STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	07/27/2022

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ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00385451. This visit included a State Residential Licensure Survey. Complaint IN00385451 - Unsubstantiated due to lack of evidence. Survey dates: July 20, 21, 22, 25, 26 and 27, 2022. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Census Bed Type: SNF/NF: 66 Residential: 24 Total: 90 Census Payor Type: Medicare: 4 Medicaid: 48 Other: 14 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 9, 2022.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 46) had the right to a dignified existence	F 0550	**What corrective action(s) will be accomplished for those residents found to have been**	08/31/2022

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	when she was not fully dressed before participation in a group activity, repeatedly "scolded" by the activity assistant, and startled several times by the activity assistant during the activity for 1 of 2 residents reviewed for dignity. Findings include: During a random, continuous observation on 7/22/22 from 10:15 a.m., until 10:30 a.m., the following was observed: A group of residents began to gather, and/or were assisted to the Pine Hall activity lounge for a group activity. Resident 46 sat in front of the television (TV). She was in a reclined broad chair with an alarm attached to her shoulder that rang if she were to lean too far forward. She was wearing a blue button up shirt, grey non-skid socks, and there was a folded sheet draped across her lap. As the residents gathered for the activity the lounge became crowded and Resident 46, who had been calm and quiet, began to appear restless. She began to lean forward repeatedly, as if to pick items off the floor, and she also began to remove her socks. She pulled at the blanket across her lap and twisted the bottom of her shirt. The Activity Assistant finished gathering supplies and began the group activity. The goal of the game was to bat an inflated balloon back and forth to each other with pool noodles. As the activity began, Resident 46 was not given a pool noodle for participation. She continued to appear restless as she began pushing the blanket off her legs. At that time, it became evident Resident 46 was not wearing pants, so that when she removed the sheet form her lap, her thighs and incontinent brief were visible. Her brief was unfastened.		**affected by the deficient practice:** Resident 46 was assessed without any findings. She was placed on psychosocial follow up without any noted for 72 hours. Activity assistant was suspended on 7/22/22 during survey when surveyor notified ED of what she had observed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected Investigation was completed during survey interviewing other residents and staff on 7/22/22. No additional concerns were noted **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be educated on Resident Rights and Abuse Prevention by DNS/designee by 8/31/22. Activity Director/designee will observe residents prior to group activities to ensure residents are appropriately clothed for group activities. If a concern is identified correction will be completed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	An unidentified Resident in the activity indicated, "there she goes!" which alerted the Activity Assistant. The Activity Assistant readjusted the blanket over Resident 46's lap and indicated, "don't do that, stay covered." The activity continued until the balloon popped. This startled Resident 46 as she gave a start. She continued to remove the blanket form her lap, and then started to try and pull her shirt off. At that time, it became evident, Resident 46 was not wearing a bra, or undershirt, so that as she pulled her shirt up, her bare breasts were exposed. Several other residents in the activity, laughed, and pointed which alerted the Activity Assistant to Resident 46. The Activity Assistant pulled Resident 46's shirt back down and tucked the blanket back over her lap and indicated, "no, this is private! Stay covered." The Activity Assistant, and other surrounding staff did not offer any additional interventions to keep Resident 46 covered. As the activity continued, Resident 46 was unable to participate. She repeatedly continued to lean forward and fidget with her clothes. She removed one of her socks, which dropped to the floor. The Activity Assistant picked the sock up and tossed it onto Resident 46's lap. Resident 46 continued to remove the blanket from her lap. At one point, the balloon fell behind Resident 46's chair. When the Activity Assistant turned to retrieve the balloon, she saw that Resident 46 had removed the blanket from her lap again. The Activity Assistant approached Resident 46, she raised the pool noodle she had been using, and brought it down on Resident 46's bare thigh, so that it made a "pop" sound. This appeared to startle Resident 46 as she gave a start and looked up at the Activity Assistant with wide eyes. The Activity Assistant put the balloon back in play. She squatted down		**recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the Dignity and Privacy QAPI tool weekly for 4 weeks and monthly for at least 6 months. Findings will be submitted to the QAPI Committee for review and follow up. If 100% compliance is not achieved an action plan will be developed.	

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	in front of Resident 46, covered her thighs with the blanket and briskly tucked the blanket behind her back and under her legs. Then the Activity Assistant pressed both her hands on top of Resident 46's thighs and shook her legs back and forth as she indicated, "No, no, no! You can't do this!" The activity continued. Resident 46 continued to attempt to undress. The Activity Assistant put on music, which Resident 46 softly sang along to until the second balloon popped. This again, startled Resident 46, as well as several other residents, and staff that had gathered to watch. This time, Resident 46 covered her face with her shirt and began to cry. Certified Nursing Assistant (CNA) 23 and another unidentified CNA sympathetically, indicated, "awwwwww that scared her." The Activity Assistant asked if Resident 46 wanted to go lay down, but the CNAs indicated they had just gotten her up and did not want to put her back to bed. A second unidentified CNA helped assist Resident 46 out of the group activity, into the quiet dining room to sit with her one on one. During an interview on 7/22/22 at 10:30 a.m., Physical Therapist (PT) 24 indicated it appeared that Resident 46 was unable to participate in the activity. She kept trying to remove her clothing and the Activity Assistant was having a hard time keeping her engaged. During an interview on 7/22/22 at 10:32 a.m., CNA 23 indicated Resident 46 had just been assisted up and brought to activities for supervision because she fell a lot. She did not know why the resident did not have pants on, but it looked like she did not like to have the blanket on since she kept			

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	removing it. During an interview on 7/22/22 at 10:45 a.m., with the Administrator and Activity Director (AD) present, the AD indicated it had been an unusually crowded activity, which was probably overwhelming for Resident 46. The AD indicated there was a bit a language and cultural barrier between the residents and the Activity Assistant probably intended the interaction between her and Resident 46 to be playful. The Administrator indicated Resident 46 should have been fully dressed before participating in an activity especially since Resident 46 had known behaviors of attempting to undress. The Administrator indicated the Activity Assistant should not have used the pool noodle to make contact with Resident 46 because she did not have the capacity to understand what was intended to be a joke. On 7/25/22 at 11:25 a.m., Resident 46's medical record was reviewed. She had recently admitted to Hospice with diagnoses which included, but were not limited to cancer, restlessness/agitation, anxiety, and repeated falls. The most recent comprehensive assessment was a significant change Minimum Data Set (MDS) assessment dated 7/14/22. The MDS indicated Resident 46 was severely cognitively impaired, and rarely able to understand others or make herself understood. She had a recent change in mental status which resulted in continuous behaviors of inattention and disorganized thinking. However, the MDS indicated the resident had been interviewed for her daily routine and preferences. A comprehensive care plan, initiated 6/24/22,			

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	indicated Resident 46 undressed herself throughout the day and may attempt to come out her room naked. The intervention for this plan of care was to encourage her to keep her clothes on and when she attempted to remove them, offer her a gown. If she attempted to remove the gown, attempt other interventions to keep her comfortable while also maintaining her privacy and preventing her from exposing her body to others when not in her room. A comprehensive care plan, initiated 6/14/22, indicated Resident 46 was at risk for signs and symptoms of anxiety, restlessness, and agitation. Interventions for this plan of care included but were not limited to maintaining a calm environment or move to quiet areas as needed. A comprehensive care plan, initiated 6/11/22, indicated Resident 46 required assistance with Activities of Daily Living (ADLs). Interventions for this plan of care included, but were not limited to assist her with dressing, grooming, and hygiene as needed. On 7/22/22 at 1:20 p.m., the Administrator provided a copy of current facility policy titled, "Activities," revised 1/2006. The policy indicated, "It is the policy of this facility to provide for an ongoing program of activities designed to mee to the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment ...." On 7/22/22 at 1:20 p.m., the Administrator provided a copy of current, but undated facility policy titled, "Resident Rights." The policy indicated, " ... you have the right to a dignified existence ... you have a right to be treated with			

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	respect and dignity...." 3.1-3(a)			
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, record review, and interviews, the facility failed to ensure a resident's dignity for a homelike environment was maintained when he was placed in isolation for 7 days despite being up to date on the COVID-19 vaccinations for 1 of 5 residents reviewed for transmission based precautions (Resident 262). Findings include: On 7/20/22 at 7:42 a.m., Resident 262 was observed with the door to his room shut. Signs were posted for droplet isolation on the outside of his door. A container was hanging from the door with personal protective equipment (PPE) inside. Upon entering the room, Resident 262 was observed sitting on the side of bed. His brief was hanging on his right leg and touching the floor. He was asking for his urinal that was out of his reach. Resident 262 pressed his call light Certified Nursing Assistant (CNA) 5 entered the room without Personal Protective Equipment (PPE) to answer his call light. CNA 5 indicated that she thought Resident 262 may have fallen. CNA 5 left to put on PPE and returned to assist Resident 262.	F 0557	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident 262 no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · Audit was completed for all admissions for last 10 days to ensure that vaccination status was obtained and appropriate isolation measures were implemented based on resident's COVID status. · Inservice IDT on checking resident vaccination status when completing admission review. **What measures will be put into place or what systemic**	08/31/2022

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	During an interview at that time, Resident 262 indicated that he had received the COVID-19 vaccinations to include a second booster. On 7/20/22 at 3:00 p.m., a chart review was conducted. Resident 262 had the following diagnoses, but not limited to secondary malignant neoplasms of genital organs, weakness, depression, hyperlipidemia, hypertension, muscle weakness, and history of falls. Resident 262's preventative medication section of the electronic medication record (EMR) lacked documentation of Resident 262 having received any COVID vaccinations. Resident 262 had orders, dated 7/13/22 (date of admission), "resident to be in contact/droplet isolation for 10 days or until criteria has been met for removal r/t [related to] new admission." A care plan, dated 7/14/22, with a problem of "resident is restricted to their room, in droplet + isolation for 10 days related to potential exposure to COVID 19 prior to admission/readmission." Interventions included to address psychosocial needs as needed and droplet + precautions for at least 10 days with all services provided in the room. On 7/21/22 at 1:41 p.m., an interview was conducted with the Infection Preventionist (IP) and Director of Nursing (DON) regarding Resident 262 in isolation. The IP indicated she would figure out what was going on with Resident 262's vaccination status. The DON indicated sometimes residents admitted and they did not have their COVID vaccination status, therefore, they were placed in transmission-based precautions like		**changes will be made to ensure that the deficient practice does not recur:** · Inservice all nurses on Covid 19 Admission Policy to be completed by DNS/Designee. · Skills validation on Donning and Doffing PPE to be completed on all staff by DNS/Designee. · Completed audit of all residents currently residing in house and re offered Covid Vaccine/Booster as eligible. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Resident Immunization Qapi will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	they do for other residents who admitted and were unvaccinated. On 7/21/22 at 2:49 p.m., interview with the IP and the DNS revealed that Resident 262 was up to date with his COVID-19 vaccinations to include a second booster. The Infection Prevention (IP) section of his electronic medical record was updated, orders for contact/droplet isolation were discontinued and Resident 262 was taken out of isolation. IP indicated that she had access to obtain resident's vaccination status. On 7/21/22 at 2:24 p.m., the Executive Director (ED) provided a policy titled, "COVID-19 Admission Policy (formerly ASC COVID-19 Admission Criteria), dated 4/3/20 with a revision date of 3/14/22. The policy indicated, "...residents that are up to date and residents within 90 days of a SARS-CoV-2 infection do not need to be placed in quarantine ...." 3.1-9(a)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that			

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	the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observations, interview, and record review, the facility failed to maintain a clean, comfortable, homelike environment in resident rooms, common showers rooms, and hallways. This deficient practice had the potential to effect 66 of 66 residents residing in the facility. Findings include: On 7/20/22 the following was observed: a. At 6:32 a.m., a live ant was observed on the floor with food debris near the nurses' station	F 0584	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** There were no residents effected. Resident 6's room and rooms, 153, 146, 208, 106, 144, 136, 116, 107, shower rooms, hallways have been cleaned. Outside plumbing services has been contacted for sewage odor. Maintenance has	08/31/2022

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	across from room 138. b. At 7:58 a.m., an active spider web was observed in the Sycamore dining room window and dead insects were observed in the window frame. c. At 8:56 a.m., Resident 6's room was observed. The room smelled like feces and there was a pile of fecal matter observed on the floor underneath Resident 6's bed. d. At 9:52 a.m., a Housekeeping Assistant was observed as she cleaned Resident 6's room. With gloved hands, she used a plastic bag to pick up the feces, then continued to clean and disinfect the floor. f. At 10:45 a.m., a large fly was observed on the door frame of room 153. g. At 10:47 am., a dead brown beetle was observed on the floor outside of room 146. h. At 10:50 a.m., a dead, squashed grasshopper was observed in the middle of the hallway outside of room 208. On 7/21/22 at 3:38 p.m., a dead, squashed spider was observed on the floor outside of room 106. On 7/22/22 the following was observed: a. At 9:30 a.m., a dead beetle was observed on the floor outside of room 144. b. At 9:31 a.m., an active spider web was observed with a live spider hanging from the potted plant decoration outside of room 136 and there was a dead spider, and dead beetle on the floor beneath the web. c. At 9:40 a.m., a dead beetle was observed on the floor outside of 116 and dead flying insect was observed stuck to handrail outside of 116. d. At 10:35 a.m., a large, alive house centipede was observed on the floor of the hallway outside of room 107. e. At 11:08 a.m., a dead spider was observed on the baseboard outside of the Sycamore shower		contacted outside contractor on replacing the missing tiles. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected All resident rooms have been inspected and cleaned to ensure the rooms are clean and pest free. All spas have been inspected and cleaned to ensure spas are clean and pest free All hallways have been inspected and cleaned to ensure halls are clean and pest free Ecolab has been notified and will complete a visit by 8/26/22. Daily housekeeping schedules have been implemented. Deep cleaning schedules have been implemented. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Housekeeping supervisor and staff have been educated on daily cleaning schedule and deep cleaning schedule of the facility by the Executive Director. Nursing staff will be in-serviced on cleaning up body fluids and then notifying housekeeping and not storing in extra supplies by	

