STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF FORT WAYNE	7125 S HANNA STREET FORT WAYNE, IN 46816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00431040, IN00432264, IN00432187, and IN00434067. Complaint IN00431040 - No deficiencies related to the allegations are cited. Complaint IN00432264 - No deficiencies related to the allegations are cited. Complaint IN00432187 - No deficiencies related to the allegations are cited. Complaint IN00434067- No deficiencies related to the allegations are cited. Survey dates: May 6, 8, and 9, 2024. Facility number: 014316 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 13, 2024	R 0000	Please accept the following as the community's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Harrison	Executive Director	05/24/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on interview and record review the facility failed to ensure staff was certified to perform CPR (Cardiopulmonary Resuscitation) or First Aid on the night shift for 101 of 101 residents who resided in the facility. Findings included: A review of the facility's as worked staff schedule dated April and May indicated the night shifts were staffed with 1 to 2 QMA's (Qualified Medication Aide) and 1 CNA (Certified Nurse Aide). The Daily Assignment Schedule sheet indicated none of the night shifts' nursing staff were certified to perform CPR nor First Aid on the following dates: 4/29/2024, 4/30/2024, 5/1/2024, 5/2/2024, 5/3/2024, 5/4/2024 and 5/5/2024. During an interview on 5/8/2024 at 11:10 A.M., the Wellness Director indicated they did not have any staff working on the night shifts who were certified in CPR or First Aid.	R 0117	All residents have the potential to be affected. No negative outcomes have been identified. Staff training for CPR/First Aid will be arranged and provided by the community. Classes have been scheduled for 6/13/2024. There will be at least one staff member scheduled at all shifts who is CPR/First Aid certified. This will be noted on the staffing schedule. The BOM will keep record of all staff CPR/First Aid certifications. Records will be audited monthly ongoing to ensure renewals are completed timely. A QAPI action plan has been	06/09/2024

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	During an interview on 5/8/2024 at 1:44 P.M., the Executive Director indicated the facility did not have a policy for CPR and First Aid Certified Staff to be on duty 24/7 (all 24 hours of the day/every day of the week). She indicated they should follow the State's Regulations to have certified CPR and First Aid staff on duty 24/7.		initiated. This plan will be reviewed/revised as needed in the community's monthly QAPI meeting. Date of compliance 6/9/2024.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of			

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	each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on interview and record review the facility failed to ensure job specific orientation was completed for 4 of 10 employee records reviewed. (Housekeeper 5, CNA (Certified Nurse Aide) 6, CNA 7 and CNA 8) Findings include: A review of the personnel records on 5/5/2024 at 2:00 P.M., indicated 4 of the 10 reviewed employee records lacked the documentation the job specific orientation had been initiated or completed for the following staff: Housekeeper 5 had a start date on 2/6/2024, CNA 6 had a start date on 4/9/2024, CNA 7 had a start date on 12/26/2023, and CNA 8 had a start date on 3/19/2024. An interview with the Executive Director (ED) on 5/8/2024 at 8:55 A.M., indicated they did not have the job specific orientation for Housekeeper 5, CNA 6, CNA 7, or CNA 8. A current facility policy was provided by the ED on 5/8/2024 at 10:45 A.M., titled, Employee Orientation and Annual In-Service Training, with a Revision Date of 4/8/2019, indicated, "...It is the policy of Silver Birch Living that all employees receive general orientation at the time of hire and job specific orientation completed...It is the responsibility of the Executive Director to see that all employees have the orientation and annual training modules assigned ...It is the responsibility	R 0119	Housekeeper #5, CNA #6, CNA #7 and CNA #8 have all been provided with job-specific orientations. All staff employee files will be audited to ensure a job-specific orientation has been completed. This will be completed by 6/9/2024. The job specific orientation will be provided to the department managers upon hire of new employees. To ensure ongoing compliance the BOM will complete a monthly review of 10% of employee files(including new employees hired within the past month) A QAPI plan has been initiated. The QAPI plan will be reviewed and revised as needed in the community monthly QAPI meeting. Date of compliance 6/9/2024.	06/09/2024

