DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a Residential State Licensure Survey and the Investigation of Complaints IN00395024, IN00394445, IN00392599, IN00392510, IN00392529, IN00392595, IN00392402, IN00391839, IN00390635, IN00390450, IN00387827, IN00386790, IN00384259, IN00384273, IN00384278, IN00383869, and IN00383799. Complaint IN00395024 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00394445 - Substantiated. State deficiencies related to the allegations are cited at R0297. Complaint IN00392599 - Substantiated. State deficiencies related to the allegations are cited at R0297 and R0240. Complaint IN00392510 - Substantiated. State deficiencies related to the allegations are cited at R0297, R0240, and R0349. Complaint IN00392529 - Unsubstantiated due to lack of evidence. Complaint IN00392595 - Substantiated. State deficiencies related to the allegations are cited at R0297. Complaint IN00392402 - Substantiated. State deficiencies related to the allegations are cited at R0297. Complaint IN00391839 - Substantiated. No deficiencies related to the allegations are cited.	R 0000	This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Heritage Woods of Newburgh respectfully requests consideration for a desk review of this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Creel	Administrator	12/18/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Complaint IN00390635 - Substantiated. State deficiencies related to the allegations are cited at R0349.

Complaint IN00390450 - Substantiated. State deficiencies related to the allegations are cited at R0240 and R0297.

Complaint IN00387827 - Substantiated. State deficiencies related to the allegations are cited at R0036, R0297, and R0407.

Complaint IN00386790 - Substantiated. State deficiencies related to the allegations are cited at R0273.

Complaint IN00384259 - Substantiated. State deficiencies related to the allegations are cited at R0297.

Complaint IN00384273 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00384278 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00383869 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00383799 - Unsubstantiated due to lack of evidence.

Survey dates: November 14, 15, 16, 17, 18, & 21, 2022

Facility number: 014377

Residential Census: 121

These State Residential Findings are cited in

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	accordance with 410 IAC 16.2-5. Quality review completed on December 2, 2022.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.			
	Based on observation, interview, and record review, the facility failed to ensure residents, resident representatives, and families were notified of suspected or confirmed COVID-19 cases in the facility during 3 of 6 days during the survey. (Resident L, Resident C, Resident H) Finding includes: During an interview on 11/17/22 at 1:20 P.M., CNA 8 indicated that Resident L had tested positive for COVID -19. During an observation on 11/17/22 at 1:30 P.M., Resident L's room door had a sign posted that the resident was on contact/droplet isolation precautions for 10 - 14 days. During an observation on 11/17/22 at 2:00 P.M., the main entrance to the facility did not have signage indicating there was a positive case of COVID-19 in the facility.	R 0036	1. **The administrator placed signage at the Main Entrance, the morning of 11/18/22 before beginning her workday. The administrator placed a message informing of COVID in the facility via Care Merge communication system to all residents and family. Signage had been placed at the main table in the foyer as you walk into the facility on 11/17/22.** **2. All residents and visitors had the potential to be affected by the lack of signage on the main entrance.** **Administrator reviewed the new guidelines with the Director of Nursing and will follow them with each outbreak in the future.**	12/23/2022