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	room, and there were 2 dead beetles on the floor outside of the courtyard exit. On 7/22/22 at 10:00 a.m., the Resident Council Minutes were reviewed. a. In July of 2021, the Resident Council complained of, "slippery, moldy shower rooms." There was no resident council response. b. In September of 2021, the Resident Council complained that there had not been resolution to the slippery/moldy showers, and now there were bugs. The Housekeeping department submitted a response to the Resident Council that indicated, "Housekeeping is cleaning showers daily and I will get with maintenance and nursing to see what can be done." c. In June of 2022, the Resident Council noted general housekeeping and cleaning concerns. The Housekeeping response was submitted and indicated, " ...we are trying to accommodate everyone on the cleaning and personals, we are very short staffed but will try and get things better soon ...." On 7/22/22 at 11:05 a.m., the shared shower/spa rooms were observed with the Infection Preventionist Nurse (IP). The Pine Hall Spa room was observed first. When the door was opened a pungent sewer smell overwhelmed the senses. When the IP nurse entered the shower room, she agreed the odor smelled like sewage and indicated, "wow, that smells awful." She did not know where the smell was coming from. Additionally, the toilet was observed with brown water. There was a folding chair attached the wall in front of a large mirror. The chair was folded up so that the bottom was observed with unidentifiable red/brown, stains. There was a large tub in the center of the shower room, but it was piled high with random and various resident care		DNS/designee. ED/designee will conduct rounds daily to ensure rooms, halls and spas are clean comfortable and homelike environment. Any concerns identified will be corrected immediately by contacting resources as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Environmental Safety-non cottage QAPI tool will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	155620	A. BUILDING 00 B. WING	07/27/2022

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	items and equipment. The IP nurse indicated there were some residents who used this shower room, but only the standing show as the tub was obviously unusable. On 7/22/22 at 11:17 a.m., the Sycamore Spa room was observed. Upon entrance into the shower room, there were 3 mechanical lifts stored at the counter where there was a salon chair and hair washing sink. There was a random detached closet door that rested against the wall beside the supply closet, and on the floor behind the door there was a pile of debris which included several dead insects. There were several areas on the floor/baseboard are of the shower room where the tile had been cracked, broken, and crumbled. The ceiling exhaust vent above the shower was coated with copious built-up debris. During an interview on 7/22/22 at 11:20 a.m., Certified Nursing Assistant (CNA) 23 indicated, the shower rooms definitely needed to be cleaned. At that time there were only two working shower rooms, and most residents preferred to use the one on Sycamore, since the shower room on Pine smelled so bad. On 7/22/22 at 11:45 a.m. an environmental tour was conducted with the Housekeeping Supervisor (HKS). The above observations were reviewed and observed with the HKS. She indicated she was both the housekeeping and laundry supervisor. She indicated the departments were short staffed, and only had one housekeeper, and a couple laundry aids. The issue was not about pest control because they had someone who came out regularly to spray for insects, but the problem was there was not enough staff to regularly sweep and mop the floor to get rid of the dead bugs. The HKS indicated the facility really needed a floor			

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	tech, because she did not have enough time to get to it as often as needed. When asked about the feces that had been observed on Resident 6's floor, the HKS indicated nursing staff are supposed to remove bodily waste and then alert Housekeeping to come and disinfect the area, but no one had told them. The HK Assistant 26 had just found it, so there was no telling how long it had been there. During an interview on 7/22/22 at 1:42 p.m., the Administrator indicated, the facility had some plumbing issues that had recently been address on the 100 hall, but he was not sure why or how long the Pine Shower room had smelled so bad. Additionally, he indicated shower rooms should not be used for storage, of mechanical lifts or other random supplies. During an interview on 7/25/22 at 1:03 p.m., the Regional Director of Clinical Services indicated it was the facilities expectations that CNAs should clean up excrement if a resident had an accident. Then they should alert housekeeping staff to come and clean/disinfect as needed. On 7/22/22 at 1:20 p.m., the ADM provided a copy of current facility policy titled, "Maintenance," dated, 811/2015. The policy indicated, " ...The community premises shall be well kept and in good repair ... the interior of the building including walls, ceilings, floors, windows, window covering, doors, plumbing, and electrical fixtures shall be in good repair...." On 7/22/22 at 1:20 p.m., the ADM provided a copy of current facility policy and procedure titled, "Deep Cleaning Practice," dated, 8/2017. The policy indicated, " ...Deep cleaning of resident rooms and common areas shall be scheduled by			

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	and maintained by the housekeeping supervisor and/or Environmental Service Supervisor ...." The procedure indicated, " ... clean corners, edging, and baseboards/cover base ... spot clean walls and door ... follow the restroom cleaning procedure ... sweep flooring including corners, edges, under beds and under furniture ...." On 7/22/22 at 1:20 p.m., the ADM provided a copy of current, but undated facility policy titled, "Resident Rights." The policy indicated, " ...you have a right to a safe, clean, comfortable and homelike environment ...." 3.1-19(f)(5)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.			

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	§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on record review and interview, the facility failed to ensure a baseline care plan that was initiated was completed for 1 of 5 residents reviewed for new admission baseline care plans (Resident 164). Findings include: A comprehensive record review was completed on 7/26/22 at 12:00 p.m. for Resident 164. Resident 164 was admitted to the facility on 7/7/22 at 1:15 p.m. He had diagnoses of the following, but not limited to cancer, left femur fracture, diabetes mellitus, myalgia (muscle aches and pain), pain, neuromuscular dysfunction of the bladder (the nerves that back and forth from the brain to the bladder do not work properly) requiring a	F 0655	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 164 no longer resides at the facility and his goals were met for a successful discharge. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. Admissions for the last 14 days	08/31/2022

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	supra-pubic catheter (a catheter that is inserted in a surgical hole made in the abdomen and inserted into the bladder), and history of urinary tract infections and ileus (a temporary lack of normal muscle contractions of the intestines). An admission observation, completed on 7/7/22 at 3:02 p.m., indicated that Resident 164 had three surgical incisions, located on his left hip, upper left quadrant of abdomen, and left lower quadrant. Resident 164 had a fall prior to admission requiring surgical intervention of his left femur. He had a fall on 7/8/22. The intervention was to remind resident to use his call light for assistance. An interview with the Therapy Supervisor on 7/26/22 at 1:14 p.m., indicated Resident 164 was a little lethargic upon admission and mostly dependent with his Activities of Daily Living (ADLs). A baseline care plan lacked identification of resident's goals and interventions relative to his health and safety needs, including his need for wound care intervention and fall intervention. During an interview, on 7/27/22 at 12:36 p.m., regarding Resident 164's baseline care plan, the Minimum Data Set (MDS) Nurse indicated that she opened Resident 164's baseline care plan but was off work until after Resident 164 discharged on 7/14/22. The MDS Nurse indicated she usually completed the care plans for new admissions and that anybody could complete the baseline care plan. During an interview, on 7/7/22 at 1:00 p.m., regarding the baseline care plan of Resident 164, the Social Services Director (SSD) indicated		have been reviewed by the RAI Specialist to ensure baseline care plans were resident specific on 8/22/22. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** RAI Specialist completed in-servicing with IDT on baseline care plans on 8/9/22. Social Service Director/IDT will be in-serviced by RAI Specialist on reviewing the baseline care plan with the resident and family during the Road to Recovery meeting by 8/31/22. MDS Coordinator/designee will review baseline care plans during clinical meeting to ensure baseline care plans are initiated with individualized goals and interventions. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Baseline Careplan QAPI tool will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure	

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	Resident 164's baseline care plan was not reviewed with the resident or family representative(s), and they were not provided a copy. During an interview, on 7/27/22 at 1:56 p.m., the MDS Nurse provided a copy of the Resident 164's comprehensive care plan. The MDS Nurse stated that after Resident 164 admitted, she was off work until after he was discharged. When she returned, she completed his care plan. A policy and procedure provided by the Regional Clinical Nurse Specialist (RCNS) titled, "IDT Baseline Care Plan," dated 10/2017 with a revision date of 4/2018, indicated, " ...It is the policy of this facility that each resident will have an interdisciplinary baseline care plan developed with 48 hours of admission ...resident and/or resident's representative will participate in the development of the resident-centered baseline care plan to the extent possible...A summary of the baseline care plan will be provided to and reviewed with the resident and/or representative during the Road to Recovery, or other scheduled IDT meeting following admission to the facility...." 3.1-35(a)		compliance.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure residents (Resident 6 and 13) received ADL (Activities of Daily Living) oral care for 2 of 2 residents	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/31/2022

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	reviewed for dental care. Findings include: 1. On 7/20/22 at 10:38 a.m., Resident 6 was observed in her wheelchair as she independently ambulated up the hallway outside of her room. At this time, Resident 6 stopped to talk. Her teeth were observed to be thickly coated with debris. A copious amount of an unidentified white substance was observed. She was missing several teeth, and the remainder of her teeth were grey in color, coated with built up residue. When asked if she was perhaps chewing a piece of gum, she shook her head "no" and used her tongue to rub around her moth, as she did, bits of the substance dissolved and broke off. Her tongue was also noted to be thickly coated with the white substance. At this time, she rolled into her room and gave permission to look for a toothbrush. At this time there was no toothbrush, toothpaste, or other oral care items observed in her bathroom, in her bedside dresser or other drawers. Resident 6 shrugged her shoulder and indicated, "I don't know." On 7/21/22 at 1:33 p.m., Resident 6 was observed laying in her bed with her eyes closed. Certified Nursing Aide (CNA) 25 was in the room and indicated she had given Resident 6 a shower earlier but had not completed oral care since that was the regularly scheduled CNA's responsibility. She was merely helping complete showers. On 7/21/22 at 1:41 p.m., Registered Nurse (RN) 14 entered the room. Resident 6 easily aroused as he called her name and answered yes/no question. When asked about the status of Resident 6's mouth, her teeth in particular, RN 14 indicated it appeared that she needed to have her teeth		**practice:** · Resident #6 and #13 have been provided oral care and added to the dental list. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · Audit was completed for all residents to ensure oral care supplies at bedside. · Inservice IDT on auditing customer care rooms daily for oral care supplies. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Inservice all nursing staff on Oral Care to be completed by DNS/Designee. · Skills validation on Oral Care to be completed on all nursing staff by DNS/Designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Dental Services Qapi will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement	

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	brushed as there was a lot of unidentified build up and there was a foul odor from her mouth. He would let the CNA know as it was the CNA's responsibility to complete and chart on resident daily care. On 7/25/22 at 10:25 a.m., Resident 6's bathroom was observed to have a brand-new tube of toothpaste. There was a toothbrush on her bedside table that appeared new, as the bristles were clean and straight, and the head of the brush had no residue. On 7/25/22 at 10:24 a.m., Resident 6's medical record was reviewed. She had active diagnoses which included but were not limited to dementia without behavioral disturbances. The most recent comprehensive assessment was an annual Minimum Data Set (MDS) assessment dated 4/15/22. The MDS indicated Resident 6 was severely cognitively impaired, and had no recent behaviors coded in the 7-day look back period (to include any refusal of care and treatment). She required extensive assistance with personal hygiene from at least one staff member. The dental status was coded as "none of the above were present" (which included, but was not limited to, D. obvious or likely cavity, or broken natural teeth). Resident 6's POC (point of Care) report indicated A.M. cares had been checked off as completed, and not refused on 7/20/22 and 7/21/22. A comprehensive care plan, initiated 1/7/21 and revised 7/20/22, indicated Resident 6 required assistance with ADLs which included, but was not limited to bed mobility, eating, transfers and toileting, and that she will at times refused oral		Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	care. Interventions for this plan of care included but was not limited to assist with oral care at least two times daily but did not specify any interventions for her refusal of oral care. A comprehensive care plan, initiated 1/7/21, indicated Resident 6 was at risk for impaired dental hygiene, pain or discomfort because she had missing teeth and the remainder of her teeth were in poor to fair conditions. Interventions for this plan of care included but were not limited to assist with oral care. The record lacked documentation of Resident 6 refusing oral care. On 7/25/22 at 11:55 a.m., the Director of Nursing (DON) provided a copy of a facility procedure titled, "A.M. Care," dated 2/2010 and revised 2/2012. At this time the DON indicated, A.M. Cares were usually completed by CNAs, but could be completed by any certified nursing staff which included ADLs like oral care. If tasks could not be completed it should be charted and a reason given why. The procedure was reviewed and indicated, " ... 7. Assist resident with oral hygiene, including denture care if applicable...." 2. On 7/25/22 at 10:04 a.m., during an interview, Resident 13 indicated staff did not brush her teeth and that she had a bad taste in her mouth frequently. If staff would set up her oral hygiene items for her, she would do it herself. Resident 13 was observed to have broken teeth in the top front of her mouth. On 7/25/22 at 10:09 a.m., Certified Nursing Aide (CNA) 8 was asked to locate oral hygiene items (toothbrush, toothpaste, mouthwash) in Resident 13's room. CNA 8 looked in Resident 13's room including drawers and could not locate any oral hygiene items to complete oral care for Resident			

