STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornton Terrace Health Campus	188 Thornton Rd Hanover, IN 47243

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. 35732 Based on record review and interview, the facility failed to ensure a resident received medications as ordered for 1 of 5 residents reviewed for pharmacy services. (Resident 34) Findings include: The record for Resident 34 was reviewed on 8/16/24 at 9:32 a.m. The resident's diagnoses included, but were not limited to, anxiety disorder and depression. The care plan, dated 7/4/24, indicated the resident had a diagnosis of anxiety and demonstrated anxiousness, restlessness, agitation, and aggressive behaviors. The interventions included, but were not limited to, encourage the resident to voice the cause for his anxiety and problem solve ways to resolve stressors, identify and avoid triggers whenever possible, provide consistency and routine, monitor for increased signs and symptoms and resolve the concerns when possible. The Quarterly MDS (Minimum Data Set) assessment, dated 6/24/24, indicated the resident was moderately cognitively intact. The resident had physical behavioral symptoms directed toward others. The nurse's notes, dated 6/5/24 at 12:02 a.m., indicated the CNA (Certified Nursing Aide) was changing the resident. The resident punched the CNA in her face, pulled her hair out of her head, and choked her. The resident had punched another CNA in her face the night before. The resident did not have a PRN (as needed) medication to give. The nurse's note, dated 6/5/24 at 10:36 a.m., indicated the physician was made aware of the resident's increased behavior and combativeness. A new order was received for Ativan 1 mg every 8 hours PRN. The NP (Nurse Practitioner) note, dated 6/13/24 at 9:32 a.m., indicated the resident had advanced dementia and had increased combativeness during personal care. On 6/5/24, the physician wrote an order for Ativan 1 mg every 8 hours PRN for agitation. The prescription was never sent to pharmacy. The staff requested a prescription today. The resident was taking Depakote 250 mg oral at bedtime. (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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(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	During an interview on 8/19/24 at 10:00 a.m., LPN (Licensed Practical Nurse) 4 indicated when the nursing staff took a physician's order they would put the order in the computer system. When the physician ordered a medication like Ativan, the physician was responsible to send the prescription to the pharmacy via the computer. If the order was not filled within a couple of hours, staff should do a follow up and call the pharmacy or the physician to see if the prescription was sent. He would not wait any longer than 2 hours. The current Guidelines for Medications Orders policy included, but was not limited to, . b. Telephone or verbal orders shall be recorded in Matrix when received by the nurse receiving the order. 3.1-25(b)(1)(c)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 34309 Based on observation and interview, the facility failed to ensure influenza vaccinations were monitored for expiration dates and disposal of the expired medication for 1 of 4 observations of medication storage. (Medication Room refrigerator) Findings include: During an observation on 8/16/24 at 1:01 p.m., of the 200 Hall medication storage room with RN 5, four boxes of Fluzone influenza vaccination, plus an open box with one vial of Fluzone influenza vaccination had an expiration date of June 2024. She indicated the influenza vaccinations were dated June 2024, and she would check to make sure the boxes and vial were expired. There were 10 vials of the influenza vaccine in each box for a total of 41 vials. During an interview on 8/16/24 at 2:10 p.m., the ED (Executive Director) indicated the influenza vaccinations were expired. She indicated they had not been administered since the influenza season ended. During an interview on 8/20/24 at 8:43 a.m., LPN (Licensed Practical Nurse) 4 indicated if an influenza vaccination was expired, it would go to the DON (Director of Nursing) for disposal. The influenza vaccination period would begin in September or October. During an interview on 8/20/24 at 9:47 a.m., LPN 3 indicated the ADON (Assistant Director of Nursing) would monitor the vaccinations for expiration dates. Influenza vaccinations began in September or October each year. During an interview on 8/20/24 at 9:57 a.m., the DON indicated the vaccination's expiration dates were monitored by herself, the ADON, and the evening shift supervisor. It was just an oversight that they missed the vaccinations were expired. The Medication Storage In The Facility policy, revised January 2018, included, but was not limited to, . G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner . 3.1-25(o)