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	of the department manager to maintain records of employee training ...."			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of			

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	active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review the facility failed to ensure a 2-Step Tuberculin skin test was completed prior to providing care at the facility for 1 of 10 staff reviewed for tuberculin testing. (Housekeeper 5) Findings include: A review of the facility's Employee Records on 5/5/2024 at 2:00 P.M., indicated documentation was lacking regarding TB Mantoux for Housekeeper 5. During an interview on 5/6/24 at 2:55 P.M., the Business Office Manager/Human Resource Director, indicated Housekeeper 5, had a TB 1st step, but it was not read when it was due. She indicated they restarted TB testing over, but no there was no documentation it was completed. On 5/8/2024 at 8:55 A.M., the ED (Executive Director) indicated on the list of missing personnel record documents, they did not have documentation TB testing was completed for Housekeeper 5. A review of the current facility's policy provided by the ED on 5/8/2024 at 10:45 A.M., titled, Tuberculosis Screening, dated, 4/16/2018, indicated, " ...All Silver Birch Living employees who work regularly at the community, must document they are free from tuberculosis ...The community Wellness Director is responsible for coordinating and conduction 2 step (Mantoux)	R 0121	Two step Tuberculin test was completed for Housekeeper #5. All employee files will be audited to ensure that 2 step TB test was completed upon hire and annual TB screen completed thereafter. The BOM will be responsible to audit the staff TB tests and annual screens on a monthly basis. The community will designate a month for all staff screens to be completed annually. A QAPI plan has been initiated. The QAPI plan will be reviewed and revised as needed in the community monthly QAPI meeting. Date of compliance 6/9/2024	06/09/2024

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	tuberculin tests for all employees ...Testing should occur with contingent offer of employment and prior to hands on care...After hire, testing will take place annually...A positive reading at time of hire or if employee has had previously documented positive reading, the employee will have a chest x-ray and medical evaluation ...."			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.			
	Based on observation and interview, the facility failed provide a clean and home-like environment for 3 of 4 floors and 1 of 4 apartments observed. Findings include: On 5/6/24 at 9:19 AM in an observation of the 200 floor hallway in between apartments 221 and 223, there was a large brown splatter on the wall. Along the hallway on the carpet, there was grey and brown debris of dirt and a paper like substance. There was a dark discoloration on the carpet, and scuff marks along the walls too mnumerous to count. At 9:21 AM in an observation in front of apartment 238, a large amount of small rocks/white substance as on the carpet. Along the hallway on the carpet there was visible debris and trash on the ground. Along the walls there were scuff marks. At 9:22 AM in an observation on the 200 floor, in the lounge, there was a water cooler. On the left hand side there were 4 large empty bottles on the floor along with several un-opened bottles of	R 0144	No residents were affected by the alleged deficient practice. On 5/10/24 all the environmental concerns identified during the survey were immediately addressed or work begun to resolve the concern. All residents that reside in the community have the potential to be affected by alleged deficiencies. No residents were identified as being adversely affected. The measures put into place and a systematic change made to ensure the deficient practice not reoccur: a ED will complete an in-service by 5/24/24 with maintenance and housekeeping staff regarding all issues cited by ISDH. In-service to include housekeeping cleaning schedule for common areas and resident apartments as well as floor care. b All hallways will be cleaned	06/09/2024

