

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Timbers of Jasper The		STREET ADDRESS, CITY, STATE, ZIP CODE 2909 Howard Dr Jasper, IN 47546	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>38770</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were stored safely or under proper temperature controls for 2 of 15 residents sampled for medications on the floor, and 2 of 2 medication storage rooms. (Resident D, Resident M, 100 Hall Medication Storage Room, 300/400 Hall Medication Storage Room)</p> <p>Findings include:</p> <p>1. On 10/15/24 at 9:19 A.M., the 100 Hall Medication Storage Room medication refrigerator log was observed to be missing temperatures. The 100 Hall medication refrigerator log lacked a temperature on days from 10/1/24 through 10/15/24. The 100 Hall medication refrigerator log was missing a temperature for night shift on 10/1/24, 10/2/24, 10/4/24, 10/5/24, 10/6/24, 10/7/24, 10/9/24, 10/10/24, 10/12/24, 10/13/24, and 10/14/24. At that time, QMA (Qualified Medication Aide) 11 indicated that temperatures were taken twice a day and logged for medication refrigerators.</p> <p>The 300-400 Hall medication refrigerator log was observed to be missing temperatures for day shift from 10/2/24 through 10/15/24. The log was observed to be missing a temperature for night shift on 10/10/24. A note on the temperature log indicated Medications must be kept 36-46 degrees F [Fahrenheit] in Refrigerator. The temperatures on night shift were recorded as the following:</p> <p>10/1/24 30</p> <p>10/2/24 32</p> <p>10/3/24 28</p> <p>10/4/24 20</p> <p>10/5/24 30</p> <p>10/6/24 33</p> <p>10/7/24 32</p> <p>(continued on next page)</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
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10/8/24 32</p> <p>10/9/24 30</p> <p>10/11/24 32</p> <p>10/12/24 34</p> <p>10/13/24 34</p> <p>During an interview on 10/17/24 at 2:35 P.M., the Administrator indicated the temperature in medication refrigerator should be in the range that was in the policy. Policy for Medication Storage indicated temperature range should be 36-46 degrees Fahrenheit. The Administrator indicated he would ask maintenance if there had been any work orders for the refrigerator.</p> <p>During an interview on 10/17/24 at 3:14 P.M., the Administrator indicated maintenance had not worked on the refrigerator, but he checked the temperatures and it was working correctly.</p> <p>2. On 10/21/24 at 8:56 A.M., an oval peach colored pill was observed lying on the floor next to bottom of bed of Resident M. At that time LPN 15 indicated the pill was Namenda 5 mg which Resident M took twice a day. She verified the identity of the pill with the pill card in the medication cart. LPN 15 indicated she didn't know why the pill was on the floor or how long it had been there. She indicated she stayed with resident while he took his medication.</p> <p>On 10/21/24 at 10:06 A.M., Resident M's clinical records were reviewed. Diagnosis included, but was not limited to dysphagia, oropharyngeal phase, and dementia, unspecified severity.</p> <p>The most recent Significant Change in Condition MDS (Minimum Data Set) assessment, dated 10/3/24, indicated Resident M had moderate cognitive impairment and required extensive assistance of two for bed mobility, transfers and toilet use and supervision with set up for eating.</p> <p>Physician orders included, but was not limited to the following:</p> <p>memantine tablet (Namenda) (medication used to treat dementia) 5 mg; oral Twice A Day 07:00 AM - 11:00 AM, 07:00 PM - 11:00 PM, dated 9/20/2024.</p> <p>Review of the MAR (Medication Administration Report) for 10/20/24 and 10/21/24 indicated memantine had been given on 10/20/24 at 7:00 P.M. - 11:00 P.M. and on 10/21/24 from 7:00 A.M. - 11:00 A.M.</p> <p>Care Plan:</p> <p>Resident frequently spits his medication, pockets his medications in his mouth and spit his food out, Interdisciplinary Team (IDT) discussed crushing medications and resident declined Start date: 9/25/24</p> <p>Approach Start Date: 9/25/24</p> <p>Staff to encourage resident not to spit food/medications out or hold food in mouth.