STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Grove	31869 Chicago Trail New Carlisle, IN 46552

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11492 Based on record review and interview, the facility failed to ensure medication and supplement orders were accurately transcribed and medications were administered timely to 2 of 3 residents reviewed for medication orders. (Resident C and J) Findings include: 1. The record for Resident C was reviewed on 10/21/2024 at 11:00 A.M. Diagnoses included but were not limited to, chronic obstructive pulmonary disease, diastolic congestive heart failure and left ventricular heart failure. A Physician's Order, dated 7/23/2024, indicated the resident's Lasix (a diuretic medication) was to be increased to 80 mg per day. The Medication Administration Records (MARs) for July 2024 and August 2024 indicated the order was documented on the administration record, but the resident only received the medication twice, on 7/27 and 8/3. On 8/13/2024 the Nurse Practitioner (NP) reordered 80 mg of Lasix medication per day. Another order, dated 9/18/2024, indicated to increase Occuvite (a vitamin supplement) to twice daily. The September 2024 MAR indicated the Occuvite was only being administered once daily from 9/19 - 9/30/2024 The order was correctly transcribed on the MAR, but the administration times were 9:00 A.M. and A.M. The A.M. box was grayed out on the boxes for the nurses to document their initials and only the 9:00 A. M. boxes were documented as administered. (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on 10/21/2024 at 4:30 P.M., she indicated the NP put her own orders into the electronic record system and if there was an order entry issue, then the order would not come up for the nurses to verify and to administer. The ADON indicated the Lasix order was not assigned a time for administration so it was not initiated timely and the resident did not receive her Lasix medication as ordered. She indicated, on 7/27/2024, a nurse noted an issue with the order and administered the proper dose of Lasix for that day, but did not fix the entry order issue in the system. In July 2024, there was no system in place to audit new physician orders to ensure they were transcribed accurately and timely. Since September, the IDT team was now reviewing new orders during the morning meetings. However, the ADON indicated she could not tell why the Occuvite order was not transcribed properly and was not administered twice daily as ordered. The ADON did not elaborate on the system implemented in September other than to say the IDT team reviewed the new physician orders in the morning meetings. 44111 2. A record review was completed for Resident J on 10/17/2024 at 1:35 P.M. Diagnoses included, but were not limited to, multiple sclerosis, spastic quadriplegic cerebral palsy and seizures. Resident J was admitted to the facility on [DATE]. A Medication Administration Record (MAR), dated 8/2024, indicated the following medications were not administered as ordered for the following dates and times: Trazodone 150 milligrams (mg) every night, 8/25/2024, 8/26/24, 8/27/24, 8/28/24 and 8/29/24. Levothyroxine 200 micrograms (mcg) every morning on 8/23/24, 8/24/24, 8/25/24. Levetiracetam 500 mg twice a day on 8/ 24/24, 8/25/24, 8/26/24. Melatonin 5 mg at bedtime on 8/24/24 and 8/25/24. Saccharomyces 250 mg every day on 8/23/24, 8/24/24, 8/25/24, 8/26/24. During an interview on 10/22/2024 at 9:20 A.M., the DON and ADON indicated Resident J had been admitted on [DATE] and a nursing progress note, dated 8/24/2024, indicated some medications were not available and the day shift was to contact the family to sign the pharmacy consent or use their own supply of medications. The ADON indicated the resident's mother was adamant the facility was to use the supply of medications the resident had brought with him first, then use the facility's pharmacy. Both the DON and ADON indicated if the facility did not have the medication ordered available to administer, the physician should have been notified. There were no nursing notes from 8/22/24 through 8/29/24 indicating the physician was notified of the missed medication doses and there was no explanation given as to why the resident missed so many routinely ordered medications from his admission through 8/29/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 9:49 A.M., the Pharmacist from the facility's pharmaceutical service provider indicated physician orders for Resident J were initially received on 8/22/2024, but were not filled and medications were not sent out because the pharmacy was informed the resident had his own supply of medications and nursing staff had directed the pharmacy not to send medications at that point in time. The Pharmacist indicated mediations were sent to the facility on the following dates on a 7 day supply roll: Levothyroxine 8/31/24, Levetiracetam 8/26/24, Florator 8/27/24, melatonin 8/26/24 and trazodone 8/29/24. On 10/22/2024 at 9:10 A.M., the ADON provided a policy titled, Medication Reconciliation, dated 4/13/2023, and indicated the policy was the one currently used by the facility. The policy indicated, Admission Processes: a. Verify resident identifiers on the information received. b. Compare orders to hospital records etc. Obtain clarification orders as needed. c. Transcribe orders in accordance with procedures for admission orders. d. Have a second nurse review transcribed order for accuracy and cosign the orders, indicating the review. e. Order medications from pharmacy in accordance with facility procedures for ordering medications. f. Verify medications received match the medication orders 3.1-25(a)