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	13. CNA 8 indicated that she was agency and was not assigned to care for Resident 13. CNA 8 indicated that residents received oral care with morning care and evening care. On 7/25/22 at 10:39 a.m., during an interview, Registered Nurse (RN) 9 indicated they were unaware of Resident 13's needs with oral care. During an interview, on 07/25/22 at 11:31 a.m., CNA 5 indicated oral care should have been given two times per day and that she gave oral care daily when she was at the facility. On 7/25/22 at 1:44 p.m., a comprehensive record review was completed for Resident 13. Resident 13 had diagnoses of, but not limited to cerebral palsy, repeated falls, chronic obstructive pulmonary disease (COPD), rheumatoid arthritis, contracture of muscles, shortness of breath, restless leg syndrome, congestive heart failure, muscle weakness and poor posture. Resident 13's care plans included a problem, " ...resident has possible caries, broken off or missing teeth; at risk for poor oral hygiene, nutritional intake, pain, and discomfort," dated 11/10/19. Interventions to address the problem indicated, "assist resident with oral care." Another care plan dated 11/10/19 include a problem, " ...requires assistance and/or monitoring AM/PM care, nutrition, hydration and elimination" with a goal of "resident will have ADL (activities of daily living) needs met," along with an intervention, " ...tasks: AM care including bathing, dressing, hair combing and oral care," and "tasks : PM care including bathing, dressing, hair combing, and oral care ...." On 7/25/22 at 11:55 a.m., the Director of Nursing			

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	(DON) provided a copy of a facility procedure titled, "A.M. Care," dated 2/2010 and revised 2/2012. At this time the DON indicated, A.M. Cares were usually completed by CNAs, but could be completed by any certified nursing staff which included ADLs like oral care. If tasks could not be completed it should be charted and a reason given why. The procedure was reviewed and indicated, " ... 7. Assist resident with oral hygiene, including denture care if applicable...." 3.1-38(a)(3)(C)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident needing consistent one on one staffing due to behavioral concerns who had an unwitnessed fall had physical and neurological assessments and notification of the physician, Director of Nursing (DON), and family post fall for 1 of 1 resident reviewed for nursing monitoring (Resident 53). Findings include: On 7/21/22 at 2:11 p.m., Resident 53's record was reviewed. A Nursing Progress Note, dated 2/15/22 at 12:19	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Neurological assessment has been completed, MD and family aware of all falls. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · Audit was completed for falls in the last 2 weeks to ensure	08/31/2022

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(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
	p.m., indicated Resident 53 had been spitting everywhere as he was pacing throughout the hall with increased restlessness and agitation. He did respond for short periods of time with re-direction but interventions were not effective for long. The resident's mother had been notified and she was going to try and make it to the facility to sit with the resident. A Nursing Progress Note, dated 2/15/2022 at 3:23 p.m., indicated Resident 53's mother was at the facility helping with 1:1 observations of her son. She was informed that the psychiatric hospital had accepted him for an inpatient psychiatric evaluation and treatment. A Nursing Progress Note, dated 2/15/2022 at 4:45 p.m., indicated Resident 53's father called and gave verbal consent for the resident to be admitted for an inpatient psychiatric stay. He also faxed over the Power of Attorney (POA) paperwork and copy was placed in chart. On 2/15/22 at 6:36 p.m., an Inter-Disciplinary Team (IDT) behavior review note indicated Resident 53 was constantly pacing and wandering hallways with little rest. He exhibited intrusive wandering into others resident rooms. He was trying to open up all doors to get out. He was spitting on the floors and furniture and flailing his arms at staff. The immediate intervention was to put him on 1:1 (one on one) with staffing. He had dementia and was unable to express his wants or needs. Resident had limited cognition and unable to acknowledge surroundings. Resident had been easily redirected with interventions until recently when interventions were not effective. On 2/18/22 at 11:41 a.m., the following progress note was recorded as a late entry: On 2/15/22 at		neurological assessment was completed and MD and family notification present. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Inservice all nurses on Fall Management Program to be completed by DNS/Designee. · Inservice all staff on One on One supervision to be completed by DNS/Designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Fall Management Qapi will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	7:58 p.m., Resident 53 was observed quickly ambulating through hallways despite repeated attempts at education regarding improved safety awareness and judgement by nursing staff. Resident 53 experienced an unwitnessed fall at approximately 7:50 p.m., in the Pine hallway. A staff nurse witnessed the resident on his right side and he was beginning to recover from the unwitnessed fall without assistance. As nurse arrived, the resident began quickly ambulating again and would not cease movement for vital sign evaluation. Resident was non-verbal and not replying to assessment questions despite repeated attempts to ensure absence of pain. His cognitive impairment was noted in his chart. Resident 53 resumed irregular, unbalanced ambulation throughout the hallways despite attempts at redirection. After the Resident 53's unwitnessed fall on 2/15/22 at 7:58 p.m., the resident's record lacked documentation of the following: progress note, assessment or vital signs, neuro checks, and indication that family, facility management, and/or the physician was called at the time of Resident 53's unwitnessed fall on 2/15/22 at 7:58 p.m. A progress note, dated 2/16/22 at 12:59 a.m., no behaviors were noted at this time, one on one (1:1) with staff continues. A progress note, dated 2/16/22 at 10:02 a.m., staff provided 1:1 in room with resident. The resident was showing no signs or symptoms of psychosocial distress. Neurological Assessment, dated 2/16/22, was started at 10:30 a.m. for the 2/15/22 fall at 7:58 p.m. The right eye assessment indicated Resident 53's eye was swollen shut. No right eye assessment			

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	was completed prior. The neurology (neuro) check documents were provided by the Minimum Data Set Coordinator (MDSC) on 7/25/22 at 12:18 p.m. There were 4 neuro checks, 15 minutes apart, ending on 11:15 a.m. The neuro checks were started 14 hours and 32 minutes after his unwitnessed fall. On 2/16/22 at 12:57 p.m., Resident 53 was assessed this morning. He had a fever of 100.3 Fahrenheit (F). He was agitated, attempted to get up, and resistive with care. Ativan (anti-anxiety) was given and was helpful. Neuro checks within normal limits with the exception of his right eye. His vital signs were taken and were blood pressure 138/76, heart rate 76, and respirations at 18. Notified the Nurse Practitioner (NP) of the resident's condition and fever. She gave new orders to send him to the Emergency Room (ER) for evaluation. The Director of Nursing (DON) was made aware, and he would notify the family. Resident left at 11:38 a.m., by ambulance. A physician's order, dated 2/16/22, indicated to send Resident 53 to the emergency room (ER). On 2/17/22 at 5:47 a.m., the resident returned from the ER via ambulance at 3:20 a.m. He had a splint on his right upper extremity because he had fractures of fingers 4 and 5. The resident was to continue for 1 on 1 for safety. Hospital discharge notes, dated 2/16/22, indicated Resident 53 was diagnosed with right hand fingers 4 and 5 fractured, head injury, and facial contusion (bruise). Additional instructions indicated to follow-up with orthopedic surgeon as surgery was required. Computer Tomography (CT) (medical imaging) of Resident 53's head and brain indicated right periorbital (around the eye)			

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	and right pre-zygomatic (around the cheek bone) with soft tissue swelling. CT of the maxillofacial (area of the jaw and face) area showed right frontal hematoma (bruise), right frontal scalp soft tissue swelling, and premolar (around the cheek) soft tissue swelling. A physician order, dated 2/17/22, to transfer Resident 53 to psychiatric hospital for psychiatric evaluation. On 2/17/22 at 5:00 p.m., Resident 53 transferred to psychiatric hospital per ambulance. The physician and family were notified. No neuro checks were completed for the 13 hours and 40 minutes Resident 53 was at the facility. On 2/18/22 at 7:36 p.m., a Fall Event was documented for Resident 53's fall on 2/15/22. It indicated it was an unwitnessed fall. The resident had been ambulating quickly throughout multiple hallways and unable to be redirected. On 2/21/22 at 9:15 a.m., IDT Fall Review Note indicated Resident 53 fell on 2/15/2022 at 7:58 p.m. He had an unwitnessed fall in the hallway and was discovered laying on his right side. He had been noted to be walking very quickly. Staff attempted to intervene and redirect and encourage him to slow his pace. The resident was noted with increased agitation and behaviors on the date of his fall. The immediate intervention was to provide increased supervision. He was offered a snack and was assisted with toileting. He was nonverbal and cannot voice what he was attempting to do or what his needs were at that time. Neuro checks were within normal limits. Resident was noted with swelling to his right side of his face and knee. He was sent to the hospital the following day after the physician assessed him. During the hospital visit, he was noted to have fractures to 2 of his fingers on his right hand. No signs of pain at the time of fall.			

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	He returned with a splinted right upper extremity. Psychiatric hospital was made aware of his injuries. On 7/26/22 at 10:37 a.m., the DON indicated they began doing 1:1 with Resident 53 when he arrived at the facility. They stopped it about a month ago. There was no physician's order for 1:1 with staff, it was a nursing intervention. With a physician order, we do a checklist. With a nursing intervention, we did not keep records like with a physician's order. We did the 1:1 when they had an extra CNA staff. The DON was not able to provide detailed records of when Resident 53 had 1:1 supervision. After his unwitnessed fall on 2/15/22, the physician and DON should have been notified and neuro checks should have started right away. When Resident 53 came back from the local hospital and before going to psychiatric hospital, the nursing staff should have done the neuro checks. On 7/26/22 at 11:22 a.m., the Executive Director (ED) indicated Resident 53 fell on 2/15/22. They tried to assess him for pain, but he was unable to express his pain because he was non-verbal. They were able to see the swelling the next day, so he was sent to the hospital for an evaluation. That was how we found out the resident had fractures of his hand. A current policy, titled, "Fall Management Program," dated 11/2017, was provided by the ED, on 7/27/22 at 9:05 p.m. A review of the policy indicated, " ...to ensure a resident residing within the facility received adequate supervision and or assistance to prevent injury related to falls ...Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided.			

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	A neurological assessment will be initiated on all un-witnessed falls...If the resident experienced an injury from the fall, contact facility DNS/ED per facility policy...physician will be contacted immediately...the family will be notified immediately by the charge nurse of fall with injury...." 3.1-37(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to ensure enteral feeding (food entered directly into the stomach) and water pouch were labeled and dated according to standard of care for 1 of 2 residents reviewed for	F 0693	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	08/31/2022

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	enteral feeding (Resident 113). Findings include: On 7/20/22 at 7:46 a.m., Resident 113's enteral feeding of Jevity 1.5 was observed without the resident's name, room number or start date. The hanging plastic bag of water was not labeled, and the tubing was undated. On 7/21/22 at 9:16 a.m., Resident 113's Jevity 1.5 was labeled with his name and today's date. The water bag had no information. The tubing was not dated. On 7/21/22 at 1:33 p.m., a different bottle of Jevity was observed hanging in his room. This bottle had no name, room number or start and finish dates. The water pouch was not labeled, and the tubing had no date. On 7/22/22 at 7:44 a.m., Resident 113's Jevity 1.5 was observed without the resident's name, room number or start date. The hanging plastic bag of water was not labeled, and the tubing was undated. On 7/22/22 at 11:34 a.m., Resident 113's medical record was reviewed. His diagnoses included, but were not limited to, acute respiratory failure with hypoxia (lack of oxygen), cerebral infarction (stroke), and gastrostomy status (opening in his stomach for feeding). A care plan, dated 7/8/22, indicated he needed assistance with his g-tube (feeding tube) status and to assist with eating and drinking as needed. A care plan, dated 7/8/22, indicated he was at risk for complications related to enteral feeding with a		Resident 113 no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with tube feedings have the potential to be affected All other residents that reside in the facility have been reviewed to ensure enteral feeding has been labeled and dated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed nurses will be educated by the DNS/designee on labeling and dating enteral feeding bottle and tubing. Enteral therapy rounding tool will be completed daily until compliance is achieved. DNS/designee will round each shift to ensure enteral feedings, water pouch and tubing are appropriately labeled. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Enteral Therapy rounding tool will be utilized weekly x 4 weeks then monthly x 6 months, with results	

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	goal he will be free from complications related to enteral feeding A physician's order indicated it was ok to use Jevity 1.5 until Jevity 1.2 arrived. On 7/22/22 at 11:44 a.m., the Director of Nursing (DON) indicated Resident 113's Jevity and water bag should have been labeled and dated, and tubing should have been dated. On 7/25/22 at 1:03 p.m., the Regional Director of Clinical Services (RDCS) indicated the enteral feeding should be labeled with the resident's name and date, but the tubing did not need to be dated. On 7/26/22 at 3:25 p.m., the RDCS indicated there was not a specific policy for labeling enteral feeding and tubing, but it was a standard of care. A current policy, titled, "Storage and Expiration Dating of Medications, Biologicals," dated 7/21/22, was provided by the ED on 7/25/22 at 12:53 p.m. A review of the policy indicated, " ...Facility should ensure that infusion therapy labels include ...date and time of administration...." 3.1-25(j)		reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the			

