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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00365838. Complaint IN00365838 - Substantiated. No State Residential Findings related to the allegations were cited. Survey dates: November 15, 16 and 17, 2021. Facility number: 014410 Residential Census: 116 Glasswater Creek of Plainfield was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00365838. Quality review completed on November 30, 2021.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure a resident with a newly identified laceration and puncture wound received first aid, pain medication, and timely emergency medical care for 1 of 1 resident randomly observed with an injury (Resident L).	R 0052	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident L experienced no adverse effects from the alleged deficient practice. Upon notification of laceration, resident	01/16/2022

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

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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	Findings include: On 11/15/21 at 12:01 p.m., Resident L was observed in the dining room with a puncture laceration on his left hand between his thumb and fore finger. It was about 0.5 inches long with the skin edges unapproximated. There was wet and dried, crusty blood on the back of his hand and on the palmar surface. The wound was not washed or dressed. He indicated Licensed Practical Nurse (LPN) 12 told him it needed stitches. He was waiting on them to take him for stitches. He was trying to open a beverage between 8:00 or 9:00 a.m. that morning, when he cut his hand with a knife. He pointed to the large bruise on the lower palm of his hand and indicated it hurt "a lot," and the center of his palm was "very tender." The knife went into his hand "pretty deep," and it was painful then and now. During an interview, on 11/15/21 at 12:10 p.m., Cook 17 saw Resident L's left hand injury and indicated she talked with the Director of Nursing (DON). The DON indicated she called Resident L's physician, and they will call her back tomorrow. During an interview, on 11/15/21 at 12:19 p.m., Qualified Medication Aide (QMA) 13 indicated Resident L cut open his hand last night. She saw his injury on 11/15/21 about 9:00 a.m., and there was blood everywhere in his room. She even saw blood in a cup. She indicated the DON knew about Resident L's injury and she did not know why it was not cleaned and dressed. During an interview, on 11/15/21 at 12:35 p.m., Licensed Practical Nurse (LPN) 12 indicated she saw Resident L's left hand puncture injury about 9:00 a.m. (sic). She thought he cut it last night but did not get report from the previous staff of his		was assessed by licensed nurse, DON notified resident's physician of the injury, and resident was transported to St. Vincent urgent care for further evaluation. Upon resident's return, all MD orders regarding treatment of laceration were followed. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practice. No residents were identified as affected by the alleged deficient practice. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. QMA 13 and LPN 12 were verbally in-serviced regarding timely notification of incidents and policy on first aid treatment. All-staff will be in-serviced no later than January 16th, 2022 on resident rights, types of abuse, incident-reporting policy and first aid policy. All nursing staff to be in-serviced on first aid and will be certified in first aid no later than January 16, 2022.	

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	injury. There was blood was in his room in several places. She called the DON at 8:22 a.m. because she needed to ask her what to do. She knew about bacteria, but she did not wash it because it looked clean. She did not dress the wound because the facility did not have gauze or dressings. They only had small band-aids that were not big enough to cover his open wound. He did not indicate he was in pain, so she did not offer any pain medication. She was working with the DON to get him sent out to the hospital. He was going by the facility's transport bus to the hospital "very soon." During an interview, 11/15/21 at 3:10 p.m., the DON indicated she was notified of Resident L's open hand laceration at 8:39 a.m. When she arrived at the facility at 8:50 a.m., she tried to reach Resident L's previous physician, by phone but no one answered. She faxed his office and did not get a response until 12:20 p.m. She notified the facility's healthcare providers. They indicated he was not their patient, but they could add him as a patient and see him tomorrow. If he needed help today, she could send him out to an urgent care facility or dispatch health (a group who provides care within 4 hours). The facility bus driver left to take Resident L to the hospital at 12:30 p.m. She indicated the facility had a lot of first aid supplies including gauze, tape, bandages, alcohol, Neosporin, bacitracin, ice packs, and tourniquets. It was a large first aid kit. The staff at the hospital indicated the wound was old and they were unable to stitch it. Her expectations for staff who encountered an injury that required first aid would be for them was to be sure the wound was clean, wash it with soap and water, use gauze it pat it dry, and apply a dressing with tape to cover it to keep anything from entering the wound.		4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. All staff will be in-serviced on resident rights, types of abuse, and reportable incidents upon hire and on an as-needed basis. Director of Nursing or designee will be assigned to ensure first aid certifications are current and that all current and new clinical staff receive in-servicing on first aid policy as it relates to reporting and treatment. Director of Nursing or designee will in-service first aid-certified staff members on location of first aid supplies. Director of Nursing or designee will complete audits regarding knowledge of first aid policy and supply storage a minimum of 2x/week for 8 weeks, then 1x/week for 8 weeks, then every other week for 8 weeks. Results to be discussed at QI meeting for six months and as needed.	