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	During an observation on 11/18/22 at 8:30 A.M., the main entrance to the facility did not have signage indicating there was a positive case of COVID-19 in the facility. During record review on 11/18/22 at 10:30 A.M., Resident L's nurses note dated 11/18/22 at 9:55 A.M., included, "resident returned from ER [Emergency Room] 11/17/22 COVID positive resident put in quarantine in residents room with isolation precautions..." During an interview on 11/18/22 at 9:16 A.M., Resident C indicated the facility usually informed residents of COVID-19 during meals or via a letter in their mailbox. Resident C indicated she has not heard of any recent COVID-19 cases in the facility. During an interview on 11/18/22 at 9:30 A.M., the Facility Administrator indicated Resident L had went out to the hospital on 11/16/22 and tested positive for COVID-19, then returned to the facility that night. During an interview on 11/8/22 at 1:25 P.M., Resident H indicated they had heard from other residents that someone had tested positive for COVID-19, but that no one from the facility had informed them. During an interview on 11/18/22 at 2:43 P.M., the Facility Administrator indicated they have been letting visitors and residents know of the COVID -19 positive case in the facility by word of mouth. The Administrator indicated they were not trying to hide the positive case and were alerting people when asked. On 11/18/22 at 2:40 P.M. the Facility Administrator supplied an updated facility packet titled, New		**3.** All department heads will be in serviced by the Administrator, DON, or designee on the new COVID Guidelines including communication to staff, residents, family, and visitors. Communication will include signage at the entrance, at the table in the facility foyer, at each door with a COVID infected individual, also an isolation cart at each door of a COVID infected individual, signage at the timeclock in the breakroom. A message via care merge system to all residents and families. 4. The DON/Administrator will monitor the signage to communicate COVID is in the building daily while COVID outbreak is in the building. The DON/Administrator will monitor the signage to communicate transmission levels and community levels weekly when facility is free of COVID. All findings will be reported to the QA Committee monthly.	

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	COVID Guidance, dated 11/16/22. The guidance included, "...Outbreak Considerations. Post signage that you have COVID-19 illness in the facility." This Residential tag relates to complaint IN00387827.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on an interview and record review, the facility failed to ensure a First Aid certified staff member was present on all shifts for 2 of 7 days reviewed.	R 0117	1. **The administrator reviewed the schedule and pay sheets for the noted dates of 11/8/22 and 11/11/22 and found the proper coverage for each of**	12/23/2022

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	Finding includes: On 11/17/22 at 1:00 P.M., the staffing schedules were reviewed for 11/8/22 through 11/14/22. The staffing schedule lacked a First Aid certified staff member for the following dates: 11/8/22 night (6:00 P.M. - 6:00 A.M.) 11/11/22 night (6:00 P.M. - 6:00 A.M.) During an interview on 11/18/22 at 2:18 P.M., the Administrator indicated that she was unsure if a First Aid certified staff member had to be in the building at all times. During an interview on 3/22/22 at 3:05 P.M., the Regional Nurse Consultant indicated there should be someone in the building at all times that was First Aid certified. On 11/21/22 at 9:45 A.M., a CPR and First Aid Certifications policy, dated 9/2021, was provided and indicated, "...It is the responsibility of the Director of Nursing or designee to ensure at least one on-duty employee has current CPR & First Aid Certifications at all times..."		**these days and the shifts of 6pm to 6am. NO DEFICIENCY WAS FOUND.** **2. All residents had the potential to be affected but were not affected as there was coverage during the dates/times noted.** **3.** Facility will provide CPR/First Aide training to all Nurses and QMA's. 4. The DON will continue to complete the schedule with the coverage in mind that all shifts must have a CPR/First Aide qualified individual at all time per shift. An audit will be completed of current nurse and QMA's not certified, and training will be scheduled. All new hires will that are not certified with CPR/First Aide will be scheduled for the next class for CPR/First Aide training.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure residents that required assistance with bathing received at least 2 baths or showers weekly for 3 of 4 residents reviewed for assistance with ADL's (activities of daily living). Residents did not receive showers on their scheduled	R 0240	1. **Director of Nursing reviewed shower days and times with residents affected. All residents affected received showers upon their next scheduled shower day.**	12/23/2022