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	comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. The facility failed to provided a nebulizer treatment, which had been discontinued, then failed to assist the resident to use the nebulizer or remove the equipment from the bed for 1 of 4 residents reviewed for respiratory (Resident 28). The facility failed to ensure respiratory tubing and equipment was labeled, changed, and stored appropriately for 3 of 4 residents reviewed for resipratory (Residents 261, 13, and 9). Findings include: 1. On 7/20/22 at 10:08 a.m., during an interview and observation, Resident 28 was observed in her bed wearing oxygen in her nose per nasal canula. The tubing was connected to a concentrator, at the bedside. A round blue disk with clear tubing and a mouthpiece attached were laying on top of the covers, below the resident's abdomen. Resident 28 indicated the nurse gave it to her to use (inhale treatment) but it was not working properly, and she could not get anything (medication) out of it. The device did not contain a label or any dispensing information. On 7/20/22 at 10:12 a.m., during an interview and observation of Resident 28, Licensed Practical Nurse (LPN) 18 indicated she was an agency nurse. She had not worked this hall before and was not familiar with Resident 28. She did not know what that device was and had never seen one like it before. She had not given it to the resident on her shift. She removed it from the room and put it in the medication cart. On 7/20/22 at 10:13 a.m., during an interview at the medication cart with LPN 18 and LPN 17, LPN 17	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Nebulizer equipment was removed from resident #28 room. Resident 261, 13, & 9 had new labeled tubing and equipment put into place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected Audit of all residents currently residing in the facility that are utilizing oxygen, CPAPs, or Bipaps have been reviewed to ensure dated & labeled respiratory equipment was in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed nurses will be in-serviced on removing discontinued equipment from resident rooms, ensuring oxygen tubing is being stored appropriately when not in use by DNS/designee by 8/26/22. DNS/Designee will complete the Medication/intervention rounding tool will be utilized daily which	08/31/2022

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	indicated she worked at the facility and was familiar with Resident 28. She thought the device was an inhaler or nebulizer. It appeared to be battery operated but she was not familiar with that type. On 07/22/22 at 12:04 p.m., the medical record for Resident 28 was reviewed. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), diabetes, respiratory failure, heart disease, and dementia. A quarterly MDS (minimum data set) assessment, dated 6/3/22, indicated Resident 28's BIMS (brief interview for mental status) score was 11 and was moderately impaired cognition. The physician orders included, but were not limited to, oxygen at 2 liters per nasal cannula. Albuterol sulfate HFA aerosol inhaler; 90 mcg/actuation, administer 2 puffs inhalation every 6 Hours PRN (as needed). There were no current orders for nebulizer treatments or any additional inhalation treatments. There was no order for a nebulizer or inhaler to be left at the bedside. On 7/25/22 at 11:50 a.m., during a random observation of the medication cart, on the 200 Hall, with Qualified Medication Aide (QMA) 10, she indicated she was agency staff. She was not familiar with the residents on that hall. Resident 28 only had an albuterol inhaler in the medication cart. She removed a small white inhaler inside a plastic bag that was labeled with the resident's name and prescribing information. On 7/25/22 at 12:00 p.m., during an interview, with the Director of Nursing (DON), related to Resident		includes oxygen, CPAP and Bipap to ensure tubing is labeled and stored properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Respiratory equipment QAPI tool will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	28, he indicated he was not familiar with it either (the blue inhalation device) but staff said it was some kind of nebulizer, he would check on it. On 7/25/22 at 12:09 p.m., during an interview, the Regional Director of Clinical Services (RDCS) indicated the device was a nebulizer. The resident previously had an order for treatments, which was discontinued on June 30, 2022. She did not know why it had been available in the resident's medication drawer for use. On 7/25/22 at 12:25 p.m., the DON provided a current undated policy, titled "Respiratory Care: Competency Assessment Form. He indicated this was the only policy for respiratory/ nebulizer care and treatments. This document indicated "Verify the physician order...identify the resident...once the treatment is complete have the resident wash their mouth out with water or mouthwash and spit it out...return the MDI [metered dose inhaler] to the medication storage unless there is an order from the physician to leave it at bedsde." 2. During an observation of Resident 261 on 7/20/22 at 7:24 a.m., Resident 261 was sitting up in bed with her eyes closed. Resident 261 had oxygen via a concentrator with the volume set to 4 liters per minute and being delivered to her through nasal cannula tubing. The humidifier and oxygen tubing were undated. Resident 261 had a nebulizer machine on her nightstand. An undated and unbagged mask and tubing were connected to the nebulizer machine. During an observation of Resident 261 on 7/20/22 at 10:20 a.m., her nebulizer mask was unbagged. Resident 261's nasal cannula, nebulizer mask and humidified water were undated. During an observation of Resident 261 on 7/22/22			

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	at 10:00 a.m., her nebulizer mask was unbagged. Resident 261's nasal cannula tubing, mask and humidified water bottle were undated. During an observation of Resident 261 on 7/25/22 at 11:10 a.m., Resident 261's nebulizer mask was unbagged. Resident 261's nasal cannula, nebulizer mask and humidified water were undated. A comprehensive chart review was completed on 7/25/22 at 2:20 p.m. Resident 261 had the following diagnoses, but not limited to chronic respiratory failure, asthma, hypertension, heart failure, hyperlipidemia, acute kidney failure, weakness, and insomnia. Resident 261 had physician's orders dated 7/9/22 for oxygen at 4 liters per minute per nasal cannula, albuterol nebulizer treatments, and change respiratory equipment weekly. Resident 261 had a care plan problem, resident to have adequate respiratory function with interventions to administer oxygen as ordered and nebulizer treatments as ordered. 3. During an observation of Resident 13 on 7/20/22 at 10:59 a.m., Resident 13 had her nasal cannula (oxygen) tubing laying on her sheets. Resident 13 indicated that her nose was dry. Resident 13 was using an oxygen concentrator. The concentrator lacked humidified water. The filter to the concentrator had dust collected on it. The oxygen tubing lacked a date to indicate when it was last changed. During an observation on 7/25/22 at 10:07 a.m., Resident 13 had her oxygen tubing in her nose. Resident 13 continued to lack humidified water attached to her oxygen concentrator. Resident 13			

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	155620	A. BUILDING 00 B. WING	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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	indicated that the staff used to provide water for her oxygen. Resident 13 complained that her nose was dry. The tubing was undated. The oxygen concentrator filter had dust on it. During an observation on 7/25/22 at 11:58 a.m., Resident 13 had her oxygen tubing lying on her bed. She did not have humidified water attached to her oxygen concentrator. Resident 13's oxygen tubing was undated. The oxygen concentrator filter had dust on it. A comprehensive chart review of Resident 13 was completed. Resident 13 had the following diagnoses, but not limited to cerebral palsy, repeated falls, chronic obstructive pulmonary disease (COPD), rheumatoid arthritis, contracture of muscles, shortness of breath, restless leg syndrome, congestive heart failure, muscle weakness and poor posture. Resident 13 had physician's orders, dated 11/10/19, for oxygen at 2 liters per minute per nasal cannula as needed and to change respiratory equipment weekly. Resident 13 had a care plan with a problem of "being at risk for impaired gas exchange related to chronic obstructive pulmonary disease with shortness of breath while lying flat." Interventions included, " ...oxygen at 2 liters per minute per nasal cannula to keep oxygen saturation greater than 92%, elevate head of bed and nebulizer treatments as ordered ...." 4. During an observation of Resident 9 on 7/20/22 at 7:30 a.m., her CPAP (Continuous Positive Airway Pressure) mask was on the floor. During an observation of Resident 9 on 7/21/22 at			

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	9:46 a.m., her CPAP mask was uncovered and sitting on her nightstand. A comprehensive chart review was completed on 7/21/22 at 11:30 a.m. for Resident 9. Resident 9 had the following diagnoses, but not limited to dementia, chronic obstructive pulmonary disease, schizophrenia, acute and chronic respiratory failure, obstructive sleep apnea, shortness of breath and cough. Resident 9 had orders for CPAP when sleeping. There were no settings for the CPAP in the order. Resident 9 had a care plan with a problem as "being at risk for impaired gas exchange related to diagnoses of obstructive sleep apnea, history of COVID-19, history of acute/chronic respiratory failure, dyspnea (difficulty breathing), COPD (chronic obstructive pulmonary disease) with shortness of breath while lying flat." Resident utilizes a CPAP machine. Interventions included "CPAP on at HS (hours of sleep) with settings at 6.0 and nebulizer treatments as ordered." An undated policy titled "Aerosolized Medication Therapy, Handheld Nebulizer," indicated, " ...Disassemble device, Place entire unit in a bag (labeled with the resident's name and date) to be maintained in the resident's room. Dispose of equipment every 24-48 hours ...." An undated policy titled "Oxygen and Devices," indicated, " ...nasal cannula, change out weekly and PRN (as needed), place in a labeled bag when not in use...." 3.1-18(a)			

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F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to complete pre and post dialysis events for 1 of 1 resident (Resident 16) reviewed for dialysis care. Findings include: On 7/20/22 at 7:30 a.m., during an interview with Resident 16, he indicated that he went to dialysis on Monday, Wednesday, and Friday. He left at 9:30 a.m. and returned later in the afternoon on the same day. On 7/22/22 at 10:24 a.m., during an interview with Registered Nurse (RN) 9 regarding Resident 16 and his dialysis event and communication sent with him for dialysis that morning, RN 9 indicated she did not know Resident 16 had left the building for dialysis. On 7/22/22 at 11:36 a.m., a record review was completed. Resident 16 had the following diagnoses, but not limited to end stage renal disease requiring dialysis, schizophrenia, and history of falls. Resident 16 had physician's orders, dated 11/17/21, that indicated staff were to complete the bottom portion of dialysis event upon return on Monday, Wednesday, and Friday. Staff were to open and complete the top portion of dialysis	F 0698	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident 16 has had completed dialysis events since 7/27/22 for all dialysis appointments. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · No other residents reside in facility that require dialysis. · Inservice to be completed for all nurses on completing pre/post dialysis events by DNS/Designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Inservice to be completed for all nurses on Dialysis Care Policy by DNS/Designee. **How the corrective action(s)**	08/31/2022

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	event on Monday, Wednesday, and Friday. Resident 16 was to receive dialysis at a local dialysis center per order, dated 11/16/21, and dialysis days were Monday, Wednesday, and Friday. Resident 16's dialysis events for the following dates were not found in his electronic medical record. These events were requested from the Director of Nursing Services (DNS) on 7/22/22 at 1:58 p.m. Missing dialysis events were from 4/1/22, 4/15/22, 4/20/22, 4/27/22, 5/6/22, 5/13/22, 5/23/22, 6/1/22, 6/22/22, 6/24/22, 6/27/22, 6/29/22, 7/1/22, 7/4/22, 7/6/22, 7/8/22, 7/11/22, 7/13/22, 7/15/22, 7/20/22, and 7/22/22. During an interview with the DNS on 7/25/22 at 11:36 a.m., he indicated a pre and post dialysis event should have been completed on Resident 16's dialysis days. The DNS could not provide the dialysis events for the dates requested. A policy was provided by the DNS on 7/26/22 at 9:24 a.m., titled, "Dialysis Care," with a date of 2/03 and a revision date of 11/2017. This current policy indicated " ...the nurse in charge at time of transfer to dialysis will provide the resident will all appropriate paperwork as required by the dialysis center ...the nurse in charge at the time of return will review paperwork for new orders and/or notes accompanying the resident ...a dialysis event will be initiated in the electronic medical record (EMR) to include time of transfer and completed upon return to the unit...." 3.1-37(a)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Dialysis Event Monitoring Tool with be completed with each scheduled dialysis day.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services			

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	The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview, and record review the facility failed to ensure a nurse had a current nursing license who worked in the capacity of a nurse for 1 of 17 nurses reviewed for unlicensed staff (Registered Nurse 14). Findings include:	F 0726	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified with this citation and residents that were cared for by RN 14 did not	08/31/2022