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	water. There visible pieces of trash on the floor surrounded the un-opened water bottles. At 9:25 AM in an observation on the 300 floor in front of Apartment 315, there was visible dirt on the floor. In between apartments 313 and 311 on the wall, there was a large slash inserted into the drywall with pieces of the drywall on the carpet. There was light reddish color stains, and dark discoloration on the carpet too numerous to measure or count. There were various colored splatters on the walls ending at room 301. At 9:28 AM in an observation starting at apartment 320 on the carpet there were visible debris, walls stained with a dark discoloration and scuffed marks too numerous to count. At 9:29 in an observation in front of apartment 330, there was visible dirt and dark discolorations too numerous to count on the carpet ending at room 338. At 9:32 AM in an observation on the 400 floor starting at apartment 430, there was a dark discoloration on side of wall. There was dirt and debris too numerous to count on the carpet, and scuff marks along the wall ending at room 420. At 9:35 AM in an observation of the 400 laundry room next to room 420 on the 4th floor. There were two trash bags laying on the floor in front of the trash can. There was dirt and visible debris on the floor too numerous to count. Behind the dryer there was visible dirty and rust colored particles on the ground. At 9:37 AM in an observation starting at room 419 there was discoloration along the carpet, dirt, and debris too numerous to count.		and painted by 6/9/2024. c Monthly carpet cleaning schedule will be implemented to ensure compliance for clean carpets. d Weekly touch up paint schedule implemented. To ensure the deficient practice does not reoccur the monitoring system established: a Environmental Services manager or designee will audit 15% of assigned housekeeping rooms cleaned per week for 3 months and then 10% for 3 months. b Department Heads will complete angel rounds for assigned apartments monthly and report on any concerns in apartments, common areas and/or hallways. c Audits will be discussed at monthly QA meetings. QA committee will determine if continued audit is necessary after 100% compliance threshold is achieved for three consecutive months. Completion date: 6/9/2024	

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On 5/6/24 at 10:19, in an interview, the Adminstrator indicated environmental services had a sheet/form they fill out and they were supposed to turn it into the Administrator. They had not been doing that, so there were no cleaning sheets to verify what was cleaned or was not cleaned.

On 5/8/24 at 9:30 AM in an interview during the observation of Room 438, the Regional Maintenance Director indicated the resident had been in the hospital, for about a week.

On 5/8/24 at 9:30 AM in an observation of Room 438, there was a sour, pungent odor. To the left, there was a clear opened trash bag of empty containers with other trash inside. There was a swarm of small flying insects, and several inches long brown-black bugs crawling inside the trash bag. Along the counter there were stacks on stacks of containers, with a several flying insects. There was trash, and clutter all over the apartment too numerous and wide spread to count.

On 5/8/24 at 9:35 AM in an interview, the administrator indicated the room looked like the trash and debris had been there a while. Those containers would have been obtaianed from the kitchen. Not sure when the staff cleaned the room last. Cleaning was a part of the rent so its not an add-on to provide cleaning servies. The staff should have been cleaning the room, the resident had been gone for about a week.

A current facility policy, Housekeeping date 5/10/18, was provided by the Administrator on 5/8/24 at 10:21 AM. The policy indicated..." to provide specific guidelines for the frequency and type of tasks that assure the highest standards of

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	sanitation for resident apartments...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review the facility failed to maintain sanitary conditions and food safety for 101 of 101 residents who ate food prepared in the facility kitchen. Findings include: An observation of kitchen, 5/6/24 at 8:43AM, noted the sink (staff indicated was for handwashing) did not have paper towels available. The white sink had drippings of a thick white substance and splashes of yellow substance. The trash can at the sink did not have a liner and had multiple food items discarded inside. The floor in the kitchen had 5 puddles on the floor. The puddles had small pieces of debris floating in them. Under all sinks, stoves, and shelving there were multiple colored drippings too numerous to count. Some appeared to be food, and some appeared to be packaging. Behind the rack of clean pans was a brown splash approximately 6 inches long by half an inch wide. The stoves had drip pans underneath. Three of the drip pans had one to one-and-a-half-inch	R 0273	No residents were affected by the alleged deficient practice. All residents that reside in the community are at risk with this alleged deficient practice. No residents were identified as being adversely affected. Supervised cleaning of kitchen, coolers, freezers, ovens and sinks completed to ensure sanitation. Items were verified to be labeled and dated properly. The measures put into place and a systematic change made to ensure the deficient practice not reoccur: a Cleaning schedules updated and will be reviewed weekly by ED or designee. b Food temps will be monitored daily by culinary manager or designee and weekly by ED or designee to ensure compliance. To ensure the deficient practice does not reoccur the monitoring system established: a Cleaning schedules and	06/09/2024