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	bathing days. (Resident C, Resident J, Resident B) Findings include: 1. During an interview on 11/15/22 at 8:53 A.M., Resident C indicated she has had an ongoing problem with receiving showers on her shower days. Resident C indicated she only receives showers once a week and has voiced her concern with the Director of Nursing (DON), and her issue has still not been resolved. During record review on 11/14/22 at 1:48 P.M., Resident C's Level of Service Assessment/ Evaluation dated 10/22/22, indicated, "...Bathing ...is highly involved in the activity but requires assistance with minimal parts of bathing, i.e., wash back, feet, rinse hair, etc. Includes person who cannot get into the bathtub/shower and may require some other standby assistance and/or bathing equipment..." Resident C's scheduled shower days were Wednesday and Saturday evenings. Resident C's documented bathing schedule during October and November, 2022 lacked showers or baths on the following dates; 10/8/22 (Saturday), 11/5/22 (Saturday) , 11/12/22 (Saturday) , and 11/16/22 (Wednesday). 2. On 11/16/22 at 11:30 A.M., Resident J indicated they had not received their scheduled shower the day prior. During record review on 11/16/22 at 11:00 A.M., Resident J's Level of Service Assessment/ Evaluation dated 6/3/22, indicated, "...Bathing ...physical help in transfer or in performing part of the bathing activity.		**2. All residents had the potential to be affected but were not affected as there was coverage during the dates/times noted.** **3.** Shower tasks reviewed in electronic record and any missing shower tasks were added by nursing director and/or designee. Inservice will be completed by December 23, 2022 by Director of Nursing for all nursing staff on use of electronic medical record for identifying daily tasks and documentation of completed/refused tasks. Director of Nursing will audit task documentation daily x 2 weeks, then weekly x 6 months. 4. Audits will be reviewed by monthly QA committee for 6 months; QA committee will make recommendations as needed.	

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Resident J's scheduled shower days were Tuesday and Friday evenings.

Resident J's documented bathing schedule during October and November, 2022 lacked showers or baths on the following dates; 10/4/22 (Tuesday), 10/14/22 (Friday), 11/1/22 (Tuesday), 11/4/22 (Friday), and 11/15/22 (Tuesday).

3. During record review on 11/14/22 at 1:00 P.M., Resident B's Level of Service Assessment/ Evaluation dated 6/8/22, indicated, "...Bathing ...physical help in transfer or in performing part of the bathing activity.

Resident B's scheduled shower days were Sunday and Thursday days.

Resident B's documented bathing schedule during October and November, 2022 lacked showers or baths on the following dates; 10/9/22 (Sunday), 10/13/22 (Thursday), 10/23/22 (Sunday), 10/27/22 (Thursday), 10/30/22 (Sunday), and 11/10/22 (Thursday).

During an interview on 11/17/22 at 12:45 P.M. CNA 5 indicated residents who require assistance with bathing should be assisted twice a week on their scheduled shower days. If residents refuse their shower or a shower is not given, staff should document why the shower was not given.

On 11/21/22 at 9:45 A.M., the Facility Administrator supplied an undated facility policy titled, Bath/Shower. The policy included, "...It is the policy of this community to provide physical assistance to residents in accordance with the resident's service plan. This service will be entered on the CNA worksheet, individualized

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	service plan and weekly shower schedule..." This Residential tag relates to Complaints IN00390450, IN00392510, and IN00392599.			
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, and record review, the facility failed to ensure food was stored and distributed in accordance with professional standards for food service safety during 2 of 2 kitchen observations of the and 1 of 1 meal services observed. Food was not labeled and dated, food was left open to air, an ice scoop was stored in the ice machine, and staff did not perform proper hand hygiene during meal service. Finding includes: During the initial tour of the kitchen on 11/14/22 at 9:19 A.M., the following was observed: Dry storage: An open bag of wide noodles, undated An open bag of premium rice, undated An open bag of nachos, dated 10/22 Refrigerator: A full can of shredded sauerkraut with the lid removed and sauerkraut was open to air. Freezer: A clear bag of sausage links sitting in a cardboard box open to air, undated. A clear bag of pork patty fritters sitting in a	R 0273	b="">1. No residents were affected by the alleged deficient practice. **2. All residents had the potential to be affected by the alleged deficient practice.3. In-Service completed by Dietary Manager with all kitchen staff. In service topics will include proper food storage including labeling and dating, hand hygiene, and proper storage of the ice scoop. All new hires in the culinary department will be trained on these topics upon onboarding.4. The Culinary Manager, or designee, will audit staff hand hygiene daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months. The Culinary Manager, or designee, will audit dry storage and walk ins daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months to ensure no food**	12/23/2022

cardboard box open to air, undated.
A clear bag of dough puff sitting in a cardboard box open to air, dated 7/15.
A clear bag of pasta shell sitting in a cardboard box, undated.