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	During an interview, on 11/16/21 at 8:42 a.m., Resident L was in the dining room waiting for his breakfast. He indicated he went to the hospital yesterday and they said the wound was "too old" to put in stitches. The hospital cleaned it and put a dressing on it. It felt "a lot better" with the dressing on it. During an interview, on 11/16/21 at 9:15 a.m., Nurse Practitioner (NP) 19 for the healthcare providers for the facility indicated the facility had already tried to add Resident L to their patient list, for some reason it didn't go through, so he was added today and to be seen tomorrow. On 11/16/21 at 10:02 a.m., Resident L's paper and electronic medical records were reviewed. He was admitted to the facility on 10/19/21. His diagnoses included, but were not limited to, dyspnea (shortness of breath), diabetes mellitus (disorder of blood sugar), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea (OSA). On 11/16/21 at 10:15 a.m., the Administrator provided documents regarding Resident L's left hand puncture injury. A fax cover sheet, dated 11/15/21 with no time, was sent to Resident L's physician. It indicated, "Urgent - We have a resident ...that has cut his hand between the thumb and forefinger - he will need stitches. Please notify us of orders. ..." A nursing note, written by QMA 13, dated 11/12/21 at 9:08 a.m., indicated Resident L's accu-check was 357 this a.m., he continued without insulin orders and awaiting to see facility healthcare providers. Resident went down to eat			

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	breakfast after his accu-check. His room had moldy food, trash, and feces on his bed and floor, and bathroom. Flying insects were noted in his room. The nurse and DON were made aware of his living conditions. Resident was provided trash bags. A nursing note, written by LPN 12, dated 11/15/21 at 8:39 a.m., indicated she was notified by QMA 13 that Resident L had cut himself during the night. She notified the DON. The left hand puncture wound was no longer bleeding, and he did not indicate he was in pain. A nursing note, written by the DON, dated 11/15/21 at 12:21 p.m., indicated she was notified of Resident L's left hand laceration to the webbed area between the thumb and forefinger. The resident's primary care physician was called but the phones were down for lunch. A fax was sent to notify him of the laceration. Resident L had requested to begin services with the facility physician group. The physician group had been sent all of this resident's information and was scheduled to see him as a new patient this week. Staff had educated the resident about good hygiene to keep his hand clean to avoid infection. Arrangements had been made for the resident to be transport to an urgent care center by the Resident Services Director for him to have his hand evaluated and treated. An educational document, provided to Resident L during with his discharge, indicated for puncture wounds, depending on how serious the wound was to control the bleeding, wash it out with a germ-free (sterile) salt-water solution, and close the wound with stitches (sutures) if it continues to bleed. Resident L's patient discharge documentation			

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	indicated he was being discharge with a primary diagnosis of puncture wound to the hand. His new prescription based on the ER visit was to take doxycycline hyclate (broad spectrum antibiotic to treat bacterial infections) 100 mg tablet. Take 1 tablet by mouth 2 times a day. A document, titled, "Incident Report," dated 11/15/21 at 8:47 a.m., was provided by the DON on 11/16/21 at 10:24 a.m. It was completed, in part, in advance of events occurring. LPN 12 indicated Resident L was found with blood on several items in his room. She was called to his room and found the resident sitting on his couch with a cut to his left hand. His hand was free of debris and blood. Resident L had appeared to provide his own care to the cut. He did not contact staff at the time of the incident, so the initial time of the incident is unknown. He indicated he was using a knife to cut open a bottle and cut his hand. She contacted the DON. The injury was a laceration, no vital signs were taken, and the resident did not receive first aid. During an interview, on 11/16/21 at 3:03 p.m., the Administrator indicated regarding Resident L's puncture wound of his left hand, he should have received first aid at the facility. LPN 12 was not first aid certified, so she should have called on Certified Nursing Assistant (CNA) 18, who was also in the building, to give the resident first aid and dress the wound. A document titled, "Glasswater Creek of Plainfield Job Description Staff Nurse," with no date, was provided by the Administrator on 11/15/21 at 3:05 p.m. A review of the nurse job description indicated, " ...Essential Position Functions ...Refers resident to appropriate medical care when needed ...."			

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	A document titled, "Glasswater Creek of Plainfield First Aid Procedure," dated 02/2022, was provided by the Administrator on 11/16/21 at 1:50 p.m. A review of the document indicated, " ...The purpose of this policy is to ensure residents, staff and visitors, receive the appropriate first aid treatment when incident/accidents occur ...It is the responsibility of the Nursing Staff to provide first aid ...."			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure staff wore a hair covering while preparing and serving food to residents, food in the kitchen was sealed, stored, and labeled properly, and food preparation equipment was kept clean, safe, and free of food and grease build-up for 1 of 1 day of observations of the kitchen that served food to 116 residents. Findings include: On 11/15/21, the facility's kitchen was surveyed. The facility's Assistant Culinary Manager (Assistant Manager) accompanied the surveyor for the duration of the survey. On 11/15/21 at 9:41 a.m., a sign on the doors to the entry of the kitchen was observed that indicated, "Notice - hairnets must be worn in this area." On 11/15/21 at 9:42 a.m., Cook 5 was observed inside the kitchen, without a hair net. He indicated	R 0154	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. All residents had the potential to be affected by the alleged deficient practices. No residents experienced adverse reactions from the alleged deficient practices. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practices. No residents experienced adverse reactions from the alleged deficient	01/16/2022

