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	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRIMROSE OF NEWBURGH	9800 LINCOLN AVE NEWBURGH, IN 47630

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00443839. Complaint IN00443839- State deficiencies related to the allegations are cited at R 216, R 241 and R 273. Survey dates: January 29 and 30, 2025 Facility number: 013846 Residential Census: 65 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 5, 2025.	R 0000		
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to ensure a resident who was self-administering medication had a physician order to self-administer medications or a self-administration of medication assessment that indicated the resident was capable of administering medications for 1 of 3 residents reviewed for self-administration of medications. (Resident F) Finding includes: On 1/29/25 at 2:50 P.M., Resident F's clinical record was reviewed. Resident F was admitted on 5/5/17. Diagnosis included, but was not limited to,	R 0216	Plan of correction: R216 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; DON immediately sent an order for self-administration with nurse verification on resident. DON completed sub assessment, self-medication administration', with resident. 2 How the facility will identify other residents having the potential to be affected by the	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Burke	RN/DON	02/14/2025

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	Diabetes Mellitus. Physician orders included, but were not limited to: Insulin lispro inject six units before meals, start date: 8/13/24. The clinical record lacked a physician order for Resident F to self administer medications. Insulin Lantus inject 15 units before bed, start date: 8/13/24. The most recent Administration of Medication Consent, dated 8/12/24, indicated Resident F and the Director of Nursing signed the form indicated Resident F would not self-administer medications. The electronic medical record indicated Resident F self-administered her own insulin medication on the following dates in January 2025: 1/1/25 1/3/25 1/8/25 1/11/25 1/12/25 1/15/25 1/17/25 1/20/25 1/22/25 1/23/25 1/25/25 1/26/25 1/27/25 During an interview on 1/30/25 at 11:37 A.M., the Director of Nursing indicated Resident F does administer her own insulin medication. On 1/30/25 at 2:26 P.M., the Director of Nursing provided a policy titled Resident Management		same deficient practice and what corrective action will be taken; All residents that self-administer medications had the potential to be affected. DON/designee verified all self-administration orders on new and active residents. DON/designee will ensure any residents that self-medicate will have sub-assessment and self-administration order in place with continued monitoring. 3 What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; The Primrose Policy, 'Resident management and self-administration of medications' was reviewed without change. Staff has been in-serviced on scope of practice including documentation and obtaining physician orders for residents to self-administer any medications. 4 How the corrective action will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place; and DON will verify all self-administration of medications on new and active residents and verification daily for one month, 3 times a week for one month,	

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	and Self-Administration of Medications, dated 12/18, that indicated "Each resident who desires to manage and/or self-administer his/her own medications is permitted to do so only if it is determined that the practice would be safe for the resident, and the practice adheres to applicable state laws and regulations." This citation relates to complaint IN00443839.		weekly for one month.. Any findings will be brought to monthly QA where plans of correction will be reviewed. 5 By what date the systemic changes will be completed POC/audits will be completed by April 2025 and will continue as any new insulin orders are active.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on interview and record review, the facility failed to ensure insulin medication was administered by licensed nursing personnel for 1 of 1 residents reviewed for self-administration of insulin. (Resident F) Finding includes: On 1/29/25 at 2:50 P.M., Resident F's clinical record was reviewed. Resident F was admitted on 5/5/17. Diagnosis included, but was not limited to, Diabetes Mellitus. Physician orders included, but were not limited to: Insulin lispro inject six units before meals, start date: 8/13/24. Insulin Lantus inject 15 units before bed, start date: 8/13/24. The record lacked a physician's order for resident to administer insulin. The electronic medication record indicated the following dates and times a Qualified Medication	R 0241	Plan of correction: R241 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; DON immediately sent an order for self-administration with nurse verification on resident. DON in-serviced all staff to address insulin administration and QMA Scope of Practice. Staff educated on nurse verifying insulin order and pen prior to QMA handing to resident to administer. QMA to add to ALIS (electronic MAR) the name of the nurse verifying insulin when documenting insulin administration. DON completed sub assessment, 'self-medication administration', with resident. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what	02/14/2025

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	Aide (QMA) prepared insulin medication, and Resident F administered the insulin injection: Insulin lispro: 1/12/25 8:00 A.M. QMA 7 1/12/25 11:30 A.M. QMA 7 1/12/25 4:30 P.M. QMA 7 1/15/25 8:00 A.M. QMA 7 1/15/25 11:30 A.M. QMA 7 1/15/25 4:30 P.M. QMA 7 1/17/25 11:30 A.M. QMA 7 1/17/25 4:30 P.M. QMA 7 1/20/25 8:00 A.M. QMA 7 1/20/25 11:30 A.M. QMA 7 1/20/25 4:30 P.M. QMA 7 1/25/25 8:00 A.M. QMA 7 1/25/25 11:30 A.M. QMA 7 1/25/25 4:30 P.M. QMA 7 Insulin Lantus: 1/1/25 8:00 P.M. QMA 5 1/03/25 8:00 P.M. QMA 5 1/11/25 8:00 P.M. QMA 5 1/12/25 8:00 P.M. QMA 5		corrective action will be taken; All residents with insulin had the potential to be affected. DON/designee verified all insulin orders on new and active residents. DON/designee will ensure insulin administration and documentation compliance with continued monitoring. 3 What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; The Primrose Policy, 'Presciber Medication Orders' was reviewed without change. Staff has been in-serviced on scope of practice including documentation and obtaining physician orders for residents to self-administer any medications. 4 How the corrective action will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place; and DON will verify all insulin orders on new and active residents and administration verification daily for one month, 3 times a week for one month, weekly for one month. Any findings will be brought to monthly QA where plans of correction will be reviewed.	