Ice Machine:
The ice scoop was resting on top of the ice in the ice machine.

During an observation on 11/14/22 at 11:15 A.M., cook 1 was observed to lather his hands for 3 seconds. Cook 1 obtained gloves, placed a hamburger on a bun, picked up a slice of cheese, tomatoes, onions, and pickles and placed them on the hamburger with his hands and failed to change gloves. Cook 1 was observed to touch the above items throughout the entire meal preparation and never changed gloves.

During an interview on 11/18/22 at 10:28 A.M., the Dietary Manager indicated food should not be open to air and should be placed in a bag that can be sealed and dated with the date the item arrived at the facility, date the item was opened, and the expiration date of the item. The ice scoop should be stored in a container on the side of the ice machine or on the hook on the ice machine. At that time, she also indicated you should sing the happy birthday song three times when hands are lathered during hand washing.

On 11/21/22 at 8:47 A.M. the Facility Administrator supplied an undated facility policy, titled Dry Food Storage. The policy included, "...Food, whether raw or prepared, if removed from the container or package in which it was obtained it shall be in a clean, covered container ...Container covers shall be resistant and nonabsorbent ...The delivery date shall be written

is left open to air in these areas. The Culinary Manager, or designee, will audit the ice machine daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months to ensure proper storage of the ice scoop. The results of the audits/reviews will be discussed at the monthly Quality Improvement Meeting monthly for 3 months and then quarterly thereafter once compliance is 100%. =""
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	or identified on each product..." On 11/21/22 at 10:05 A.M., the Facility Administrator supplied an undated facility policy, titled Hand Hygiene. The policy included, "...All personnel must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water ...before and after eating or handling food..." This Residential tag relates to Complaint IN00386790.			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.			
	Based on interview and record review, the facility failed to ensure medications were available for administration as prescribed by the physician for 5 of 7 residents reviewed for medications. Residents did not receive medications as ordered. (Resident L, Resident J, Resident D, Resident H, and Resident K) Findings include: 1. During an interview on 11/18/22 at 10:00 A.M., Resident L indicated they were not receiving some of their medications. During record review on 11/18/22 at 10:30 A.M, Resident L's diagnoses included, but were not limited to, polyneuropathy, chest pain, and general anxiety.	R 0297	b="">1. No residents were affected by the alleged deficient practice. **2. All residents had the potential to be affected by the alleged deficient practice.3. In-service training for the nursing staff to be completed by the Director of Nursing by December 23, 2022. All new nursing staff hires will be trained during onboarding by the Director of Nursing on the policy for med administration and documentation.4. Administrator /Director of Nursing or designee will audit eMAR**	12/23/2022

Resident L's physician orders included, but were not limited to; hydrocodone-acetaminophen 7.5-325 mg (milligrams) 1 tablet every 6 hours (started 5/11/22) and Aspercreme lidocaine 4% patch apply 1 patch every morning and remove after 12 hours every evening (started 2/4/22).

Resident L's MAR (medication administration record) for the months of November and October, 2022, the facility failed to provide the following medications on the following dates and times:
Hydrocodone-acetaminophen 7.5-325 mg
10/27/22 at 12:00 A.M. - no documentation
11/2/22 at 6:00 P.M. - "Missed - Too close to when she took noon meds [sic]"
11/4/22 at 6:00 P.M. - no documentation
11/7/22 (no time documented) - "Missed"
11/11/22 at 12:00 P.M. - "Other - Resident states that [family] is picking up medication..."
11/14/22 at 6:00 P.M. - no documentation