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	he was a cook for the facility. He had arrived at 6:30 a.m. that day and had been cooking and serving food to residents since he arrived. He indicated he should wear a hair net while he was in the kitchen. On 11/15/21 at 9:44 a.m., the dry storage room was observed. Shelving units lined 3 of the 4 walls in the room, with another set of shelving placed in the center of the room. Plastic cups, plastic coffee cup lids, and paper debris was observed under the shelves. On a center shelving unit, two 55 ounce (oz) packages of corn tortillas were observed open to air. Neither package had a label that indicated when the packages were opened. During an interview on 11/15/21 at 9:51 a.m., the Assistant. Manager indicated, the packages of tortillas were both opened and not dated. They would need to be thrown out. On 11/13/21, the facility served chicken fajitas. That was the last time he could think of the tortillas being used. On 11/15/21 at 9:56 a.m., the walk-in refrigerator was observed. The outside handle to the walk-in refrigerator was covered in a dried brownish red substance that extended the length of the door handle. The Assistant. Manager indicated he was not sure what the substance was. Inside the refrigerator was a 128-oz container of French salad dressing. The container was 1/8 full. There was no label that indicated when the salad dressing had been opened or when it would expire. A 128-oz container of honey mustard salad dressing was observed, more than half full. There was no label that indicated when the salad dressing had been opened or when it would expire. A 3.5 L (liter), lidded, clear plastic container was observed to contain an unidentified orange food product. The Assistant. Manager indicated the food was cut		practices 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. The kitchen and all equipment were thoroughly cleaned, and cleaning checklist binder was created and implemented on October 15, 2021. All items in the kitchen were audited for labels and dates. Items without dates were immediately discarded. Current and new dietary staff members will be in-serviced no later than January 16, 2022, on proper practices related to kitchen cleaning schedule, Check list binder and expectations, proper food labelling and food storage practices. All staff will be in-serviced no later than January 16, 2022, on proper usage of hair nets in the kitchen. All dietary staff will be educated on proper practices related to kitchen cleaning schedule and expectations, proper food labelling and food storage practices during general or job-specific orientation moving forward. All staff will be educated on proper usage of hair nets in the kitchen during general or job-specific orientation moving forward. 4. Describe how the corrective actions(s) will be monitored to	

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	mandarin oranges. He was not sure when the oranges had last been served. The container lacked a label that indicated what was in the container, when it was prepared, by whom it was prepared, or when it would expire. A clear plastic bag of unidentified meat was observed on a slotted shelf. The bag was not in a container and did not have a pan under it. The Assistant. Manager indicated the bag contained salmon fillets. The bag was tied shut. There was no label on the bag that indicated what food item was in it, when it was prepared, by whom it was prepared, or when the food would expire. A cling-wrapped package of sliced ham and a cling-wrapped package of half a ham, was observed on a slotted shelf. Neither package of ham was placed in a container or had a pan underneath. The Assistant. Manager indicated, all food items should be placed on a sheet pan or in a container so that they did not drain or leak onto food stored in lower shelves. On 11/15/21 at 10:05 a.m., the deep fryer was observed. The sides and front of the deep fryer were coated with dried grease and food debris. The Assistant. Manager indicated, "you could scrub all day and not get that [the grease] off there [the sides and front of the deep fryer]." On 11/15/21 at 10:08 a.m., a white, granulated sugar storage container was observed with the scoop placed in with the sugar. The Assistant. Manager indicated the scoop should not be stored in the sugar, it should be placed in the scoop holder, which was on the container lid. Bacteria from a person's hand could get on the scoop handle, and then into the sugar if the scoop was stored in the sugar and not the scoop holder. On 11/15/21 at 10:09 a.m., a 3-compartment sink		ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. Administrator or designee will audit food storage and labels, cleaning practices, and hair net usage 5x/week for 2 weeks, then 2x/week for 10 weeks, then 2x/month for 2 months, then 1x/month for 1 month, then ongoing as needed. Results will be reviewed at monthly QI meeting for six months as needed.	

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	was observed with running water over sealed bags of chicken that had been placed in one of the sink compartments. A green scouring pad was observed floating in the sink with the bags of chicken. The Assistant Manager indicated the chicken was being thawed for service that day. The scouring pad should not have been placed in the sink with the thawing chicken. The scouring pad could have bacteria on it that could spread to the bags of chicken. If the bags of chicken leaked, E. Coli (Escherichia coli, bacteria found in the environment, foods, and intestines of people and animals) and Salmonella (bacteria that live in animal and human intestines and are shed through feces) could spread from the chicken to the scouring pad. Someone could use the scouring pad, not knowing it was in with the chicken, and spread bacteria around, which could cause people to get sick. During an interview on 11/15/21 at 10:25 a.m., the Assistant. Manager indicated, kitchen cleanliness was a concern because it can affect the food quality and can attract pests. On 11/15/21 at 11:37 a.m., Cook 5 was observed as he exited the kitchen with tray of food, and delivered it to a resident in the dining room. He did not have on a hair net. Cook 5 returned to the kitchen. Inside the kitchen, he stood over open pans of food, on the hot serving line, and retrieved food trays to be served to the residents. He did not wear a hair net while in the kitchen. On 11/16/21 at 1:50 p.m., the Administrator (Admin) provided a document titled, "Daily Dietary Cleaning Schedule". Under "Description of Assignment", "polish all stainless steel" was identified as a task to be completed daily by "PM Servers". Cleaning the sides and front of the deep			