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	On 7/26/22 on 11:12 a.m., Registered Nurse (RN) 14's license was reviewed. He had a temporary nursing license from 2/4/22 to 5/4/22. His temporary license expired on 5/5/22. His RN license started on 5/23/22. He was unlicensed from 5/5/22 to 5/22/22. On 7/26/22 at 11:58 a.m., the Director of Nursing (DON) provided the nursing schedules from 5/4/22 to 5/23/22. RN 14 was scheduled to work as a nurse and had the responsibility of working a medication cart. On 5/9/22, he was responsible for the residents on the Sycamore Hall and worked the Sycamore medication cart for 2 shifts, from 7:00 a.m. to 11:00 p.m. On 5/10/22, he was responsible for the residents on the Pine Hall and worked the Pine medication cart for 2 shifts, from 7:00 a.m. to 11:00 p.m. On 5/12/22, he was responsible for the residents on the Sycamore Hall and worked the Sycamore medication cart for 1 shift from 7:00 a.m. to 3:00 p.m. On 5/13/22, he was responsible for the residents on the Sycamore Hall and worked the Sycamore medication cart from 7:00 a.m. to 3:00 p.m. On 5/15/22, he was responsible for the residents on the Sycamore Hall and worked the Sycamore medication cart for 1 shift from 7:00 a.m. to 3:00 p.m. On 5/19/22, he was responsible for the residents on the Pine Hall and worked the Pine medication cart for 2 shifts, from 7:00 a.m. to 11:00 p.m.		have any adverse effects. RN 14 was taken off all nursing duties until license was renewed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. Audit completed for all Licensed Nurses and Qualified Medical Assistances that are currently employed by the facility on 8/5/22. No additional concerns were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Regional Director of Clinical Services provided education to DNS and ED on verifying that active licenses are in place for any new hires that require certifications or licenses on 8/24/22. Licensed Nurse/QMA audit tool will be completed for any new hires of licensed nurses or QMA's . All licensed nurses and QMA will be audited monthly to ensure licenses are current by DNS/designee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	On 7/26/22 at 1:21 p.m., the DON indicated when RN 14 arrived from a foreign country. He was aware RN 14 had a temporary nursing license. On 7/26/22 at 1:26 p.m., the Executive Director (ED) indicated RN 14 was from a foreign country. They did not want to hurt him financially, so we let him work. But he was not supposed to be on a medication cart after his license expired and before he got his RN license. The ED indicated he told the DON, the scheduler, and the nursing management staff not to schedule RN 14 to work as a nurse. On 7/26/22 at 2:18 p.m., the ED indicated the facility found out RN 14 was working without a current license on 5/13/22. After that date, he worked 3 additional shifts as a nurse. The ED indicated RN 14 was aware he did not have a license. ED confirmed RN 14 was here and responsible for residents and medication carts on 5/9, 5/10, 5/12, 5/13, 5/15, and 5/19/22. A current policy titled, "Storage and Expiration Dating of Medications, Biologicals," dated 7/21/22, was provided by the ED, on 7/25/22 at 12:53 p.m. It indicated, "...Facility should ensure that only authorized Facility staff, as define by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas...." The Indiana State Board of Nursing's "Compilation of the Indiana Code and Indiana Administrative Code," the 2013 edition, was reviewed. It indicated, "Any person who practices or offers to practice nursing as either a registered or licensed practical nurse in Indiana shall hold a current Indiana license as proof of their legal authorization to practice. (b) The Indiana board of		**into place:** Licensed Nurse/QMA audit tool will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	nursing (board) shall be responsible for the following... Assuring that imposters are not functioning in roles normally assumed by the licensed nurse...." 3.1-14(j) 3.1-14(s) 3.1-25(b)(1)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure less than 5% medication errors were observed during medication administration for 2 of 5 residents reviewed for medication administration (Resident 24 and 18). 7.69% Findings include: 1. On 7/22/22 at 7:54 a.m., Registered Nurse 14 did not wash or sanitize his hands. He put on gloves and removed the glucometer from the medication cart. He did not clean it. He walked over to the Resident 24 in the Sycamore/Pine living room and placed the glucometer on an unclean bookshelf. He did not clean it before he used it on Resident 24 and did not clean it before he put it in the alcohol swab box and placed it back in the medication cart. He removed the Novolog (insulin) pen from the medication cart and dialed in 8 units per the physician's order. He did not prime the insulin needle before he injected the resident. He did not wash or sanitize his hands before or after using the glucometer and giving Resident 24 his	F 0759	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 24 and 18 did not have any adverse effects related to insulin administration. RN 14 has been in-serviced on medication administration, cleaning & use of glucometer, priming and use of insulin pens, and handwashing & use of ABH policies, and completed return demonstration skills validation on medication administration, cleaning & use of glucometer, priming and use of insulin pens, and handwashing & use of ABH. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	08/31/2022

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	insulin. On 7/22/22 at 8:09 a.m., the Director of Nursing (DON) provided RN 14 with a Medication Pass Procedure skills validation checklist and laid it on the medication cart. RN 14 did not review it before he continued with medication administration. 2. On 7/22/22 at 8:28 a.m., RN 14 did not wash or gel his hands and pulled 11 medications for Resident 18. He removed the Basaglar (insulin) pen from the medication cart and dialed in 27 units per the physician's order. He did not prime the insulin needle before he injected the resident. RN 14 provided the medications to Resident 18, and she swallowed them. On 7/22/22 at 8:42 a.m., RN 14 indicated he cleaned the glucometer with alcohol wipes when it was dirty. He should have cleaned it before and after using it. He indicated he should have washed or gelled his hands between residents. For the insulin pen priming, he indicated by leaving the needle in the skin for a few seconds after injection, all the insulin was delivered. On 7/22/22 at 1:33 p.m., the Director of Nursing (DON) indicated during medication administration the nursing staff should have washed their hands between residents, the glucometer should have been cleaned before and after resident use, and insulin needles should have been primed. On 7/22/22 at 9:15 a.m., Executive Director (ED) indicated during medication administration, staff should have washed their hands between residents and insulin administration included cleaning the glucometer before and after use and insulin needles should have been primed before insulin was given.		**action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. DNS/designee will in-service All Licensed Nurses and Qualified Medical Assistants on medication administration, cleaning & use of glucometer, priming and use of insulin pens, and handwashing & use of ABH policies, and completed return demonstration skills validation on medication administration, cleaning & use of glucometer, priming and use of insulin pens, and handwashing & use of ABH. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/designee will complete Daily hand hygiene observation tool to ensure appropriate hand washing occurs.daily x 6 weeks or until compliance is achieved. DNS/designee will complete Medication/Insulin administration/Glucometer use rounding tool daily x 6 weeks or until compliance is achieved. To ensure appropriate medication administration/glucometer use occurs All Licensed Nurses and Qualified Medical Assistants will be in-serviced by the DNS/designee on medication administration,	

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	On 7/27/22 at 9:58 a.m., the DON provided the initial nursing skills and validation check off lists for RN 14's orientation and education to the facility. Ten separate nursing skills and validation check off lists were provided. No check off list for nursing skills and validation was provided for giving insulin. A nursing skills and validation check off list, titled, "Glucose Meter Cleaning and Testing," dated 4/11/22, was signed off as completed by Licensed Practical Nurse (LPN) 7 and RN 14. It indicated RN 14's skills were validated to complete glucometer cleaning and testing. It specifically indicated to wipe the entire external surface of the glucometer with a germicidal wipe for 3 minutes and let it air dry on a clean surface before and after residential use. A nursing skills and validation check off list, titled, "Hand Hygiene," dated 4/12/22, was signed off as completed by LPN 7 and RN 14. It indicated RN 14's skills were validated to complete appropriate hand hygiene. It specifically indicated there were times for hand hygiene; before and after touching a resident and their surroundings, before a clean or aseptic procedure, and after body fluid exposure risk. A current policy, titled, "Hand Hygiene Policy," dated 3/2018, was provided by the ED, on 7/22/22 at 1:55 p.m. A review of the policy indicated, " ...Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations ...Indications for Hand-rubbing [sic] but not limited to ...Before the starting a medication preparation ...." A current policy, titled, "Blood Glucose Meter		cleaning & use of glucometer, priming and use of insulin pens, and handwashing & use of ABH policies, and completed return demonstration skills validation on medication administration, cleaning & use of glucometer, priming and use of insulin pens, and handwashing & use of ABH. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Daily Hand Hygiene and Medication/Insulin/Glucometer use rounding tools will be utilized daily x 6 weeks, weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	Cleaning/Disinfecting and Testing," dated 5/2021, was provided by the ED, on 7/22/22 at 1:55 p.m. A review of the policy indicated, "...Perform hand hygiene. Place a paper towel, plastic cup, or other clean barrier on hard surface. Don gloves. Obtain germicidal wipe approved for the glucometer approved for use on glucometer ...Clorox Bleach Germicidal Wipes ...DO NOT use alcohol preps to clean glucometer, as they are not effective in killing bloodborne pathogens ...Proceed to resident room with cleaned meter ...." A current policy, titled, "Insulin Pen Administration," dated 6/2018, was provided by the ED, on 7/22/22 at 1:20 p.m. A review of the policy indicated, "...Prime the insulin pen by dialing 2 units. Push the end of the pen to push out the 2 units. (A small drop of insulin should be visible. If insulin does not appear, repeat)...." 3.1-18(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure a medication cart was locked at all times for 1 of 1 random observation, medications were not stored in resident rooms for 2 of 2 random observations (Resident 113 and 46), unqualified personnel did not have access to the medication room for 1 of 1 random observation, pharmacy labels were complete on medications (Resident 6) for 1 of 2 medication carts observed, medication refrigerators were storing a medication at the proper temperature for 1 of 2 medication rooms observed, and medication refrigerator temperature logs were consistently updated for 1 of 2 medication rooms observed. Findings include: 1. On 7/20/22 at 8:12 a.m., the Maple Hall medication cart was observed unlocked. At 8:24 a.m., the Director of Nursing (DON) was observed to lock the medication cart. A current policy, titled, "Medication Pass Procedure," dated 12/2016, was provided by the Executive Director (ED) on 7/22/22 at 11:59 a.m. A review of the policy indicated, " ...Med room and med/tx (treatment) carts locked when unattended ...."	F 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 113 no longer resides at the facility. Resident 46 had cream removed from bedside. Resident 6 medication label added to medication. Nurse educated on locking medication cart when they are not at the cart. C.N.A./scheduler was educated on not being in the medication room on 8/24/22. Medication refrigerators are at correct temperature and have monitoring logs in place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected Medication carts have been audited to ensure labels are in	08/31/2022

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	2. On 7/20/22 at 7:46 a.m., Resident 113 had an unsealed bottle of chlorhexidine 0.12% rinse (prescription antiseptic mouthwash) on a small dresser. The pharmacy label indicated to use 15 mL, mucus membranes, two times a day. There was an open jar of Vaseline, with no lid and no pharmacy label on a different small dresser. These two items remained in his room throughout several observation over several days: 7/21/22 at 9:16 a.m., 7/21/22 at 1:33 p.m., 7/21/22 at 1:43 p.m., and 7/22/22 at 7:44 a.m. On 7/22/22 at 1:31 p.m., the DON indication the chlorhexidine 0.12% should have been stored in the medication cart. On 7/25/22 at 1:23 p.m., Resident 113's physician orders were reviewed. He did not have an order to self-administer any medications. He was unable to administer medications, but the Executive Director (ED) indicated his wife helped with his care. On 7/21/22 at 9:24 a.m., Resident 46 had an open tub of hydrocortisone cream 2.5% (treats skin conditions) on her dresser. It had no lid on it. On 7/25/22 at 11:36 a.m., the ED indicated Resident 46 did not have a physician's order to self-administer any medications. On 7/21/22 at 2:11 p.m., Resident 53's chart was reviewed for wandering behaviors. On 2/15/22 at 6:36 p.m., an Interdisciplinary Team (IDT) Behavior Review Note indicated Resident 53 was constantly pacing and wandering hallways, intrusively wandering into other's rooms. He was trying to open up all the doors or get out.		place on 8/24/2022. Resident rooms have been audited to ensure there are no medications or treatments at bedside 8/24/2022. Medication rooms have been audited to ensure temperature of refrigerator is in normal range and there is a temperature monitoring log in place 8/24/22. Nursing staff has been educated that medication rooms/carts must be locked and unauthorized personnel are not to be in medication rooms. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All Licensed Nurses and Qualified Medical Assistants will be in-serviced on ensuring medication carts are locked when they are not at the medication cart, medications and treatments will not be left at residents' bedside, unauthorized facility staff will not be in medication rooms, and refrigerator temperatures are to be monitored twice per day. Medication room rounding tool will be completed daily x6 weeks or until compliance is achieved. To ensure refrigerator temps are monitored and temp log is completed, pharmacy labels are present, **How the corrective action(s)**	

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	A current policy, titled, "Storage and Expiration Dating of Medication, Biologicals," dated 7/21/22, was provided by the ED on 7/25/22 at 12:53 p.m. A review of the policy indicated, " ...Facility should ensure that all medications and biologicals, including treatment items are securely stored in a locked cabinet/cart or locked medication room that in inaccessible by residents and visitors ...." 3. On 7/25/22 at 10:05 a.m., the Scheduler/CNA (Certified Nursing Aide) was observed exiting the Sycamore medication room with cleaning equipment. She indicated LPN 12 opened the room for her. She was not aware she should not have been in there without a licensed, authorized staff person with her. On 7/25/22 at 10:11 a.m., the DON indicated he was not sure if the Scheduler/CNA was authorized to be in the medication storage room alone. On 7/25/22 at 10:13 a.m., LPN 12 indicated the CNA was just going to sweep and floor to she let her in the Sycamore medication storage room. A current policy, titled, "Storage and Expiration Dating of Medication, Biologicals," dated 7/21/22, was provided by the ED on 7/25/22 at 12:53 p.m. A review of the policy indicated, " ...Store all drugs and biologicals in locked compartments ...permitting only authorized personnel to have access ...." 4. On 7/25/22 at 11:55 a.m., the Sycamore Medication Cart was observed with RN 9. Medications were observed for Resident 6 with half of the pharmacy label missing. RN 9 indicated she did not know if the pharmacy label should have been complete. She indicated Resident 6		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Medication Storage Review audit tool will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	received medications from the missing label bottles. The medications were sertraline (antidepressant) and 2 bottles of pantoprazole sodium DR (treats heartburn). A current policy, titled, "Storage and Expiration Dating of Medication, Biologicals," dated 7/21/22, was provided by the ED on 7/25/22 at 12:53 p.m. A review of the policy indicated, " ...Facility should ensure that medications and biologicals that ...have an expired date on the label ...." 5. On 7/25/22 at 9:52 a.m., an observation of the PINE medication storage room with LPN 13 showed the medication refrigerator temperature to be at 54 degrees Fahrenheit (F). Stored in the warm refrigerator was Apisol (for tuberculous skin testing). A review of the Food and Drug Administration (FDA) package insert for Apisol, it indicated to keep the drug between 36 - 46 degrees F. A current policy, titled, "Storage and Expiration Dating of Medication, Biologicals," dated 7/21/22, was provided by the ED on 7/25/22 at 12:53 p.m. A review of the policy indicated, " ...Refrigeration: 36 degrees - 46 degrees F ...." 6. On 7/25/22 at 10:09 a.m., LPN 13 provided a copy of the PINE medication room's incomplete refrigerator temperature log. The last temperature logged was 7/20/22. On 7/25/22 at 10:20 a.m., the Sycamore medication refrigerator temperature log was reviewed. The temperature was not logged on 7/21/22. A current policy, titled, "Storage and Expiration Dating of Medication, Biologicals," dated 7/21/22,			