Aspercreme lidocaine 4% patch
10/1/22 through 10/19/22 - "Not available"
10/22/22 - "Resident out of medication"
10/23/22 - "Not available"
10/27/22 through 10/29/22 - "Not available"
11/1/22 through 11/6/22 - "Not available"
11/10/22 - "Not available"
11/14/22 - 11/16/22 - "Not available"

2. During record review on 11/16/22 at 11:00 A.M., Resident J's diagnoses included Parkinson's disease.

Resident J's physician orders included, but were not limited to; Oxycodone-acetaminophen 7.5 - 325 mg 1 tablet 4 times daily (started 11/4/22), Trazodone 100 mg 1 tablet at bedtime (started 5/3/22), and Oxycodone 5 mg 1 tablet every 6

documentation to ensure appropriate documentation and administration of meds. Audit of eMAR will be daily for 1 week, then 5 times a week for 4 weeks, then weekly for 3 months. The results will be discussed at the monthly QA meeting monthly for 3 months and then quarterly thereafter once compliance is 100%.=""
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

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hours (started 10/5/22 - discontinued 11/4/22).

Resident J's MAR for the months of November and October, 2022, the facility failed to provide the following medications on the following dates and times:
Oxycodone-acetaminophen 7.5 - 325 mg
11/4/22 at 4:00 P.M. - "Not available"
11/4/22 at 8:00 P.M. - "Not available"
11/5/22 at 8:00 A.M. - "Not available"
11/5/22 at 12:00 P.M. - "Not available"

Trazodone 100 mg
10/19/22 at 8:00 P.M. - "Did not have"
10/20/22 at 8:00 P.M. - "Not available"
11/13/22 at 8:00 P.M. - no documentation

Oxycodone 5 mg
10/16/22 at 11:00 P.M. - no documentation
10/17/22 at 11:00 P.M. - no documentation
10/20/22 at 11:00 P.M. - no documentation
10/22/22 at 11:00 P.M. - no documentation
10/26/22 at 5:00 A.M. - no documentation
10/27/22 at 5:00 A.M. - no documentation
3. During an interview on 11/15/22 at 1:45 P.M., Resident D indicated, after returning to the facility from the hospital, she did not receive her Xanax medication for several days.

During record review on 11/15/22 at 12:30 P.M., Resident D's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and anxiety.

Resident D's physician orders included, but were not limited; to Xanax 0.25 mg take 1/2 tablet three times a day (started 9/19/22), Ferrous sulfate 325 mg 1 tablet daily (started 9/19/22), and Sodium Chloride 1 gm (gram) 1 tablet by mouth twice daily (started 9/20/22).

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Resident D's MAR from September through November 2022, indicated Resident D did not receive Xanax on September 20, 21, 22 and October 4, 5, 6, 7, 8, 9, 10, and 11. Resident D did not receive Ferrous sulfate on September 20, 21, and 22. Resident D did not receive Sodium Chloride on September 20, 21, 22 and October 2, 3, 9, 10, and 11.

4. During record review on 11/16/22 at 9:45 A.M., Resident H's diagnoses included, but were not limited to; manic depressive disorder.

Resident H's orders included, but were not limited to, Buspar 10 mg by mouth twice daily (started 1/29/21), Dexilant 60 mg 1 capsule by mouth daily (started 1/20/21), Topamax 1 tablet by mouth twice daily (started 1/29/21), Artane 2 mg 1 tablet by mouth twice daily (started 1/29/21), and Effexor 75 mg 1 tablet by mouth once daily (started 1/31/22).

Resident H's MAR (medication administration record) from October 2022 indicated Resident H did not receive Buspar on October 5. Resident H did not receive Dexilant on October 5 or October 22. Resident H did not receive Topamax on October 5 or October 22. Resident H did not receive Artane on October 5 or October 22. Resident H did not receive Effexor on October 5 or October 22.

5. During an interview on 11/21/22 at 8:54 A.M., Resident K indicated she does not always receive her Repatha when she is supposed to and the physician wanted her to start on a low dose of insulin, but she has not received it due to the insulin not coming in.