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	fryer was not listed as a cleaning task to be completed. On 11/16 21 at 1:50 p.m., the Admin. provided an undated policy titled, "Refrigerated Storage Policy". She indicated this was the current policy in use by the facility at that time. The policy indicated, "Potentially hazardous food requiring refrigeration after preparation shall be labeled or tagged with the date, time, discard date, initials of the person who made it." On 11/16 21 at 1:50 p.m., the Admin. provided an undated policy titled, "Dietary Uniform and Dress Code Practices". She indicated this was the current policy in use by the facility at that time. The policy indicated, "Caps/ hats or hairnets must be worn in the kitchen." The Indiana Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24-146, indicated, "Food labels...(b) Label information shall include the following: (1) The common name of the food or, absent a common name, an adequately descriptive identity statement. (2) If made from two (2) or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives if contained in the food. (3) An accurate declaration of the quantity of contents." The Indiana Department of Health, "Retail Food Establishment Sanitation Requirements", 410 IAC 7-24-295, Section 295, indicated, "(a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

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	equipment shall be kept free of an accumulation of: (1) dust; (2) dirt; (3) food residue; and (4) other debris". The Indiana Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24-138, indicated, "Effectiveness of hair restraint...food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles."			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure residents, who self-administered their medications, monitored their vital signs prior to taking medications, as ordered by a physician (Residents C and P). This affected 2 of 4 residents reviewed for medication self-administration.	R 0216	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Residents C and P did not experience any adverse effects from the alleged deficient practice. DON verified that both residents owned the proper equipment to	01/16/2022

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	Findings include: 1. On 11/15/21 at 10:43 a.m., Resident C was observed and interviewed. He indicated he administered his own medications. Shortly after he moved in to the facility, a nurse went over his medications with him to determine if he could safely administer his own medications, without the assistance of nursing staff. At that time, packages of medications were observed in Resident C's apartment for digoxin (used to treat heart failure and irregular heart rate and rhythm), metformin (used to treat type 2 diabetes), xarelto (used to prevent blood clots), acetaminophen (used to treat pain), diltiazem (used to treat high blood pressure and irregular heart rate and rhythm), ergocalciferol (a vitamin D supplement), trazodone (an antidepressant medication used to treat insomnia), a multivitamin, and atorvastatin (used to treat high cholesterol). The package of diltiazem indicated, Resident C was to take 1 tablet by mouth three times daily, and to not take the scheduled dose if his heart rate was less than 60 or his systolic blood pressure (the measure of the pressure in the arteries when the heart beats) was less than 110. Resident C indicated, he did not have a blood pressure cuff or heart rate monitor to check his blood pressure or heart rate before he took his medication. Resident C indicated, the facility nursing staff did not check his blood pressure, heart rate, or any other vital signs. He indicated the facility used to check his vital signs, but that had stopped about 3 weeks ago. Resident C indicated, he had been admitted to the facility in September 2021, from a local hospital. He was admitted to the hospital in August (of 2021) after he went to his doctor with complaints of dizziness and severe headaches. Tests showed Resident C had swelling on his brain. Resident C indicated, he did not have an accident or any head trauma, and		manage their vitals, provided education on proper procedure for taking vitals, and verified both residents understood this procedure by asking residents to complete a returned demonstration. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. Any resident self-administering medications requiring vitals equipment had the potential to be affected by the alleged deficient practice. No additional residents were identified as affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. Education will be provided to all LPNs completing self-medication assessments no later than January 16, 2022. Education and in-servicing will consist of the following: ensuring residents self-administering medications with parameters for vitals have the proper equipment, understand the parameters of the order, and that LPN must document understanding and competence on	

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	that the brain swelling resulted from, "just getting old". Resident C indicated, while he was in the hospital, he had a drain placed in his head to relieve the pressure on his brain. His doctors advised him it was important to keep his blood pressure under control to help prevent any future complications. On 11/16/21 at 10:00 a.m., Resident C's record was comprehensively reviewed. Census information indicated, Resident C admitted to the facility on 9/21/21. He had diagnoses to include, but not limited to, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), diabetes mellitus (type 2 diabetes), hypertension (high blood pressure), hypercholesterolaemia (high cholesterol), and idiopathic normal pressure hydrocephalus (a buildup, of unknown cause, of fluid in the ventricles (cavities) in the brain. The excess fluid increases the size of the ventricles and puts pressure on the brain, which can cause damage to brain tissue and brain function problems). Resident C had a physician's order dated 9/20/21, for Diltiazem 60 mg (milligrams), take 1 tablet by mouth three times daily, hold for HR (heart rate) < (less than) 60 or SBP (systolic blood pressure) <110. Vital signs records indicated, Resident C had his HR checked on: 10/26/21, 10/24/21, 10/23/21, 10/7/21, 10/3/21, 10/2/21, 10/1/21, 9/30/21, 9/24/21, and 9/21/21. He had his blood pressure checked on 9/25/21 and 9/21/21. 2. On 11/15/21 at 3:03 p.m., Resident P was observed and interviewed. He indicated he administered his own medications since he moved to the facility in December of 2019. The facility		self-medication administration assessment. All new LPNs will receive this training during job-specific orientation moving forward. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON or designee will audit completed self-medication administration assessments with current resident orders to ensure compliance for education on vitals and equipment required to do so. DON or designee will audit a minimum of 1x/week for 8 weeks, then 1x every other week for 8 weeks, then 1x/month for 2 months. Results to be reviewed and discussed at monthly QI meeting for six months and as needed.	

