's physician order's included, but were not limited to, gabapentin 600 milligrams (mg) for chronic pain (started 9/29/23), acetaminophen 325 mg every six hours for pain (started 12/25/24), hydrocodone-acetaminophen 10-325 mg for moderate pain every six hours as needed (started 11/26/23), oxycodone 10 mg for severe pain every two hours as needed (started 12/28/24), and fentanyl 72-hour patch 50 micrograms (mcg) per hour for pain once every three days (started 12/31/24). Resident D's Medication Administration Record (MAR) for the months of December 2024 and January 2025 indicated that the resident received her first dose of oxycodone 10 mg on 12/28/24 at 5:27 P.M. Resident continued to receive oxycodone 10 mg as needed for pain on; 12/29/24 at 3:32 P.M., 12/30/24 at 1:10 P.M., 3:14 P.M., and 7:21 P.M., 12/31/24 at 1:23 A.M., 1/1/25 at 6:44 A.M., 1/2/25 at 10:38 P.M., 1/8/25 at 2:55 P. M., 1/10/25 at 5:36 P.M., 1/13/25 at 4:50 P.M., and 1/14/25 at 10:42 A.M. Resident D also received hydrocodone-acetaminophen 10-325 mg as needed for pain on 12/29/24 at 10:01 A.M., 1/2/25 at 5:15 A.M., 1/6/25 at 11:18 P.M., 1/7/25 at 6:59 P.M., 1/8/25 at 8:21 A.M., 1/9/25 at 8:58 A.M., 1/10/25 at 1:31 A.M., 1/11/25 at 11:23 A.M. and 8:00 P.M., 1/12/25 at 1:53 A.M., 1/13/25 at 12:29 A.M. and 8:13 P.M. Resident D's nurses progress notes included, but were not limited to, the following: 12/20/24 at 6:33 P.M. - Triage contacted regarding resident pain becoming unmanageable. Resident moans and yells out in pain. Resident has been on hydrocodone-acetaminophen (Norco) at home for several years per family which may be why this medication is not effective if resident has built up a tolerance over the years. 12/24/24 at 1:10 A.M. - Resident is alert and responsive. Speech is slurred a per typical for resident but resident is able to express wants and needs. 12/23/24 at 3:33 P.M. - Orders received for hospice evaluation. 12/30/24 at 5:21 P.M. - New order received and noted to apply a fentanyl patch 50 mcg once every 3 days for pain. 1/6/25 at 2:48 P.M. - Resident has been very hard to transfer today. During an observation and interview on 1/14/25 at 2:05 P.M., Licensed Practical Nurse (LPN) 8 indicated that Resident D was hard of hearing and that she could answer questions and make self understood. LPN 8 then tried arouse Resident D while she slept in her recliner. Resident D had saliva hanging from her chin to her chest. LPN 8 was unable to arouse Resident D at the that time. LPN 8 indicated that Resident D did go in and out of alertness. During an interview on 1/1425 at 2:40 P.M., Resident D's family member indicated the resident has had a decline in her alertness and had nearly stopped talking over the past two weeks. Resident D's family member indicated they had noticed Resident D would seem to be more alert in the evening hours. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 12:10 A.M., Registered Nurse (RN) 4 indicated that if a resident was experiencing increased pain and began a new pain regimen, nursing staff would create a pain event that would trigger staff to assess and monitor the resident for pain levels, effectiveness of medications, and for signs or symptoms of adverse reactions from the medications. RN 4 indicated if increased lethargy was observed, that would be documented in the pain event or in the nurse's progress notes. During an interview on 1/15/25 at 11:00 A.M., hospice nurse 7 indicated that the contracted hospice nurse had been visiting Resident D twice a week since her admission to hospice. Hospice nurse 7 indicated that hospice does monitor the resident for any adverse reactions to new medications, but that they rely on the routine monitoring by the facility nursing staff. Hospice nurse 7 indicated that she was not very familiar with Resident D as she was not typically her nurse and had not yet met the resident. During an observation and interview on 1/15/25 at 11:15 A.M., Certified Nurse Aide (CNA) 6 and CNA 11 entered Resident D's room to assist her with toileting. Resident D was sitting in her recliner and appeared to be sleeping. CNA 6 was able to arouse Resident D. CNA 6 spoke to Resident D and the resident stood with the assist of 2 and transferred to a bedside commode. Resident D responded quietly and was difficult to understand. CNA 6 indicated Resident D's level of consciousness and alertness had declined since starting hospice and the increase in pain medications. CNA 6 indicated that the resident used to hear her room door when staff knocked and would respond, but lately staff have been having to wake her up when they come in to assist her. During an interview on 1/15/25 at 12:35 P.M., RN 2 indicated that if a resident displayed increased pain or started a new pain regimen, a change in