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	black burnt on debris sporadically throughout. The drip pan under the grill portion of the stove was not able to be taken out due to the amount of buildup. The four large trash cans on wheels were not covered. Cook 4 was able to provide 2 of the four lids and indicated they were using them. The lids were soiled with brown, yellowish, and black stuck on particles too numerous to count. The walk-in refrigerator had wilted lettuce on the floor as well as other smaller pieces of unidentifiable items under the shelving. There were 3 aluminum pans with foil coverings without any labeling. One pan had sausage patties. One pan had sausage links. The third pan had meatballs; but the foil was ripped in 2 places. Cook 3 was unable to identify when these items were prepared or placed in the refrigertaor. There were 2 trays with fruit and possibly oatmeal in bowls, uncovered, and no labels. Cook 3 was unable to identify when these items were prepared or placed in the refirgerator. Cook 3 took a green washcloth and rinsed it under the sink to wipe down the prep area. There was no labeled sanitizing solution used. In an interview on 5/6/24 at 9:06 AM, Cook 4 and Cook 3 indicated they were unaware of a cleaning schedule and if there was one it was possibly in the manager's office. There was no cleaning schedule visibly available. In an observation of kitchen, on 5/6/24 at 11:02AM, there was one puddle of water on the floor, still containing flakes of debris. The kitchen prep and stove area were slippery but not wet.		food temp logs will be reviewed weekly by ED or designee and documented on audit form. b Kitchen will be inspected weekly by ED or designee for cleanliness, dating and labeling and proper equipment uses. c Any areas of concern will be addressed at monthly QAPI meetings until 100% compliance noted for 3 consecutive months. Completion date: 6/9/2024	

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Two of the four large trash cans remained without lids. The handwashing sink did not have paper towels, the inside of the sink remained splattered with white and yellow substances, and the trash can next to the sink remain without a liner.

A Blank dietary cleaning schedule was provided by the ED (Executive Director) on 5/8/24 at 10:20AM. The schedules were broken down to specific duties for cook and dietary aids. There were daily, weekly, and monthly items listed. No dietary cleaning schedules with documentation were given by the time of exit.

A review of the food temperature logs on 5/6/24 at 11:15AM dated December 2023 through April 2024; indicated there were days and meals without any information documented as follows:
The month of December 2023, 70 of 93 meals did not have a record of food temperatures.
December 1 no temperatures were documented for dinner.
December 3 no temperatures were documented for dinner.
December 7 no temperatures were documented for breakfast, lunch, or dinner.
December 8 no temperatures were documented for breakfast or lunch.
December 9 no temperatures were documented for breakfast, lunch, or dinner.
December 11 no temperatures were documented for breakfast, lunch, or dinner.
December 12 no temperatures were documented for breakfast, lunch, or dinner.
December 13 no temperatures were documented for breakfast, lunch, or dinner.
December 14 no temperatures were documented for breakfast, lunch, or dinner.
December 15 no temperatures were documented for breakfast, lunch, or dinner.

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	December 16 no temperatures were documented for breakfast, lunch, or dinner. December 17 no temperatures were documented for breakfast, lunch, or dinner. December 18 no temperatures were documented for breakfast or lunch. December 19 no temperatures were documented for breakfast, lunch, dinner. December 20 no temperatures were documented for breakfast, lunch, or dinner. December 21 no temperatures were documented for breakfast, lunch, or dinner. December 22 no temperatures were documented for breakfast, lunch, or dinner. December 23 no temperatures were documented for breakfast, lunch, or dinner. December 24 no temperatures were documented for breakfast, lunch, or dinner. December 25 no temperatures were documented for breakfast, lunch, or dinner. December 26 no temperatures were documented for dinner. December 27 no temperatures were documented for breakfast, lunch, or dinner. December 28 no temperatures were documented for breakfast, lunch, or dinner. December 29 no temperatures were documented for breakfast, lunch, or dinner. December 30 no temperatures were documented for breakfast, lunch, or dinner. December 31 no temperatures were documented for breakfast, lunch, or dinner. The month of January 2024, 85 of 93 meals did not have a record of food temperatures. January 1 no temperatures were documented for dinner. January 2 no temperatures were documented for breakfast, lunch, or dinner. January 3 no temperatures were documented for dinner.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF FORT WAYNE	7125 S HANNA STREET FORT WAYNE, IN 46816

