STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155490	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Healthcare	705 E Main St Centerville, IN 47330

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. 28309 Based on observation, interview, and record review, the facility failed to ensure medication administration was conducted in a safe manner and did not include leaving medication at a resident's bedside unattended for 1 of 25 residents rooms observed for unattended medications. (Resident G) Findings include: During random observations of 25 resident rooms for unattended medications on 12/4/24, between 12:58 p. m. and 2:00 p.m., with the facility's Director of Nursing (DON), one resident room was observed with two medication cups of two similar-looking white oblong tablets and observed in close proximity to Resident G. Resident G was observed seated in his recliner with his rollator located adjacent to the recliner. On the rollator, one pill cup containing two large, white oblong tablets were observed, with a second pill cup containing two large, white oblong tablets were observed on his overbed table. All four tablets appeared to resemble each other. Resident G indicated he had asked the nurse who provided the medication to him to leave the meds for him to take later. During the conversation, the resident was observed to pick up the pill cup on the rollator and take both pills. Resident G was unable to identify what the medications were or what they were to be taken for. The DON was immediately informed of the situation and was observed to immediately enter the room to speak with the resident and shortly thereafter, she indicated she had spoken with the nursing staff. In an observation, on 12/5/24 at 9:04 a.m., of Resident G's room, no medications were observed to be unattended in his room. In an interview with the DON, on 12/5/24 at 1:30 p.m., she indicated she had addressed Resident G's medication being unattended with the nurse involved. She shared the nurse indicated the resident had requested for the nurse to leave his medication for him to take shortly afterward and she honored his request. In an interview with the DON, on 12/9/24 at 11:00 a.m., she indicated when she was informed of the unattended medications, on 12/4/24, she only observed one pill cup with two similar-looking pills and did not realize Resident G had already consumed a different cup of pills in the presence of the state surveyor. She indicated in either situation, the nursing staff should not leave medication unattended for a resident to consume, unless the resident has been assessed to be able to do so safely. She indicated Resident G had not been assessed for consumption of medications independently. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	The DON was observed to view the nursing schedule for the date, of 12/4/24, and determined the two nurses who provided medication she assumed to be sevelamer 800 milligrams (mg), (a medication used for persons with chronic kidney disease to lower the phosphate levels in their blood) to determine the 12/4/24, 6:00 a.m., dose was provided by Licensed Practical Nurse (LPN) 3 and the 11:00 a.m. dose was provided by Registered Nurse (RN) 4. The clinical record review for Resident G was conducted on 12/9/24 at 9:45 a.m. His diagnoses included, but were not limited to, stage 5 chronic kidney disease, end-stage kidney disease, dependence on dialysis and Alzheimer's disease. His most recent Minimum Data Set assessment, dated 10/26/24, indicated he was moderately cognitively impaired and received dialysis treatment. Resident G's most current physician recapitulation orders, for December 2024, indicated he was ordered, on 8/3/24, to receive sevelamer carbonate 800 mg, two tablets orally, before meals. His associated medication administration record (MAR) for this same order, indicated the administration times were 6:00 a.m., 11:00 a. m. and 4:00 p.m. On 12/4/24, the MAR indicated this medication was administered, at 6:00 a.m., by LPN 3, and the 11:00 a.m. dose was administered by RN 4. A review of the nursing progress notes, for 12/4/24, did not reflect any notations by the nursing staff regarding any medication related information. On 12/9/24 at 3:13 p.m., the DON provided a copy of a document entitled, Medication And/Or Treatment Incident Report. This document indicated Resident G had received the 12/4/24, doses of the 6:00 a.m., and 11:00 a.m., of sevelamer 800 mg, two tablets, at the wrong time, as the medications had been left at resident [sic] bedside. Resident took one dose on own, RN watched resident 11am dose. It indicated the resident was not sent out to the hospital, but the resident was made aware of the incident, on 12/4/24 at 12:20 p.m., and the physician was notified of the incident on 12/9/24 at 3:00 p.m. The document was signed as completed, on 12/9/24 at 3:08 p.m., by the DON. On 12/9/24 at 1:32 p.m., the DON provided a copy of a facility policy entitled, Administering Medications. This policy had a revision date of December 2012. It indicated its policy statement was, Medications shall be administered in a safe and timely manner, and as prescribed. In an associated interview with the DON, on 12/9/24 at 2:35 p.m., she indicated her expectations related to medication administration included, but were not limited to, the staff member administering the medication to each resident would remain with the resident until the medication is taken in order to observe the resident consuming the medication. This citation relates to Complaints IN00443195 and IN00447316. 3.1-25(b)(1) 3.1-25(b)(3) 3.1-25(b)(9)