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	1/17/25 8:00 P.M. QMA 7 1/22/25 8:00 P.M. QMA 5 1/23/25 8:00 P.M. QMA 5 1/25/25 8:00 P.M. QMA 5 1/26/25 8:00 P.M. QMA 5 1/27/25 8:00 P.M. QMA 5 During an interview on 1/30/25 at 2:26 P.M., the Director of Nursing indicated the QMA's had prepared the insulin medication doses and gave to Resident F to administer, but that it was not company policy for QMA's to prepare or administer insulin medication. On 1/30/25 at 2:51 P.M., the Director of Nursing provided a document titled Qualified Medication Aide Scope of Practice that indicated "Administer regularly prescribed medication which the QMA has been trained to administer only after personally preparing the medication to be administered. The QMA shall not document in a resident's clinical record any medication that was administered by another person. The following tasks shall not be included in the QMA scope of practice: Administer medications by the injection route." This citation relates to complaint IN00443839		5 By what date the systemic changes will be completed POC/audits will be completed by April 2025 and will continue as any new insulin orders are active.	

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R 0273 Bldg. 00	. 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to ensure safe preparation of food and in accordance with state and local sanitation and safe food handling standards during 4 random observations of the kitchen and dining room in main facility and memory care unit. Staff did not properly use hair nets and hand washing in the kitchen and dining areas of the main facility and memory care unit. (Main Kitchen, Memory Care Dining Room) Findings include: 1. During the initial kitchen tour in the main building on 1/29/25 at 9:08 A.M., the floor in front of the reach in freezer and reach in refrigerator was observed to be sticky. 2. During the initial kitchen tour in the memory care building on 1/29/25 at 9:19 A.M., the floor in front of the juice machine was observed to be sticky. The Dementia Care Director was observed in the kitchen retrieving a tray of breakfast food for a resident without wearing a hair net. When the Kitchen Manager entered the kitchen, the Dementia Care Director retrieved a hair net from a holder by the door and placed it on her head covering only the roots of her hair leaving the long part of her hair outside the net.3. During an observation on 1/29/25 at 11:10 A.M., staff in the main kitchen were observed grabbing the inside of bowls with their bare hands without performing	R 0273	R273 1 DSD immediately completed an audit, Primrose of Newburgh identifies a deficiency in 410 IAC 16.2-5-5.1 (f) Food and Nutritional Services and will implement comprehensive staff training on proper preparation of food, the correct use of hair nets, proper hand washing in the kitchen and dining areas and floor care within 10 days. 2 All residents have the potential to be affected by this deficiency. The dietician and Director of Dining will provide training to all kitchen staff on 2/17/25. Follow up observations and education as well as regular quality audits to monitor and ensure consistent adherence to protocols will be put into place. 3 Primrose policy 'Hand Sanitation' was reviewed without change. DSD or designee will continue monitoring staff compliance as it relates to food preparation, hair nets, and proper hand hygiene. Any findings will be brought to monthly QA and addressed applicably. 4 Audits include 3x per week on hairnet compliance, hand	02/17/2025

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	hand hygiene, putting food from the salad bar into the bowls, then serving to residents in the dining area. One staff member was observed with a hairnet on but bangs not covered; another staff member was observed with a hairnet on but not covering the hair hanging out of the back of the hairnet along the neck.4. On 1/29/25 at 11:36 A.M., during a random observation of lunch in the memory care dining room Certified Nurses Aide(CNA) 2 was observed with strands of hair and bangs not covered with a hair net when serving meals to residents on the memory care unit. During an interview on 1/30/25 at 11:45 A.M., the Administrator indicated hair nets should completely cover the entire head of hair and hands should be washed prior to serving food and in between tasks as necessary. On 1/30/25 at 1:15 P.M., the Director of Nursing (DON) provided a current policy "Hand Washing" revised on 1/1/2015. The policy indicated "...the community recognizes that effective handwashing is the most important means to prevent the spread of infectious organisms...compliance with the proper hand hygiene procedure before and after resident contact is an expectation of all employees..." On 1/30/25 at 1:15 P.M., DON provided a current, nondated policy "Hair Restraints". The policy indicated "... hair restraints shall be worn by all dining services staff when in food production...or when serving food from the steam table...Hair restraints...shall be used to prevent hair from contacting exposed food..." This is related to complaint IN00443839		washing compliance, proper food preparation and handling compliance, and proper floor cleaning compliance for 30 days, then, 2x per week for 30 days then random audits ongoing. 5 Date implemented: immediately, 2/17/25. Findings will be brought to QA.	