During record review on 11/21/22 at 9:45 A.M.,

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Resident K's diagnosis included, but were not limited to, congestive heart failure, chronic kidney disease, depression disorder, hyperlipidemia, and hypertension.

Resident K's orders included, but were not limited to, Repatha 140 mg/ml inject 1 ml subcutaneous every 2 weeks (started 12/24/20), Levemir Flextouch inject 25 units subcutaneous daily (started 11/14/22).

Resident K's MAR from October 2022 indicated Resident K did not receive Repatha on October 13.

Resident K's MAR from November 2022 indicated Resident K did not receive Levemir on November 15, 16, 17, 18, 19, and 20.

During an interview on 11/21/22 at 8:56 A.M., LPN 4 indicated if the residents are not administered a medication, a nurse's note should document why the medication was not given. LPN 4 indicated that, at times, medications are unavailable especially when it's a new order for a resident.

On 11/21/22 at 9:45 A.M., the Facility Administrator supplied a facility policy titled, Medication Management, Administration, & Storage, dated 03/2022. The policy included, "...B. Medication Administration: Medication administration shall be administered as ordered by the resident's physician and shall be administered by a licensed nurse or a QMA [Qualified Medication Assistant]."

This Residential tag relates to Complaints IN00387827, IN00390450, IN00392595, IN00392510, IN00384259, IN00394445, IN00392599, and IN00392402.

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R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			
	Based on interview, and record review the facility failed to maintain clinical records that were complete and accurate for residents receiving controlled substance for 3 of 5 residents reviewed for medications. Resident's narcotic drug count sheets lacked documentation and resident medication administration records were inaccurately documented. (Resident B, Resident J, Resident M) Finding includes: 1. During record review on 11/14/22 at 1:00 P.M. Resident B's diagnoses included, but was not limited to; schizoaffective disorder, depressive type, anxiety, and pain. Resident B's physician orders included, but were not limited to; alprazolam 0.5 mg (milligrams) 1 tablet every 8 hours as needed (started 8/22/22). Resident B's narcotic count inventory sheet dated 8/24/22, for medication alprazolam 0.5 mg 1 tablet every 8 hours as need lacked documentation between 8/31/22 at 8:54 A.M. and 9/1/22 at 8:30 A.M. The medication count for tablet #25 and #24 did not contain the time, amount given, amount remaining, or the staff initials that administered	R 0349	b="">1. No residents were affected by the alleged deficient practice. **2. All residents receiving controlled substances had the potential to be affected by the alleged deficient practice.3. In-service training for all nurses and QMAs to be completed by the Director of Nursing by December 23, 2022. All new nursing staff hires will be trained during onboarding by the Director of Nursing on the policy for delivery, handling, and storage of controlled substances. 4. Director of Nursing or designee will audit eMAR documentation and pharmacy count sheets to ensure appropriate documentation and administration of controlled substances. Audit of eMAR will be daily for 1 week, then 5 times a week for 4 weeks, then weekly for 3 months. The**	12/23/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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the medication.

2. During record review on 11/16/22 at 11:00 A.M., Resident J's diagnoses included Parkinson's disease.

Resident J's physician orders included, but were not limited to; hydrocodone-acetaminophen 5 - 325 mg 1 tablet every 6 hours as needed.

Resident J's narcotic count inventory sheet dated 07/2022, for medication hydrocodone-acetaminophen 5 - 325 mg 1 tablet every 6 hours as needed lacked documentation between 7/23/22 at 12:00 A.M. and 7/26/22 at 9:45 P.M. The medication count for tablets #23 thru #11 did not contain the date, time, amount given, amount remaining, or the staff signature that administered the medication.

During an interview on 11/17/22 at 11:40 A.M. QMA 78 indicated the narcotic count sheets must be signed, dated, and new count given each time a medication is administered. QMA 7 indicated the facility had an issue with medications going unaccounted for.

During an interview on 11/18/22 at 2:49 P.M. the DON (Director of Nursing) indicated the staff were not using the narcotic medication count sheets, and were just signing the medications off on the medication administration record (MAR).