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	completed an assessment at least once a year to determine if he was safe to self-administer his own medications. Resident P indicated he took several medications. A review of medications kept in the residents apartment included, but was not limited to, metoprolol (used to lower blood pressure by relaxing blood vessels and slowing heart rate in order to improve blood flow). A review of the medication label at that time indicated Resident P should hold the dose of metoprolol if his heart rate was less than 50. Resident P indicated, he did not check his heart rate before he took the medication. The facility did not check his vital signs regularly. On 11/16/21 at 11:08 a.m., Resident P's record was comprehensively reviewed. He had diagnoses to include, but not limited to, hyperlipidemia (high cholesterol), HTN (high blood pressure), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), and GERD (gastroesophageal reflux disease). Resident P had a physician's order dated 5/26/20, for Metoprolol Suc ER (succinate extended-release) 25 mg, take ½ tablet by mouth daily, hold for HR <50. Vital signs records indicated, Resident P had his heart rate checked on 10/9/21, 10/6/21, 10/5/21, 10/3/21, 10/2/21, 10/1/21, and 9/30/21. During an interview on 11/16/21 at 1:50 p.m., the DON (Director of Nursing) indicated, all residents were given a Self Administration Medication Assessment upon admission to the facility. Residents must be assessed in order to administer their own medications. The DON used the Self Administration Medication Assessment form to assess the resident, and made sure the resident			

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	could demonstrate all the assessment criteria. At that time the assessment form was reviewed. The assessment form lacked criteria for monitoring blood pressure or heart rate. The DON indicated, if a resident was self administering blood pressure medications, she would need to know that the resident was checking their blood pressure and make sure they had the equipment to check their blood pressure. Residents should have something that can track their HR to monitor their pulse. If a physician had ordered vital signs parameters to be checked prior to taking a medication, the medication should not be taken until the vital sign was checked. Resident C had a history of swelling on his brain. High blood pressure could affect the pressure in the resident's brain. If resident vital signs were not monitored, it could result in bad effects from the medications. Facility staff should check all the residents' vital signs at least daily. On 11/17/21 at 10:45 a.m., the Administrator provided a policy titled, "Universal Screening Policy", dated last revised 8/2021. She indicated, this was the current policy in use by the facility at that time. The policy indicated, "All residents shall have a Daily Wellness Check completed on a specified schedule ...During the Daily Wellness Check, the following is monitored, including but not limited to: temperature, pulse oximetry [oxygen saturation], pulse [HR], and signs & symptoms of COVID-19 or COVID-19 like illness ...The Daily Temperature & Pulse Ox Log shall also be updated at the time of Daily Wellness Check completion." 410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the			
R 0217 Bldg. 00				

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	services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, interview, and record review, the facility failed to ensure resident inclusion in the creation and revision of a service plan, and that service plans were signed by the resident for 1 of 5 residents reviewed for service plans (Resident C). Findings include: On 11/15/21 at 10:43 a.m., Resident C was observed and interviewed. He indicated he had lived at the facility for about two months. He had not been involved in any service or care plan	R 0217	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident C experienced no adverse effects from the alleged deficiency. Resident C's Initial Service Plan and Level of Service Assessment were both reviewed with resident and documented with resident and DON signature. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same	01/16/2022

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	meetings. He thought he could probably voice his preference regarding the services he received, but no one had ever met with him about it. On 11/16/21 at 10:00 a.m., Resident C's record was comprehensively reviewed. A document titled, "Initial Service Plan", dated 9/21/21, was signed by the DON (Director of Nursing). The space labeled, "Resident Signature" was blank. The date on the resident signature line was blank. A document titled, "Level of Service Assessment/ Evaluation - Full List of Items" was dated 9/21/21. On the bottom of each page of the document was the label, "Indiana LOC [level of care] Assessment". The document was signed by the DON. It was not signed by the resident. A document titled, "Level of Service Assessment/ Evaluation - Full List of Items" was dated 10/1/21. On the bottom of each page of the document was the label, "Indiana LOC [level of care] Assessment". The document was signed by the DON. It was not signed by the resident. Resident C's nursing and progress notes lacked documentation a service plan or level of care meeting had been completed with the resident. During an interview on 11/16/21 at 2:25 p.m., the DON indicated, the facility's practice was the initial assessment was done prior to move in. The resident signed the initial assessment. The day the resident moved in; the assessment was reviewed again. The resident signed again. The initial service plan was good for the first 6 months after a resident admitted to the facility. The facility used the LOC as the service plan. The LOC		deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficiency. All residents Initial Service Plans and Level of Service Assessments will be audited for resident inclusion no later than January 16, 2022. Any resident with an Initial Service Plan or Level of Service Assessment found out of compliance will be reviewed by DON with resident inclusion. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. DON and current staff LPNs to be in-serviced on resident inclusion and signature form for Initial Service Plan and Level of Service Assessment no later than December 31, 2021. New LPN hires will be in-serviced on this policy and form during job-specific orientation moving forward. DON or designee will be responsible for auditing all completed Initial Service Plans and Level of Service Assessments for resident inclusion and signature moving forward. 4. Describe how the corrective actions(s) will be monitored to	