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	January 4 no temperatures were documented for dinner. January 5 no temperatures were documented for dinner. No other food temperature log sheet available for January 2024. The month of February 2024, 76 of 87 meals did not have record of food temperatures. February 2 no temperatures were documented for dinner. February 4 no temperatures were documented for breakfast, lunch, or dinner. February 5 no temperatures were documented for breakfast, lunch, or dinner. February 6 no temperatures were documented for breakfast, lunch, or dinner. February 7 no temperatures were documented for breakfast, lunch, or dinner. February 8 no temperature was documented for dinner. February 9 no temperatures were documented for breakfast, lunch, or dinner. February 10 no temperatures were documented for breakfast, lunch, or dinner. February 11 no temperatures were documented for breakfast, lunch, or dinner. February 12 no temperatures were documented for breakfast, lunch, or dinner. February 13 no temperatures were documented for breakfast, lunch, or dinner. February 14 no temperatures were documented for breakfast, lunch, or dinner. February 15 no temperatures were documented for breakfast, lunch, or dinner. February 16 no temperatures were documented for breakfast, lunch, or dinner. February 17 no temperatures were documented for breakfast, lunch, or dinner. February 18 no temperatures were documented for breakfast, lunch, or dinner.			

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	February 19 no temperatures were documented for breakfast, lunch, or dinner. February 20 no temperatures were documented for breakfast, lunch, or dinner. February 21 no temperatures were documented for breakfast, lunch, or dinner. February 22 no temperatures were documented for breakfast, lunch, or dinner. February 23 no temperatures were documented for breakfast, lunch, or dinner. February 24 no temperatures were documented for breakfast, lunch, or dinner. February 25 no temperatures were documented for breakfast, lunch, or dinner. February 26 no temperatures were documented for breakfast, lunch, or dinner. February 27 no temperatures were documented for breakfast, lunch, or dinner. February 28 no temperatures were documented for breakfast, lunch, or dinner. February 29 no temperatures were documented for breakfast, lunch, or dinner. The month of March 2024, 93 of 93 meals there were no temperatures recorded. The month of April 2024, 63 of 90 meals there were no temperature recorded. April 1 there were no temperatures documented for breakfast, lunch, or dinner. April 2 there were no temperatures documented for breakfast, lunch, or dinner. April 4 there were no temperatures documented for breakfast, lunch, or dinner. April 6 there were no temperatures documented for breakfast, lunch, or dinner. April 7 there were no temperatures documented for breakfast, lunch, or dinner. April 8 there were no temperatures documented for breakfast, lunch, or dinner. April 9 there were no temperatures documented for breakfast, lunch, or dinner.			

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	April 10 there were no temperatures documented for breakfast, lunch, or dinner. April 11 there were no temperatures documented for breakfast, lunch, or dinner. April 13 there were no temperatures documented for breakfast, lunch, or dinner. April 14there were no temperatures documented for breakfast, lunch, or dinner. April 15 there were no temperatures documented for breakfast, lunch, or dinner. April 16 there were no temperatures documented for breakfast, lunch, or dinner. April 17 there were no temperatures documented for breakfast, lunch, or dinner. April 18 there were no temperatures documented for breakfast, lunch, or dinner. April 19 there were no temperatures documented for dinner. April 20 there were no temperatures documented for breakfast, lunch, or dinner. April 21 there were no temperatures documented for breakfast or lunch. April 26 there were no temperatures documented for breakfast, lunch, or dinner. April 28 there were no temperatures documented for breakfast, lunch, or dinner. April 29 there were no temperatures documented for breakfast, lunch, or dinner. April 30 there were no temperatures documented for breakfast, lunch, or dinner. Menus for the above dates verified hot foods were served during the meals missing documented temperatures. No further food temperature logs were made available by time of exit conference. A policy titled "Dietary Cleaning" provided by ED (Executive Director) on 5/8/24 at 10:20AM last revision dated 6/15/18 indicated; 1. All equipment, food contact services, and utensils shall be			