condition or pain event would be created and any signs of increased drowsiness or other adverse reactions to any new pain medications would be documented. If a decrease in alertness was noted, triage would be contacted and notified. During an interview on 1/15/25 at 12:40 P.M., the Director of Nursing (DON) indicated that no events were created for Resident D regarding her new pain medications because the chronic pain had been an ongoing issue. On 1/15/25 at 2:45 P.M., the DON provided Resident D's hospice notes. The notes included, but were not limited to: 12/26/24 at 6:45 A.M. - Resident is alert to name. Resident is hard to understand. Resident denies pain. 12/27/24 at 12:25 P.M. - Resident was in chair in her room. Resident was hard to understand because of a low voice level. Resident read from her newspaper during the entirety of the visit. 12/30/24 at 4:05 P.M. - Resident was sitting in wheelchair upon arrival and very uncomfortable, moaning in pain. Facility nurse gave oxycodone one hour prior to visit and resident still in considerable pain. New order for fentanyl Duragesic patch 50 mcg, change every 72 hours was obtained. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/31/24 at 2:24 P.M. - Resident was very lethargic this morning. Facility staff stated the resident did not respond very well and was difficult to awaken this morning and did not want to eat breakfast. Resident had been continuing to require pain medication. Fentanyl patch was applied this morning after breakfast. 1/1/15 at 10:50 A.M. - Resident was not responsive during visit. Facility nurse state she was up for breakfast and did eat well and was awake and alert. Resident was moaning in pain this morning and nurse administered oxycodone. Resident relaxed after that. 1/2/25 at 1:24 P.M. - Resident is alert but very drowsy. She opens eyes to answer questions and then drifts back to sleep but remains easily rousable. 1/4/25 at 5:19 P.M. - Resident resting comfortably in recliner. Patient's pain is much more controlled. 1/9/25 at 6:29 P.M. - Resident asleep upon arrival. She did open her eyes but did not respond very much today. She did state, no when asked if any pain. On 1/15/25 at 3:00 P.M., a facility policy titled, Guidelines for Pain Observations and Management, dated 12/17/24, was reviewed. The policy indicated, Purpose . To ensure each resident's pain including its origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be observed and documented according to the needs of each individual . 4. If there is a change in pain indicators or verbalizations from the resident, a pain event form will be completed to indicated the changes and care plan update . 7. Evaluate the effectiveness of pain management interventions and modify as indicated. This citation relates to complaint IN00449735. 3.1-48(a)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39130 Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during 1 of 3 observations of care. Staff failed to complete hand hygiene after removing their gloves and staff performed handwashing with less than a 20 second scrub time. (Resident D) Finding includes: During an observation on 1/15/25 at 11:15 A.M., Certified Nurse Aide (CNA) 3, CNA 6, and CNA 11 assisted Resident D with toileting. CNA 6 and CNA 11 assisted Resident D from her recliner to a bedside commode and removed the resident's brief. CNA 11 and CNA 6 both removed their gloves and performed handwashing. CNA 11 performed handwashing with a 10 second scrub time. CNA 3, CNA 6, and CNA 11 then assisted Resident D to stand from the commode, perform perineal care, apply a new brief, and pulled the resident's pants up. CNA 3 then placed a wheelchair behind Resident D as CNA 6 and CNA 11 lowered the resident into the chair. CNA 3 then removed gloves and performed handwashing with a 5 second scrub time. CNA 6 performed handwashing with a 9 second scrub time. CNA 6 removed her gloves and handed Resident D a tissue to wipe her face prior to performing hand hygiene. During an interview on 1/15/25 at 11:45 A.M., the Director of Nursing (DON) indicated that if/when contracted staff in the facility providing care to residents, they would be expected to follow the facility's policies. The DON indicated all staff should perform handwashing with at least a 20 second scrub time. On 1/15/25 at 12:40 P.M., the DON supplied a facility policy titled, Guidelines for Handwashing/Hand Hygiene, dated, 12/17/24. The policy indicated, .3. Health Care Workers (HCW) shall use hand hygiene at times such as: .c. Before/after having direct physical contact with residents. d. After removing gloves . 1. Handwashing . c) Wash well for at least 20 seconds, using a rotary motion and friction . This citation relates to complaint IN00449891. 3.1-18(b) 3.1-18(l)