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	assessment assigned points to the different assessment areas, which gave a total, that determined the level of care. The DON completed the LOC assessments. Sometimes the resident was involved, sometimes not. On 11/17/21 at 10:45 a.m., the Administrator provided a policy titled, "Service Plans" dated last revised 4/2016. The Administrator indicated this was the current policy in use by the facility at that time. The policy indicated, "Each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs ...A. Within 24 hours of admission, an Initial Service Plan will be completed that identifies potential immediate problems. B. Within seven days of completion of assessment tool (i.e. RAI [resident assessment instrument]), all areas of concern will be addressed via the Service Plan. Licensed nursing will also complete documentation in the resident's progress notes. C. The nursing staff along with the resident and/ or family members will identify resident problems, needs and strengths."		ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. Administrator, DON, or designee will audit completed Initial Service Plans and Level of Service Assessments for resident inclusion and signature a minimum of 1x/week for 8 weeks, then 1x every other week for 8 weeks, then 1x/month for 2 months. Results to be reviewed and discussed at monthly QI meeting for six months and as needed.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to use a clean glucometer (instrument to read resident blood sugar) for 4 of 4 resident reviewed for glucometer monitoring	R 0241	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Residents N, P, Q, R, W, X,	01/16/2022

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	(Resident N, P, Q, and R), failed to provide all diabetes mellitus (disorder of blood sugar) medications (oral and injection) for 4 of 7 residents reviewed with scheduled diabetes mellitus medications (Resident Q, R, W, and X), and failed to provide all ordered accu-checks (to monitor resident blood sugar) for 3 of 7 residents reviewed with accu-checks ordered by their physician (Resident Q, R, and L). Findings include: 1a. On 11/15/21 at 11:17 a.m., Qualified Medical Assistant (QMA) 13 indicated the glucometer she was using was for multiple residents. She removed the glucometer from her medication tote and set it on the resident's kitchen counter. She gelled (used hand sanitizer) her hands, put on gloves, and wiped the glucometer with Super Sani Cloth Wipes for 10 seconds. She placed it back on the same place on the resident's kitchen counter. She removed her gloves and did not wash her hands. She put on clean gloves and used the glucometer on Resident N to get her blood sugar (BS), then placed it back into the medical tote without cleaning it. 1b. On 11/16/21 at 10:31 a.m., QMA 16 washed her hands, took the glucometer out of the medication tote, put on gloves, and used Super Sani Cloth Wipes to clean the glucometer and the lancet device (used on the skin to attain one drop of blood) for 5 seconds each. She removed her gloves and did not wash her hands. She put on clean gloves and took Resident P's blood sugar. She wiped the glucometer and the lancet device for 5 seconds each with the Super Sani Cloth Wipes and placed them back in the medical tote. 1c. On 11/16/21 at 10:35 a.m., QMA 16 washed her		and L experienced no adverse effects from the alleged deficiency. MD notified of missed medications. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents with orders for accu-checks and insulin-administration had the potential to be affected by the alleged deficiency. All residents with orders for accu-checks and insulin-administration were audited for missing accu-checks and insulin-administration. Residents identified during this audit were assessed by licensed nurse for adverse effects and resident MD notified. No residents experienced adverse effects from the alleged deficiency. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All current clinical staff will be in-serviced on accu-checks and insulin-administration as it relates to timely completion, proper documentation, and infection-control no later than	

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	hands, took the glucometer out of the medication tote, put on gloves, and used Super Sani Cloth Wipes to clean the glucometer and the lancet device for 5 seconds each. She removed her gloves and did not wash her hands. She put on clean gloves and took Resident Q's blood sugar. She wiped the glucometer and the lancet device for 5 seconds each with the Super Sani Cloth Wipes and placed them back in the medical tote. 1d. On 11/16/21 at 10:46 a.m., QMA 16 washed her hands, took the glucometer out of the medication tote, put on gloves, and used Super Sani Cloth Wipes to clean the glucometer and the lancet device for 5 seconds each. She removed her gloves and did not wash her hands. She put on clean gloves and took Resident R's blood sugar. She wiped the glucometer and the lancet device for 5 seconds each with the Super Sani Cloth Wipes and put them back in the medical tote. 2a. Resident Q's November Medical Administration Record (MAR) was reviewed. Resident Q had a physician's order to receive accu-checks three times a day. Her MAR was missing the documentation for the accu-check on 11/8/21 at 4:00 p.m., and the 8:00 a.m. accu-checks on 11/13/21 and 11/14/21. Resident Q had a physician's order to receive a scheduled dose of Levemir (insulin to treat diabetes mellitus) Flextouch 100 U/mL (units per milliliter) at 8:00 p.m. Her MAR was missing the documentation for the Levemir doses on 11/4/21 and 11/7/21. 2b. On 11/17/21 at 9:28 a.m., Resident R's November MAR was reviewed.		January 16, 2022, and as needed moving forward. All new staff will be educated on accu-checks and insulin-administration as it relates to timely completion, proper documentation, and infection-control during job-specific orientation and as needed. b. Individual Glucometers to be obtained from USMed for residents with ordered Accu-checks. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. Director of Nursing or designee will conduct accu-check, insulin-administration, proper documentation, and infection-control audits related to insulin administration three (3) times per week for eight (8) weeks, then two (2) times per week for eight (8) weeks, then weekly for eight (8) weeks, then as needed until next survey to ensure proper insulin administration and infection-control practices. Results will be reviewed at monthly QI meeting and then on an as-needed basis.	