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	was provided by the ED on 7/25/22 at 12:53 p.m. A review of the policy indicated, " ...Facility should monitor the temperature of medication storage areas at least once a day ...." 3.1-25(k) 3.1-25(m)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interviews, the facility failed to serve food at adequate temperatures to 1 of 1 resident (Resident 5) observed during tray service and failed to ensure equipment temperatures were monitored for the dishwasher, freezer, and two refrigerators (coolers) in the	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All culinary staff will be in serviced on the policies related to Food	08/31/2022

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	kitchen (produce cooler and dairy cooler) for 1 of 1 month reviewed. Findings include: 1. On 7/20/22 at 8:08 a.m., a large metal cart was observed on the hallway. Multiple staff were opening and closing the cart doors to obtain resident room trays from the cart. On 7/20/22 at 8:43 a.m., the Director of Nursing (DON) was requested to test the last tray on the cart. The tray belonged to Resident 5. On the tray was a sausage patty, a piece of French toast and a small bowl of oatmeal. The DON placed the thermometer into the sausage patty. The temperature was 81.3 degrees, oatmeal was 129 degrees, and the French toast was 79.9 degrees. The DON indicated he was unaware of what the temperatures of the food should have been, and the facility did not have a dietary manager. A policy titled, "Food Temperatures," dated 2/02, with a revision date of 6/21, provided by the Executive Director (ED) on 7/22/22 at 11:59 a.m., indicated, "hot food will be held at or above 135 degrees Fahrenheit. If minimum temperature requirements are not maintained, food will need to be reheated to a minimum of 165 degrees Fahrenheit before serving." 2. During a kitchen tour with Dietary Aide (DA) 6, on 7/20/22 at 6:35 a.m., observed produce cooler temperature with the last documented temperature on the log for 7/14/22 at 7:00 p.m. at which time the temperature was recorded as 40 degrees. The dairy cooler temperature log was observed. The temperature was last documented on 7/14/22 at 7:00 p.m. The temperature documented was 40		Temperatures, Refrigerator temperatures and monitoring, dish machine temperatures and monitoring Daily rounding to be completed by culinary manager/designee to ensure temperature record compliance for refrigerators and dish machine (to be done 2 times daily) Weekly test tray QA by the culinary manager/designee to monitor food temperatures **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All culinary staff will be in serviced on the policies related to Food Temperatures, Refrigerator temperatures and monitoring, dish machine temperatures and monitoring Daily rounding to be completed by culinary manager/designee to ensure temperature record compliance for refrigerators and dish machine (to be done 2 times daily) Weekly test tray QA by the culinary manager/designee to monitor food temperatures **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Daily rounding to be completed by culinary manager/designee to	

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	degrees. The freezer temperature log was observed. The temperature was last documented on 7/14/22 at 7:00 p.m. It was documented at zero degrees. The dishwasher temperature log was observed. The last temperatures for the dishwasher were obtained on 7/15/22. Dietary Aide (DA) 6 checked the temperatures. The temperature was 170 degrees. DA 6 indicated the temperatures should have been obtained two times daily for the equipment and that sometimes people forgot, on the weekends too. A policy titled "Cleaning Dishes and Dish Machine," with a date of 10/17, provided by the ED on 7/26/22 at 10:40 a.m., indicated, " ...Check the temperature and pressure. Follow manufacturers' recommendations (see chart below) ." There was no mention of how often to obtain and document the temperatures of the dishwasher. A policy titled, "Food Storage," with a date of 2/02 with a revision date of 6/21, indicated, "Thermometers should be checked utilizing an internal thermometer at least two times each day." 3.1-21(i)(l)		ensure temperature record compliance for refrigerators and dish machine (to be done 2 times daily) Weekly test tray QA by the culinary manager/designee to monitor food temperatures **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **Test Tray QA tool** will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Culinary AM check off sheet will be completed daily to ensure temperature monitoring compliance and reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

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	infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or			

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	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review the facility failed to ensure staff followed routine infection control measures for medication administration, failed to ensure hand washing was completed between residents, failed to ensure staff did not touch the resident medication with bare unwashed hands, failed to replace medication that had dropped on the medication cart, and failed to ensure the glucometer was cleaned before and after use for a resident for 5 of 5 residents reviewed for medication administration (Resident 24, 15, 52, 30, and 18).	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 24, 15, 51, 30, & 18 did not have any adverse effects related to infection control practices. RN 14 will be educated on infection prevention & control policies related hand hygiene and	08/31/2022

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	Findings include: 1. On 7/22/22 at 7:54 a.m., Registered Nurse 14 did not wash or sanitize his hands. He put on gloves and removed the glucometer from the medication cart. He did not clean it. He walked over to the Resident 24 in the Sycamore/Pine living room and placed the glucometer on an unclean bookshelf, in the Sycamore/Maple living room. He did not clean it before he used it on Resident 24 and did not clean it before he put it in the alcohol swab box and placed it back in the medication cart. He removed the Novolog insulin pen from the medication cart and dialed in 8 units per the physician's order. He did not prime the insulin needle before injecting the resident. He did not wash or sanitize his hands before or after using the glucometer and giving Resident 24 his insulin. 2. On 7/22/22 at 8:00 a.m., RN 14 did not wash or gel his hands prior to setting up Resident 15's medications. He popped the medication directly into his bare, unwashed hand. a. Daily-vite (vitamin) 400 mcg (micrograms) was popped into his bare, unwashed hand and placed in the medication cup. b. Metformin (anti-diabetic) 500 mg was popped into his bare, unwashed hand and placed in the medication cup. c. Prozac (anti-depressant) 20 mg was popped into his bare, unwashed hand and placed in the medication cup. d. Trajenta (anti-diabetic) 5 mg was popped into his bare, unwashed hand and placed in the medication cup. e. Vitamin D3 (supplement) 400 units x 2 pills were popped into his bare, unwashed hand and placed in the medication cup.		when to perform, glucometer cleaning, and medication administration and complete return demonstration skills validations for hand hygiene and when to perform, glucometer use and cleaning, medication administration by DNS/designee. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, post-test, observation, and QA tools. · All staff will be educated on Infection Prevention & Control Policies related to hand hygiene and when to perform, having hand hygiene items available, glucometer cleaning and use, and infection control practices during medication administration by IP/designee by IP/DNS/designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	At 8:07 a.m., RN 14 provided the medications to Resident 15 and he swallowed them. He did not wash or sanitize his hands before he was observed removing tape and a cotton ball from Resident 15's antecubital (inner elbow) area and indicated it was from an earlier blood draw. On 7/22/22 at 8:09 a.m., the Director of Nursing (DON) provided RN 14 with a Medication Pass Procedure skills validation checklist and laid it on the medication cart. RN 14 did not review it before he continued with medication administration. 3. On 7/22/22 at 8: 09 a.m., RN 14 gelled his hands and pulled the medications for Resident 51. He did not have all the medications. He was missing lisinopril/hydrochlorothiazide 20/25 mg (milligram) and acetaminophen 650 mg. He pulled the remaining medications. a. Gabapentin (for nerve pain) 600 mg was popped into his bare, unwashed hand and placed in the medication cup. b. Metformin (anti-diabetic) 500 mg in his bare, unwashed hand and placed it in the medications cup. c. Sertraline (anti-depressant) 25 mg was popped from the blister card and dropped on the medication administration cart, RN 14 picked it up with his bare, unwashed hand and placed in the medication cup. At 8:16 a.m., Resident 51 was offered her medications, RN 14 indicated two medications were missing. She indicated she did not want to take partial medications. She would wait until he had all the medications together. RN 14 took the medication cup back to the medication cart, after placing her name on the medication cup, he placed it in the top drawer and indicated he would give it to her later.		·A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause. ·The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, observation, and QA tools. ·The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy. ·All staff will be educated on the Policies including Infection Prevention & Control Policies related to hand hygiene and when to perform, having hand hygiene items available, glucometer cleaning and use, and infection control practices during medication administration by the IP/designee by 8/31/22. · Daily observational rounds will be conducted for 6 weeks until compliance is maintained by the IP/designee using the Infection Control observational rounds tool to observe · Daily hand hygiene observation tool will be conducted for 6 weeks or until compliance is maintained by IP/designee. · The consultant IP will	

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	4. On 7/22/22 at 8:18 a.m., RN 14 did not wash or gel his hands and pulled medications for Resident 30. a. Bupropion (anti-depressant) 100 mg was popped into his bare, unwashed hand and placed in the medication cup. b. Carvedilol (antihypertensive) 6.25 mg was popped into his bare, unwashed hand and placed in the medication cup. c. Fluticasone (seasonal allergies) nasal spray, 2 sprays in each nostril was removed from the medication cart with his unwashed hands. d. Lasix (diuretic) 40 mg was popped into his bare, unwashed hand and placed in the medication cup. e. Lipitor (for high cholesterol) 40 mg was popped into his bare, unwashed hand and placed in the medication cup. f. Losartan (antihypertensive) 100 mg was popped into his bare, unwashed hand and placed in the medication cup. g. Potassium ER (mineral supplement) 20 mEq (milliequivalents) was popped into his bare, unwashed hand. He broke the pill into 2 pieces and placed in the medication cup. h. Iron (mineral supplement) 9 mg was popped into his bare, unwashed hand and placed in the medication cup. i. Tylenol (pain reliever) 325 mg x 2 pills were popped into his bare, unwashed hand and placed in the medication cup. At 8:26, Michael indicated the resident liked the potassium broken into 2 pieces. 5. On 7/22/22 at 8:28 a.m., RN 14 did not wash or gel his hands and pulled medications for Resident 18. a. Tylenol 325 mg x 2 pills were popped into his bare, unwashed hand and placed in the medication cup.		provide ongoing training, oversight, resources, and competencies as needed based on the Observation Rounds Audit and QA tools identifying on-going areas of concern or not meeting threshold. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 6 weeks and until compliance is maintained. · Infection Control Hand Hygiene, Glucometer Use & Cleaning, Medication Administration tool will be completed daily by IP/designee x6 weeks and until compliance is maintained. · The IP/designee will be responsible for the completion of the Medication Administration Infection Control QA Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. · The facility will review,	

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	b. Allegra (for season allergies) 180 mg was popped into his bare, unwashed hand and placed in the medication cup. c. Aspirin (antiplatelet) 81 mg was popped into his bare, unwashed hand and placed in the medication cup. d. Calcium and Vitamin D3 (supplements) 600/400 mg was popped into his bare, unwashed hand, he broke the pill into 2 pieces, and placed in the medication cup. e. Vitamin D3 (supplement) 2000 units was popped into his bare, unwashed hand and placed in the medication cup. f. Clonidine (antihypertensive) 0.1 mg was popped into his bare, unwashed hand and placed in the medication cup. g. Desvenlafaxine (antidepressant) 25 mg was popped into his bare, unwashed hand and placed in the medication cup. h. Metformin 500 mg was popped into his bare, unwashed hand and placed in the medication cup. i. Lisinopril (antihypertensive) 30 mg was popped into his bare, unwashed hand and placed in the medication cup. j. Norvasc (antihypertensive) 10 mg was popped into his bare, unwashed hand and placed in the medication cup. k. Basaglar (insulin) 27 units was dialed into the insulin pen. He did not prime the needle before injecting the resident with insulin. On 7/22/22 at 8:42 a.m., RN 14 indicated he cleaned the glucometer with alcohol wipes when it was dirty. He should have cleaned it before and after using it. He indicated he should have washed or gelled his hands between residents and should not have popped the resident pills in his bare hands. On 7/22/22 at 1:33 p.m., the DON indicated during		update, and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	medication administration the nursing staff should have washed their hands between residents, Glucometer should have been cleaned before and after resident use, medications should have been dropped into the medication cup after being pushed out of the blister packet, not in the nursing staff hand, and if a pill was dropped on the medication cart it should have been destroyed. On 7/22/22 at 9:15 a.m., Executive Director (ED) indicated during medication administration, staff should have washed their hands between residents, the resident's pills should not have been popped into the nurse's hand from the medication blister pack, pills dropped on the medication cart should have been replaced. Insulin administration included cleaning the glucometer before and after use. On 7/27/22 at 9:58 a.m., the DON provided the initial nursing skills and validation check off lists for RN 14's orientation and education to the facility. Ten separate nursing skills and validation check off lists were provided. No check off list for nursing skills and validation was provided for giving insulin. A nursing skills and validation check off list, titled, "Glucose Meter Cleaning and Testing," dated 4/11/22, was signed off as completed by Licensed Practical Nurse (LPN) 7 and RN 14. It indicated RN 14's skills were validated to complete glucometer cleaning and testing. It specifically indicated to wipe the entire external surface of the glucometer with a germicidal wipe for 3 minutes and let it air dry on a clean surface before and after residential use. A nursing skills and validation check off list,			