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/21/24 at 9:46 A.M., the Director of Nursing (DON) indicated Resident M would pocket medications and food sometimes, and an action plan had been started to make sure all residents were taking their medications when administered. At that time, she indicated no other residents had that concern. She indicated she had met with all staff administering medications on all shifts individually to go over the action plan.</p> <p>3. On 10/21/24 at 9:11 A.M., Resident D's room was observed. A small pink round pill was observed on the floor under the bedside table with marking 1 on one side, and 30 on the other. At that time, Licensed Practical Nurse (LPN) 17 indicated it was a 10mg (milligram) rosuvastatin, which Resident D took once a day at around 4:00 P.M.</p> <p>On 10/21/24 at 10:02 A.M., Resident D's clinical record was reviewed. Diagnosis included, but were not limited to, diabetes mellitus, anxiety, and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 8/18/24, indicated no cognitive impairment. Resident D required setup assistance with eating, and substantial to maximum assistance with showering, toileting, and transfers.</p> <p>Current physician orders included, but were not limited to:</p> <p>Crestor (rosuvastatin) 10mg once a day, at 5:00 P.M., dated 10/17/23.</p> <p>Resident D's Medication Administration Record (MAR) for October 2024 indicated the last time rosuvastatin was administered was at 5:00 P.M. the previous evening, 10/20/24.</p> <p>On 10/21/24 at 9:23 A.M., LPN 15 indicated when passing medications, staff should stay with the resident to make sure the pills were taken, and if one dropped, it should be put into the drug buster and a new pill administered.</p> <p>On 10/21/24 at 10:14 A.M., an action plan for medications on the floor was provided that was initiated 10/15/24. Actions to be taken from staff included, but were not limited to, asking resident to open mouth after taking medications to make sure they were swallowed, staff to offer additional water when taking medications to ensure they were swallowed, and guiding the resident's hand to mouth when taking medications.</p> <p>On 10/21/24 at 10:27 A.M., the DON provided a current General Dose Preparation and Medication Administration policy, dated 4/30/24, that indicated If a medication which is not in a protective container is dropped, facility staff should discard it according to facility policy . Observe the resident's consumption of the medication(s)</p> <p>On 10/17/24 at 1:30 P.M., a Medication Storage policy, dated August, 2022 was provided by the Administrator which indicated Temperature is maintained between 36-46 degrees Fahrenheit. Daily temperature logs must be maintained and visible.</p> <p>This citation relates to Complaint IN00445700.</p> <p>3.1-25(m)</p> <p>46882</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933</p> <p>Based on interview, observation, and record review, the facility failed to ensure food was stored and prepared safely in accordance with professional standards for food service for 1 of 2 kitchen observations. Foods were not labeled correctly, food was stored uncovered, and the facility failed to dispose of outdated food.</p> <p>Findings include:</p> <p>On [DATE] at 9:13 A.M., the following was observed in the kitchen:</p> <p>Freezer in the kitchen:</p> <ul style="list-style-type: none"> -- 5 undated, uncovered, and unlabeled bowls of pink ice cream -- 5 covered bowls undated and unlabeled. <p>Refrigerator in the kitchen:</p> <ul style="list-style-type: none"> -- clear container with cheese that had a label printed on [DATE] with a discard date of [DATE] -- applesauce with an opened date of [DATE] and a discard date of [DATE] -- clear container of lettuce undated and unlabeled -- 3 trays of fruit with several bowls uncovered on all 3 trays -- silver container with hotdogs and hamburgers undated and unlabeled -- silver container with an unknown substance that was undated and unlabeled <p>Walk in freezer</p> <ul style="list-style-type: none"> -- apple roasted pork prepared on [DATE] with a discard date of [DATE] <p>During an interview on [DATE] at 11:30 A.M., the Dietary Manager indicated if there are multiple items of the same food, staff only placed a label on one time. All items should be covered and all staff is required to dispose of expired items, and she does a morning walk through to discard of expired items.</p> <p>(continued on next page)</p>		

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