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	Resident R had a physician's order to receive accu-checks four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 7:00 p.m. Her MAR was missing the documentation for the accu-checks on 11/8/21 at 7:00 p.m., and 11/14/21 at 4:00 p.m. and 7:00 p.m. Resident R had a physician's order to receive a scheduled dose of Basaglar (insulin) 100 U/mL Kwikpen (pen delivery system) subcutaneously (under the skin) every evening at 7:00 p.m. Her MAR was missing the documentation for the Basaglar dose on 11/8/21. 2c. On 11/17/21 at 9:51 a.m., Resident L's November MAR was reviewed. Resident L had a physician's order to receive accu-checks once a day at 8:00 a.m. His MAR was missing the documentation for the accu-check on 11/13/21 and 11/14/21. Resident L had a physician's order to receive a scheduled dose of oral dose of metformin (diabetic medication) 1000 mg twice daily at 8:00 a.m., and 4:00 p.m. His MAR was missing the documentation of the metformin at 4:00 p.m. on 11/2, 11/3, 11/4, 11/9, 11/10, and 11/11/21. During an interview, 11/15/21 at 3:10 p.m., the DON indicated she told the staff to use Cavi-wipes (disinfection wipes) for the resident glucometer and the staff should have been doing accu-checks before the residents go to lunch. 2d. On 11/17/21 at 9:35 a.m., Resident S's November MAR was reviewed. He had a physician's order to receive a scheduled dose of Basaglar (insulin) 100 U/mL Kwikpen (pen delivery system) subcutaneously (under the skin)			

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	every evening at 7:00 p.m. Her MAR was missing the documentation for the Basaglar dose on 11/8/21. 2e. On 11/17/21 at 9:42 a.m., Resident W's November MAR was reviewed. He had a physician's order to receive a scheduled dose of Lantus Solostar 100 U/mL, inject 40 units twice daily at 8:00 a.m. and 9:00 p.m. His MAR was missing the documentation for the Lantus doses at 9 :00 p.m. on 11/3/21, 11/5/21, and 11/14/21. 2f. On 11/17/21 at 9:49 p.m., Resident X's November MAR was reviewed. Resident X had a physician's order to receive a scheduled dose of Basaglar (insulin) 100 U/mL Kwikpen subcutaneously every evening at 7:00 p.m. His MAR was missing the documentation for the Basaglar dose on 11/1, 11/2, 11/3 and 11/5. During an interview, on 11/16/21 at 8:48 a.m., QMA 13 indicated the resident accu-checks she missed before lunch on 11/15/21, were Resident W and X. She went to Resident W's room at 11:00 a.m. and Resident X's room at 11:15 a.m. She observed the residents were already in the dining room about 11:20 a.m. During an interview, on 11/17/21 at 10:47 a.m., the Administrator indicated the glucometers used for Resident accu-check should be cleaned according to policy and the manufacturer's wipes. On 11/17/21 at 12:17 p.m., the Administrator provided an undated document, titled, "Technical Data Bulletin, Super Sani-Cloth, Germicidal Disposable Wipe." It indicated, " ...most organisms are killed within two (2) minutes by			

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	exposure to the liquid in the wipe ...." A current policy, titled, "Glasswater Creek of Plainfield Cleaning/Disinfecting of Glucometer," with no date, was provided by the Administrator, on 11/17/21 at 11:36 a.m. A review of the policy, indicated, " ...ALL glucometers will be cleaned and disinfected using Clorox Germicidal wipe ...ALL glucometers that will be shared by multiple residents will be thoroughly wiped with disinfectant and allowed to air dry after every used and between every resident ...." A current policy, titled, "Medication Oversight, Administration, Storage," with no date, was provided by the Administrator, on 11/15/21 at 3:05 p.m. A review of the policy, indicated, " ...If a resident is assessed as needing medication administration, it is the responsibility of the licensed nursing personnel or qualified medication aide to administer the medications to the resident. It is the responsibility of the Nursing Supervisor and/or Staff Nurse to administer all injectable medications ...Medication administration shall be provided as ordered by the resident's physician ...The individual administering the medication shall document the administration in the electronic medication (or treatment) administration record ...."			
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on observation, interview and record review, the facility failed to ensure a resident's (Resident D) diet order was reviewed/revised as needed by a physician to accommodate her needs for 1 of 5 residents reviewed for diet orders.	R 0275	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident D experienced no adverse effects from the alleged	01/16/2022

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	Findings include: On 11/15/21 at 2:34 p.m., Resident D was observed in her room. She sat in a recliner and during an interview at this time indicated, she had lived at the facility for almost a year and was doing okay. The food was not too bad, but sometimes she preferred to stay in her room and make her own meals. She indicated she had a special diet for her diabetes, and sometimes was given too many carbohydrates on her meal trays. On 11/16/21 at 10:00 a.m., Resident D's medical record was reviewed. She had an admission order sheet dated 1/27/21, where the physician wrote in a special diet order, "low carb, diabetic diet." The order sheet was signed and dated by the physician. Resident D's current Physician order sheet dated 11/1/21, did not indicate her special diet. Neither were, "regular" or "heart healthy" options circled/indicated. During an interview on 11/16/21 at 11:25 a.m., the Director of Nursing (DON) indicated, the facility did not offer special diet plans, and only offered two types of diets, regular, or heart healthy. The DON indicated, whoever completed the admission paperwork for Resident D missed the written special order and did not contact the physician at that time to revise the order. Usually, when the facility faxed the admission order sheet to the physician, they would check one of the boxes for regular or heart healthy, but this physician hand-wrote in a diet order that was not provided by the facility, so they would need to call the physician and have it re-ordered.		deficiency. Following the survey, DON contacted resident's MD to notify that the facility is unable to accommodate a "low carb, diabetic" diet, and requested the order be changed to heart healthy. Resident is currently hospitalized and facility requested diet order to be changed prior to resident return. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficiency. No residents experienced adverse effects from the alleged deficiency. All resident diet orders will be reviewed no later than January 16, 2022. Any diet order found out of compliance with facility policy will be addressed with resident's MD for further direction. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All licensed nursing personnel will be in-serviced on therapeutic diet policy no later than January 16, 2022 and as needed. All new	