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	titled, "Medication Pass Procedure," dated 4/11/22, was signed off as completed by LPN 7 and RN 14. It indicated RN 14's skills were validated to administer medications to residents. It specifically indicated to open medications without contaminating them and to destroy any dropped pills. A nursing skills and validation check off list, titled, "Hand Hygiene," dated 4/12/22, was signed off as completed by LPN 7 and RN 14. It indicated RN 14's skills were validated to complete appropriate hand hygiene. It specifically indicated there were times for hand hygiene; before and after touching a resident and their surroundings, before a clean or aseptic procedure, and after body fluid exposure risk. A current policy, titled, "Hand Hygiene Policy," dated 3/2018, was provided by the ED, on 7/22/22 at 1:55 p.m. A review of the policy indicated, " ...Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situation ...Indications for Hand-rubbing [sic] but not limited to ...Before the starting a medication preparation ...." A current policy, titled, "Medication Pass Procedure," dated 12/2016, was provided by the ED, on 7/22/22 at 9:15 a.m. A review of the policy indicated, " ...Medications are opened without contaminating ...dropped medication destroyed properly and documented per policy ...." A current policy, titled, "Blood Glucose Meter Cleaning/Disinfecting and Testing," dated 5/2021, was provided by the ED, on 7/22/22 at 1:55 p.m. A review of the policy indicated, " ...Perform hand hygiene. Place a paper towel, plastic cup, or other clean barrier on hard surface. Don gloves. Obtain			

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	germicidal wipe approved for the glucometer approved for use on glucometer ...Clorox Bleach Germicidal Wipes ...DO NOT use alcohol preps to clean glucometer, as they are not effective in killing bloodborne pathogens ...Proceed to resident room with cleaned meter ...." 3.1-18(a) 3.1-25(b)(1)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical			

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	contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on record review and interview, the facility failed to ensure a resident (Resident 18) was offered a pneumococcal vaccination for 1 of 5 residents reviewed for immunizations. Findings include: On 7/25/22 at 12:08 p.m., Resident 18's medical record was reviewed. She had admitted to the facility in 2018 and remained a long-term care resident with active	F 0883	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 18 was given pneumococcal vaccination on 8/11/22 per resident consent. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	08/31/2022

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	diagnoses which included, but were not limited to Schizophrenia, Type II Diabetes (an impairment in the way the body regulates and uses blood sugar), and age-related osteoporosis (a medical condition in which the bones become brittle and fragile). She had been offered and accepted the influenza vaccination each year since her admission. The record lacked documentation of consent for pneumococcal vaccination. During an interview on 7/25/22 at 1:00 p.m., the Regional Director of Clinical Services indicated she had double checked the resident's record and could not find documentation that the pneumococcal vaccination had been offered or given. At that time, she indicated it was facility policy to offer each resident the influenza and pneumococcal vaccination upon admission, annual, and as needed. 3.1-13(a)		**action(s) will be taken:** All residents have the potential to be affected Pneumococcal Vaccination audit was completed for all residents that currently reside in the facility by DNS/designee to ensure residents who consented to receive the vaccine, received the vaccine **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed nursing staff educated on Pneumococcal vaccination policy by DNS/designee. Any new admission/readmission will be offered the pneumococcal vaccine. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Resident Immunizations QA tool will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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F 0919 SS=D Bldg. 00	483.90(g)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. Based on observation and interview, the facility failed to ensure that 2 of 15 residents reviewed for functioning call lights (Resident 13 and Resident 261) had call lights that were within reach and functioning. Findings include: 1. On 7/20/22 at 7:25 a.m., Resident 261 was observed as she sat in bed with her eyes closed. Her call light was out of her reach and was on the floor. On 7/20/22 at 10:26 a.m., during a random observation, Resident 261's call light was on the floor. Resident 261 was unable to reach her call light to request assistance. A comprehensive review of Resident 261's clinical record indicated that she had the following diagnoses, but not limited to chronic respiratory failure, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, acute kidney failure, difficulty in walking, history of falling, pain in left ankle and joints of left foot, muscle weakness, and lack of coordination. Resident 261's care plan revealed a problem of "risk for falls," dated 7/11/22, with an intervention of "call light in reach," dated 7/11/22.	F 0919	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 13 & resident 261 call lights were fixed and placed in resident reach during survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected Audit of all call lights in resident rooms completed 8/2/22 to check for placement and functionality **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Call light rounding tool will be completed each shift daily 5 times per week x 4 weeks or until compliance is achieved. to ensure call lights are within reach and are functioning properly. All staff will be in-serviced on call	08/31/2022

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	2. During an observation and interview of Resident 13 on 7/20/22 at 7:25 a.m., the call light was pulled out of the wall outlet and was laying on the floor between the wall and bed. Resident 13 indicated the facility knew that it did not light up in the hallway. She would have her husband (Resident 12), who resided in the same room, and push his call light when she needed assistance. During an observation of Resident 13 on 7/20/22 at 10:29 a.m., the call light continued to lay on the floor between the wall and bed. During an observation of Resident 13 on 7/21/22 at 3:00 p.m., the call light remained on the floor. During an interview with the Director of Nursing Services (DNS) regarding the call light, at that time, the DNS indicated that Resident 13 should have had a working call light and should not have had to depend on Resident 12 to request assistance for her by initiating his call light. He would request to have Resident 13's call light addressed immediately. During an observation of Resident 13 on 7/22/22 at 9:27 a.m. Her call light was within reach and was functioning. The light in the hallway came on when the call button was pushed. On 7/22/22 at 11:00 a.m., a comprehensive review of Resident 13's medical record revealed the following diagnoses, but not limited to cerebral palsy, repeated falls, chronic obstructive pulmonary disease (COPD), rheumatoid arthritis, contracture of muscles, shortness of breath, restless leg syndrome, congestive heart failure, muscle weakness, and poor posture. Resident 13's care plan indicated a problem, "at		lights being in reach and ensuring they are functioning. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Call light audit tool will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	risk for falls," with an initiation date of 11/10/2019, and an intervention "keep call light within reach," with a date of 1/21/20. On 7/26/22 at 11:20 a.m., the Director of Nursing (DON) indicated the facility did not have a policy for call lights. All residents should have had functioning call lights within the reach of residents. 3.1-19(u)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00385451. Complaint IN00385451 - Unsubstantiated due to lack of evidence. Survey dates: July 26 and 27, 2022. Facility number: 000538 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 9, 2022.	R 0000		
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in			

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	advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure in-service education and training related to Residents' Rights, abuse, and dementia was provided and documented for 2 of 5	R 0120	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	08/31/2022

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	employees' records reviewed for current in-service training. This deficient practice had the potential to effect 24 of 24 residents who resided in the assisted living facility. Findings include: On 07/27/22 at 10:30 a.m., a review of the facility personal records was conducted from a random sample of 5 current employees. 1. Registered Nurse (RN) 23's hire date was listed as 8/8/18. RN 23's employee Course Completion History record indicated she last completed training for abuse on 1/25/21, there was no education (prior to start of the survey) for Residents' Rights or dementia. 2. Licensed Practical Nurse (LPN) 24's hire date was listed as 11/13/20. LPN 24's employee Course Completion History record indicated she last completed training (prior to the start of the survey) for Resident Rights on 4/1/21 and had completed one (1) portion of the dementia training on 6/21/22 but had not met the full requirement for hours. On 7/27/22 at 11:00 a.m., during an interview, the Assisted Living General Manager (GM) indicated they had been trying to reach employees to have them complete their online training. She was aware some were not current. On 7/27/22 at 11:40 a.m., the GM provided a current policy, dated 11/15, and titled, "In-Service Education." This policy indicated, "The frequency and content of in-service education and training programs shall be in accordance with the skills and knowledge of the community personnel...For nursing personnel this shall include at least eight		· RN 23 has completed in-service education and training related to Residents' Rights, abuse, and dementia. · LPN 24 has completed in-service education and training related to Residents' Rights, abuse, and dementia. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · The General Manager/designee will complete an audit of all personnel educational records to ensure that all personnel have completed in-service education and training related to Residents' Rights, abuse, and dementia per facility policy by August 31, 2022. · The General Manager and Clinical Director will be in-serviced by Corporate Consultant on the Educational In-services and Training policy including record keeping and auditing by August 31, 2022. · All staff will be in-serviced on the requirements of abuse, resident rights, and dementia training per the Educational In-Services and Training policy by the General Manager/designee by August 31, 2022	

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	(8) hours of in-service per calendar year and four (4) hours of in-service per calendar year for non-nursing personnel...In addition to the above required in-service hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia specific training within six (6) months of hire and three (3) hours annually thereafter to meet the needs or preference, or both, of the cognitively impaired residents effectively and to gain understanding of their current standards of care for residents with dementia...All staff shall have training upon hire and annually thereafter which includes, but not limited to: Patient Rights...abuse...."		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The General Manager and Clinical Director will be in-serviced by Corporate Consultant on the Educational In-services and Training policy including record keeping and auditing by August 31, 2022. · The General Manager/designee will audit the personnel educational records monthly to ensure that all personnel have completed in-service education and training related to Residents' Rights, abuse, and dementia per facility policy. · All staff will be in-serviced on the requirements of abuse, resident rights, and dementia training per the Educational In-Services and Training policy by the General Manager/designee by August 31, 2022 · Education and training on abuse, and resident rights will be completed with general orientation for newly hired employees and verified using the General Orientation Acknowledgment Form and comparing to the new hire employee roster weekly. · The Clinical Director/designee will run reports from the Learning Management	

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			System monthly to verify that they 6 hours of initial dementia training was initiated upon hire and completed within 6 months. Any staff member who has not completed the training within the specified time frame will be removed from the schedule. · The annual in-service calendar will be updated to include annual in-service education and training related to Residents' Rights, abuse, and dementia offered on specific months in the Learning Management System for consistency of auditing and tracking purposes by the Corporate Consultant by August 31, 2022 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Educational Inservice and Training QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the General Manager/Executive Director. ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation and interview, the facility failed to monitor equipment temperatures for the dishwasher, freezer, and two refrigerators (coolers) in the kitchen (produce cooler and dairy cooler) and ensure dietary staff in the kitchen wore hair restraints. This deficient practice had the potential to effect 24 of 24 residents who resided on the Assisted Living. Findings include: During a kitchen tour with Dietary Aide (DA) 6, on 7/20/22 at 6:35 a.m., the following observations were made: a.) The produce cooler temperature with the last documented temperature on the log for 7/14/22 at 7:00 p.m. at which time the temperature was recorded as 40 degrees. b.) The dairy cooler temperature log was observed. The temperature was last documented on 7/14/22 at 7:00 p.m. The temperature documented was 40 degrees. c.) The freezer temperature log was observed. The temperature was last documented on 7/14/22 at 7:00 p.m. It was documented at zero degrees. The dishwasher temperature log was observed. The last temperatures for the dishwasher were obtained on 7/15/22. DA 6 checked the temperatures. The temperature was 170 degrees. DA 6 indicated the temperatures should have	R 0145	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The produce cooler temperature was taken and recorded. No corrective action was required. · The dairy cooler temperature was taken and recorded. No corrective action was required. · The freezer temperature was taken and recorded. No corrective action was required. · The dishwasher temperature log was taken and recorded. No corrective action was required. · DA 21 was educated on the use of hair restraints. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · An audit will be completed by the General Manager/designee by August 31, 2022 to identify all	08/31/2022

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	been obtained two times daily for the equipment and sometimes people forgot, on the weekends too. On 7/26/22 at 11:50 a.m., DA 21 was observed in the kitchen without a hairnet on. The dietary aid immediately placed a hairnet on. A policy titled, "Food Temperatures," dated 2/02, with a revision date of 6/21, provided by the ED on 7/22/22 at 11:59 a.m., indicated, " ...hot food will be held at or above 135 degrees Fahrenheit. If minimum temperature requirements are not maintained, food will need to be reheated to a minimum of 165 degrees Fahrenheit before serving...." A policy titled "Cleaning Dishes and Dish Machine," with a date of 10/17, provided by the ED on 7/26/22 at 10:40 a.m., indicated, " ...Check the temperature and pressure. Follow manufacturers' recommendations (see chart below) ...." There was no mention of how often to obtain and document the temperatures of the dishwasher. A policy titled, "Food Storage," with a date of 2/02 with a revision date of 6/21, indicated, " ...Thermometers should be checked utilizing an internal thermometer at least two times each day ...."		equipment in the culinary department that requires temperature monitoring and ensure there is a correct temperature log present. · An in-service will be conducted for culinary department on Culinary Personal Hygiene and Recording Temperatures policies including temperature logs, frequency of monitoring and corrective action by the General Manager/designee by August 31, 2022. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be conducted for culinary department on Culinary Personal Hygiene and Recording Temperatures policies including temperature logs, frequency of monitoring and corrective action by the General Manager/designee by August 31, 2022. · The General Manager/designee will complete a daily audit of all identified culinary equipment that requires temperature monitoring to ensure that it was completed per policy using the temperature log observation audit tool. · The General Manager designee will complete a Meal/Kitchen observation tool every meal to ensure that culinary	