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	cleaned.2. surfaces must be cleaned with a sanitizing solution or agent ...6. The floor of the kitchen must be cleaned daily and after each spill or contamination...8. Wall surfaces that become splattered during the food preparation process must be cleaned daily ...11. Documentation of cleaning must be maintained. A policy titled, "Food Temperatures" undated was provided by ED on 5/8/24 at 10:20AM, indicated ...3. Record reading on Food Temperature Chart at beginning of service line and end of service line ...10. Maintain food temperature records from survey to survey or in accordance to state regulations.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			
	Based on observation, interview, and record review, the facility failed to ensure complete and accurate records for 2 of 6 residents reviewed (Resident 3 and Resident 5). Findings include: 1) Resident 3's record was reviewed on 5/7/24 at 3:10PM. Resident 3's diagnoses included macular degeneration, bradycardia, and hypertension. Resident 3 had an active physician's order dated	R 0349	The order for resident #3 for monthly weights and vitals has been reviewed to present on the EMAR. Resident #5 medications have been removed from their apartment. All resident have the potential to be affected by the noted deficiencies. An audit was	06/09/2024

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	1/21/23 for a full set of vitals and weight every evening shift, every 4 weeks on Friday for monitoring. Resident 3's MAR (Medication Administration Record) had these documented as completed by licensed staff. There were no values for weight, blood pressure, temperature, pulse, respiration, and oxygen level. Resident 3's vital signs indicated the last weight was recorded 7/14/23. Resident 3's blood pressure readings were documented daily. Resident 3's last temperature value documented was dated 7//25/23. The last pulse documented for the resident was dated 2/21/24. The last documented respirations for Resient 3 were dated 7/14/23. In an interview on 5/8/24 at 3:20 PM, the Regional Director of Health Services indicated whoever entered the order did not complete it correctly. Therefore there were no boxes to document the values. The Regional Director of Health Services indicated a progress note should have been placed each month and was not. 2) In an observation and interview, on 5/8/24 at 9:38AM, Resident 5 indicated she had 2 inhalers on the counter. One inhaler was albuterol sulfate and was on number 0, with no doses remaining. The albuterol had no labeling to indicate directions for use or Resident 5's name. The other inhaler was Air Supra 90mcg. The inhaler was labeled with the resident's name and instructions for use. Resident 5 indicated she was not able to take medications on her own, she received her meds from the nurses. Resident 5 indicated the inhalers were given to her because they were needed and when she needs them; she needs them. Resident 5		completed on all residents to ensure that all had monthly vitals and weights to be recorded in the EMAR. An audit also completed on all residents who have their medications administered by the community. Apartments checked to ensure that no medications are being kept in rooms and being administered without proper physician orders and assessment. Staff education has been provided regarding medication policy. Resident apartments will be checked and medications reviewed with scheduled service plan reviews at least bi-annually. A QAPI plan has been initiated and will be reviewed at the community monthly QAPI meeting. Date of compliance 6/9/2024.	

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was unable to indicate when she last took the albuterol, or how often she was using the albuterol. Resident 5 was able to indicate the Air Supra was a new inhaler.

Resident 5's record was reviewed on 5/8/24 at 11:18AM. Resident 5's diagnoses included anxiety, disease of upper airway, and paraplegia.

Resident 5 did not have an order to self-administer medications. Resident 5 did not have an active order for albuterol or Air Supra inhalers.

Physician orders indicated Air Supra was ordered on 4/29/24 and discontinued 5/2/24; with directions for one puff as needed for shortness of breath. The Air Supra was then ordered 5/2/24 and discontinued 5/7/24; directions were 2 puffs every 4 hours as needed for shortness of breath.

The most current medication self-administration safety screen was completed 12/2/21.

On 5/8/24 at 10:20 AM in an interview, the Regional Director of Health Services indicated Resident 5 was not given self-administration of medication screens due to nursing was to administer all meds to Resident 5.

Resident 5's service plan indicated she did not know the name, reason, or time of medications.

A policy titled, "Weight Monitoring Policy" dated 2/14/20, indicated residents were to be weighed upon admission and at least semiannually.

No policy was provided for medication self-administration or clinical documentation at time of exit.