3. During record review on 11/18/22 at 1:30 P.M., Resident M's diagnoses included, but was not limited to; diabetes, anxiety, and restless leg syndrome.

Resident M's physician orders included, but was not limited to; Ropinirole 5 mg 1 tablet 4 times

results will be discussed at the monthly QA meeting monthly for 3 months and then quarterly thereafter once compliance is 100%.="" span="">
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	daily. During an interview on 11/16/22 at 8:30 A.M., the Facility Administrator indicated Resident M's Ropinirole medication had gone missing. The Facility Administrator indicated during an investigation into the missing medication, QMA 13 admitted to documenting the Ropinirole had been administered on 11/14/22 at 12:00 P.M., and 4:00 P.M., when it had not been so the MAR would not show a medication had been missed. On 11/21/22 at 9:45 A.M., the Facility Administrator supplied a facility policy titled, Medication Management, Administration, & Storage, dated 03/2022. The policy included, "...E. Delivery, Storage, & Handling of Controlled Substances: ...8. Each time a controlled substance is delivered, it will be reconciled with the Pharmacy Count Sheet and stored in a controlled medication binder. Completed count sheets will be filed in the resident record... 11. Upon the request of the resident for a PRN [as needed] medication, the licensed nurse or QMA must document the controlled substances medication administration by signature date and time on the controlled substances Inventory Sheet. This must occur at the time the medication is removed from the controlled substances medication lockbox." This Residential tag relates to allegations IN00392510 and IN00390635.			
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.			

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	(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 interview, and record review, the facility failed to ensure residents, resident representatives, and families were notified of suspected or confirmed COVID-19 cases in the facility for 3 of 6 days of the survey. (Resident L) Finding includes: During an interview on 11/17/22 at 1:20 P.M., CNA 8 indicated that Resident L had tested positive for COVID -19. During record review on 11/18/22 at 10:30 A.M., Resident L's nurses note dated 11/18/22 at 9:55 A.M., included, "resident returned from ER [Emergency Room] 11/17/22 COVID positive resident put in quarantine in residents room with isolation precautions..." During an interview on 11/18/22 at 9:30 A.M., the Facility Administrator indicated Resident L had went out to the hospital on 11/16/22 and tested positive for COVID-19, then returned to the facility that night. During an interview on 11/18/22 at 3:20 P.M., the Facility Administrator indicated they had not informed the state agency of a new COVID-19 outbreak in the facility. On 11/18/22 at 2:40 P.M. the Facility Administrator supplied a facility policy titled, COVID-19	R 0407	1. **The administrator placed signage at the Main Entrance, the morning of 11/18/22 before beginning her workday. The administrator placed a message informing of COVID in the facility via Care Merge communication system to all residents and family. Signage had been placed at the main table in the foyer as you walk into the facility on 11/17/22.** **2. All residents had the potential to be affected by the lack of signage on the main entrance.** **Administrator reviewed the new guidelines with the Director of Nursing and will follow them with each outbreak in the future.** **3.** All department heads will be in serviced by the Administrator, DON, or designee on the new COVID Guidelines including communication to staff, residents, family, and visitors. Communication will include signage at the entrance, at the table in the facility foyer, at each	12/23/2022

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	Infection Control Policy, dated 7/2022. The policy included, "...Required Communication During an Outbreak A. Under the direction and in collaboration with the RDO (Regional Director of Operations), the administrator, or designee is responsible for communications with public health authorities during a COVID-19 outbreak..." This Residential tag relates to complaint IN00387827.		door with a COVID infected individual, also an isolation cart at each door of a COVID infected individual, signage at the timeclock in the breakroom. A message via care merge system to all residents and families. 4. The DON/Administrator will monitor the signage to communicate COVID is in the building daily while COVID outbreak is in the building. The DON/Administrator will monitor the signage to communicate transmission levels and community levels weekly when facility is free of COVID. All findings will be reported to the QA Committee monthly.	