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			staff are wearing hair restraints properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Meal and Kitchen Observation QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the General Manager/Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
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 distribute food to residents in a sanitary manner for 2 of 2 random dining observations. This deficient practice had the potential to effect 22 of 24 residents who received dining services in the dining room. Findings include: On 7/26/22 at 11:10 a.m., during a random dining	R 0273	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Dietary Aid 20 was educated by the Culinary Manager on how to properly restrain hair, on safe food handling standards including covering food transported from the kitchen, serving food in	08/31/2022

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	observation, Dietary Aid (DA) 20 was observed preparing to serve lunch and passing ice water to residents in the assisted living dining room. She had a bouffant cap covering a large bun (hair style) on the top of her head. The back and sides of her hair were not contained in a hair restraint. DA 20 passed from the dining room to the kitchen frequently during the observation. On 7/26/22 at 11:25 a.m., DA 20 was observed as she transported bowls of creamed broccoli soup through the dining area on an open sided three (3) tier cart. The individually dipped bowls of soup were uncovered and traveled throughout the dining room from table to table as she offered it and served each resident. On 7/26/22 at 11:32 a.m., DA 20 brought plated food from the kitchen on the open sided three (3) tier cart. The cart contained uncovered chef salads with breadsticks, on plates, and individual bowls of mixed berries. The fluted bowls of berries had drink cup lids lying inside the top of the bowl with edges inside and touching the fruit. The lids were smaller than the bowl rim. DA 20 wheeled the cart throughout the dining room, where she stopped at each table and served salads to the residents. As she removed the salad plates from the cart her thumbs touched the inside surface of the plates. On 7/26/22 at 11:38 a.m., the Executive Director (ED) was observed as he put on a bouffant cap and entered the kitchen. On 7/26/22 at 11:40 a.m., an unidentified late arrival to the dining room was served a bowl of soup and a plate of chef salad, carried from the kitchen by DA 20. As she carried the bowl and plate, uncovered through the dining room, to the		sanitary manner, and hand hygiene. Dietary Aid 20 had a hand hygiene skill competency completed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practices. · Culinary staff will be in-serviced on the Hand Hygiene, and General Food Preparation and Handling policies by the General Manager/designee by August 31, 2022 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Culinary staff will be in-serviced on the Hand Hygiene, and General Food Preparation and Handling policies by the General Manager/designee by August 31, 2022 · The General Manager/designee will make observations daily during all meals to ensure that culinary staff's hair covered in hair restraint, food coming from the kitchen is covered properly, food is served in a sanitary manner, and hand hygiene occurs per policy using the meal service observation tool.	

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	resident, her thumbs rested on the inner surface of the bowl and plate. During the meal service, from 11:10 a.m. to 11:40 a.m., DA 20 did not wash or sanitize her hands at any time. On 7/26/22 at 11:43 a.m., DA 20 was observed wiping down the surfaces of the counter tops adjacent to the dining area. She took a wet cloth from a red cleaning bucket and wiped down the cart and other counter surfaces. On 7/26/22 at 11:46 a.m., DA 20 walked to the sink, turned on the faucet, put soap on her hands from the dispenser rubbed hands together under the water for 4 seconds, turned faucet off with bare hands then took towels from the dispenser. DA 20 walked into the dining area with paper towels in hand (drying hands) and served additional coffee to an unidentified resident. On 7/26/22 at 12:00 p.m., during an interview the ED indicated he had spoken to DA 20 about her hair, during the dining observation. She had put a hair net with a hole in it over her head (back and sides) and wore the bouffant cap to cover her bun on top. She should have not touched the inner rims of plates and bowls with her thumbs, during serving and the food should have been covered. On 7/27/22 at 11:40 a.m., during a second random dining observation, DA 20 was observed as she wheeled a three (3) tier, open sided, cart throughout the dining room. The cart contained plated sandwiches on toast and deviled eggs. The food was not covered. All of the residents in the dining room were served from the cart. On 7/27/22 at 2:48 p.m., the ED provided a current		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Meal and Kitchen Observation QA tools will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the General Manager/Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	policy, dated 11/15, titled, "Hand Washing." This policy indicated, "An essential component of infection control is hand washing...duration of the entire procedure 40-60 seconds...use towel to turn off the faucet...." On 7/27/22 at 2:48 p.m., the ED provided a current policy, dated 10/17, titled, "General Food Preparation & Handling." This policy indicated "Food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and be free of injurious organisms and substances...Prepared foods will be transported to other areas in covered containers...Handle utensils, cups, glasses, and dishes in such a way as to avoid touching surfaces with which food or drink will come in contact ...."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility failed to ensure a resident's medication had a correct medication label with the physician's current order for 1 of 3 residents reviewed for medication administration (Resident 8). Findings include: On 7/27/22 at 10:43 a.m., the Residential 600 Hall medication cart was reviewed. On 7/27/22 at 12:01 p.m., Resident 8's bottle of	R 0300	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 8's bottle of carbamide peroxide has been destroyed per policy and medications are labeled and administered as ordered. · Residential 600 hall cart was audited, and all medications have correct label and with the current physician's order.	08/31/2022

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	carbamide peroxide 6.5% was observed. The pharmacy label, dated 4/1/22, indicated to give one drop in both ears, twice a day for 7 days. The bottle had an open date of 6/24/22 and did not have a manufacturer's expiration date on it. On 7/27/22 at 12:04 p.m., Resident 8's Medication Administration Record (MAR) was reviewed with Licensed Practical Nurse (LPN) 21. She indicated the order for Resident 8 to receive the carbamide peroxide 6.5% was hand-written on 3/31/22 at the end of the March MAR. She said the order did not transfer over to the April MAR and the physician ordered medication was not given. The resident should have received the medication from 4/1/22 to 4/7/22 prior to going to the doctor to get her ears cleaned out. It should have been destroyed after the medication administration was completed. Instead, it was used for a new physician order for 4 drops in each ear Mondays, Wednesdays, and Fridays. On 7/27/22 at 11:24 a.m., the Clinical Support (CS) staff indicated the first bottle of carbamide peroxide 6.5% should have had a change of directions sticker on it. She indicated the staff should have been following Medication Administration Record (MAR) for the physician ordered dosage of carbamide peroxide 6.5% for 4 drops in each ear on Mondays, Wednesdays, and Fridays. On 7/27/22 at 1:58 p.m., the Residential Clinical Director (RCD) indicated Resident 8 should have received the ordered medication. A current policy, titled, "Suggested Medication Administration Procedures," dated 9/1/10, was provided by the Clinical Support (CS) staff, on 7/27/22 at 12:41 p.m. A review of the policy		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents that received medication have the potential to be affected by the alleged deficient practice. · An in-service on Medical Labels, and General Dose Preparation and Medication Administration policies will be given to all licensed nurses and QMAs by the Clinical Director/designee by August 31, 2022. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service on Medical Labels, and General Dose Preparation and Medication Administration policies will be given to all licensed nurses and QMAs by the Clinical Director/designee by August 31, 2022. · Medication cart audits will be done daily to ensure that all medications are correctly labeled with current physician's orders, date medication opened, and that there are no expired medications on the medication cart by the Clinical Director/designee. · The Clinical Director/designee will make	

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	indicated, " ...Residents' rights and dignity must be preserved during medication administration/observations...."		medication pass observations on all shifts to ensure that medications are administered per physician's orders using the nurse rounds audit tool. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Medication Storage/Administration QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of.			

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	(6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, interview, and record review, the facility failed to ensure expired medications were destroyed, and failed to ensure medications were not given from a discontinued medication bottle for a new physician's order for 2 of 3 residents reviewed for medication storage in the 600 hall medication cart (Residents 8 and 3). Findings include: On 7/27/22 at 10:43 a.m., the Residential 600 Hall medication cart was reviewed. 1. On 7/27/22 at 10:46 a.m., Licensed Practical Nurse (LPN) 21 indicated Resident 8's Murine Ear Wax Removal system (carbamide peroxide) 6.5% was unopened in the medication cart. The nursing staff had been using the other discontinued bottle of carbamide peroxide 6.5%. The bottle did not have a manufacturer's expiration date on it. The nursing staff should have been using the correct medication bottle because the orders were different. The discontinued, with no expiration date, bottle indicated to give one drop in each ear twice a day for 7 days. The current order was to give 4 drops in each ear on Mondays (M), Wednesdays (W), and Fridays (F). On 7/27/22 at 11:24 a.m., the Clinical Support (CS) staff indicated the first bottle of carbamide peroxide 6.5% should have had a change of directions sticker on it. She indicated the staff should have been following Medication Administration Record (MAR) for the physician	R 0306	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 8 carbamide peroxide 6.5% was destroyed per policy. · Resident 3 Travoprost 0.004% eye drops were reordered and opened bottle was destroyed per policy. · Resident 8 receives medication per physician's order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · The Clinical Director/designee will complete an audit of all medication carts, and medication refrigerators to ensure that all opened medications are not expired and have the date opened and/or expiration date on each open medication by August 31, 2022. · An in-service on General Dose Preparation and Medication Administration policy will be given to all licensed nurses and QMAs by the Clinical Director/designee by August 31, 2022.	08/31/2022

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	155620	A. BUILDING 00 B. WING	07/27/2022

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	ordered dosage of carbamide peroxide 6.5% for 4 drops in each ear on M W F. On 7/27/22 at 1:58 p.m., the Residential Clinical Director (RCD) indicated Resident 8 should have received the ordered medication. 2. A review of Resident 3's Travoprost 0.004% indicated to give 1 drop in each eye daily at 5:00 p.m. There was no open date on the bottle. It came from pharmacy on 6/22/22. LPN 21 indicated it was expired because eye medications were only good for 28-30 days. On 7/27/22 at 11:21 a.m., the Residential Clinical Director (RCD) indicated eye drops were good for 30 days. On 7/27/22 at 11:24 a.m.., the CS staff indicated whatever date Resident 3's Travoprost arrived from the pharmacy would be consider the open date for the medication if an open date was not on the bottle. A current policy, titled, "Common Medication Storage Guidance and Terminology," dated 9/1/10, was provided by the Clinical Support (CS) staff, on 7/27/22 at 12:41 p.m. A review of the policy indicated, " ...Expiration or expiry date: The date up to which a product is expected to remain usable ...." A current policy, titled, "Medication Storage Guidance," dated 9/1/10, was provided by the Clinical Support (CS) staff, on 7/27/22 at 12:41 p.m. A review of the policy indicated, " ...Ophthalmic (eye) Products ...Date when opened and discard unused potion after 28 days ...." A current policy, titled, "Storage and Expiration		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service on General Dose Preparation and Medication Administration policy will be given to all licensed nurses and QMAs by the Clinical Director/designee by August 31, 2022. · The Clinical Director/designee will complete medication cart/storage area audits daily to ensure that all medications have a date that they were opened, or expiration date listed on the medication. · Medication Storage Guides will be placed at the nurses' station and in the medication cart/24 hour books as a reference for clinical staff. · The Clinical Director/designee will make medication pass observations on all shifts to ensure that medications are administered per physician's orders, and that there are no expired medications administered to residents using the nurse rounds audit tool. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	Dating of Medications, Biologicals," dated 8/1/18, was provided by the Clinical Support (CS) staff, on 7/27/22 at 12:41 p.m. A review of the policy indicated, " ...The Community should ensure that medications and biologicals have an expiration date on the label; have not been retained longer than recommended...."		·Medication Storage/Administration QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to ensure medications were provided to the resident in a sanitary manner for 1 of 5 observed medication administrations (Resident 22). Findings include: On 7/27/11 at 12:20 p.m., Licensed Practical Nurse (LPN) 21 popped two Tylenol 325 mg pills into a medication cup for Resident 22. They were	R 0407	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 22 had no negative outcome and receives medication in a sanitary manner. · LPN 21 received education on handling medication in a sanitary manner and the proper	08/31/2022

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	accidentally spilled onto the medication cart, she used a spoon and put them back into the medication cup. On 7/27/22 at 12:28 p.m., Resident 22 was observed swallowing them. On 7/27/22 at 12:32 p.m., LPN 21 indicated she should have had replaced the dropped medications with new ones. On 7/27/22 at 12:34 p.m., the Executive Director (ED), over both and Long Term Care (LTC) residents and the Assisted Living (AL) residents indicated the pills should not have been administered to the resident. On 7/27/22 at 12:35 p.m., the AL Clinical Support (CS) staff indicated the medications should have been wasted, and new medications pulled for the resident. A current policy, titled, "General Dose Preparation and Medication Administration," dated 9/1/10, was provided by the Clinical Support (CS) staff, on 7/27/22 at 12:41 p.m. A review of the policy indicated, " ...staff should follow the Community's infection control policies ...The Community staff should not touch the medication when opening a bottle or unit dose package ...."		process when a medication is dropped. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents receiving medication have the potential to be affected by the alleged deficient practice. · All licensed nurses and QMAs will be in-serviced on the General Dose Preparation and Medication Administration policy including discarding medication that is dropped out of its protective container per the drug destruction policy by the Clinical Director/Designee by August 31, 2022. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All licensed nurses and QMAs will be in-serviced on the General Dose Preparation and Medication Administration policy including discarding medication that is dropped out of its protective container per the drug destruction policy by the Clinical Director/Designee by August 31, 2022. · The Clinical Director/designee will make random observations daily during	

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			medication administration using the Nurse Rounds Observation Tool to ensure that any medication that is dropped is not administered and disposed of per policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Medication Storage/Administration QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the General Manager/Executive Director. ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	