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	On 11/17/21 at 12:36 p.m., the Administrator (ADM) provided a copy of current, but undated, facility policy titled, "Therapeutic Diets." The policy indicated, "It is the policy of this facility to offer therapeutic diets to residents. The therapeutic diets that will be offered are version of the No Added Salt (NAS), Consistent Carbohydrates (Diabetic), Low Fat/Low Cholesterol Diet.... The menu shall include food choices that allow a resident to choose foods that will meet the requirements of a therapeutic diet as ordered by a resident's physician... The Nursing Supervisor will communicate in writing all physician ordered therapeutic diets to the Dietary Service Manager. the Dietary Service Manager will ensure the therapeutic diet is prepared and served as prescribed...."		licensed nursing personnel will receive in-servicing on therapeutic diet policy during job-specific orientation and as needed moving forward. All new admission diet orders will be reviewed by DON moving forward. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON or designee will review all resident diet orders prior to resident admission to the facility. Any orders found out of compliance of current therapeutic diet policy will be reviewed with resident MD prior to resident admission to ensure compliance. DON will monitor any new diet orders as needed. Results to be reviewed at monthly QI meeting for six months and as needed.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the			

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	resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure a resident had a correct code status according to the resident's desire for end-of-life choices for 1 of 5 residents reviewed for end-of-life choices (Resident L). Findings include: On 11/16/21 at 10:02 a.m., Resident L's paper and electronic medical records were comprehensively reviewed. He was admitted to the facility on 10/19/21. His diagnoses included, but were not limited to, dyspnea (shortness of breath), diabetes mellitus (disorder of blood sugar), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea (OSA). A doctor's orders page from Resident L's paper chart, dated 10/12/21, signed by Resident L's physician indicated the resident was a full code (to perform cardiopulmonary resuscitation) in the event Resident L's heart stopped. An Indiana Physician Orders for Scope of Treatment (POST) form, dated 10/19/21, indicated Resident L was a do not resuscitate (DNR). It was signed by the resident as his wishes for his end-of-life choices. It was not valid because it was not signed by a physician.	R 0356	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident L experienced no adverse effects from the alleged deficient practice. Resident L's code status was added to EMR and changed to DNR upon receipt of POST form signed by MD that indicated resident wished to change code status to DNR. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practice. No residents experienced adverse effects from the alleged deficiency. Administrator and DON audited EMR for code status discrepancies and made necessary changes. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the	01/16/2022

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	Resident L's electronic medical record (EMR) was reviewed for his end-of-life choices. There was no code information in his EMR. During an interview, on 11/16/21 at 10:56 a.m., the Director of Nursing (DON) indicated Resident L signed his DNR POST form when he admitted on 10/19/21. He indicated the DNR was his choice for end-of-life care. The physician's orders from Resident L indicated he was a full code on 10/12/21. She talked with Resident L, and he indicated to her he did not care what the physician order said, he wanted to be a DNR. His code status had not been changed because his physician was hard to reach, and she had not yet signed him up for the facility healthcare providers, Grace at Home (GAH). Resident L was signed up with GAH on 11/16/21. When she arrived as DON here, she has had a mountain of work to do here. She checked Resident L's EMR and indicated his POST form was not in the computer, but the nurses know to looked in the paper medical chart under tab 1. During an interview, on 11/16/21 at 11:11 a.m., Licensed Practical Nurse (LPN) 12 indicated if she needed a code status for a resident, she looked in the computer. During an interview, on 11/16/21 at 3:16 p.m., the DON indicated she tried to get Resident L's POST form signed by his physician by fax. She received information from the physician's office indicating Resident L was no longer his patient and would not sign the POST form. GAH indicated would not sign his POST form until they saw him as a patient. The first day GAH saw him was 11/16/21. A current policy, titled, "Resident Code Status		deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All clinical personnel will be in-serviced on code status policy and proper documentation of code status no later than January 16, 2022. DON to audit current code status of new admissions for discrepancies, as well as any changes in order for code status of current residents moving forward. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON or designee will audit orders for current code status of new admissions. DON or designee will audit EMR for code status discrepancies with current MD orders a minimum of 1x/week for 8 weeks, then 1x every other week for 8 weeks, then 1x/month for 2 months. Results to be reviewed and discussed at monthly QI for six months meeting and as needed.	

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	Identification System" dated 11/2021, was provided by the Administrator on 11/16/21 at 1:50 p.m. A review of the policy, indicated, " ...The purpose of this policy is to provide guidelines and procedures for the decision to initiate, terminate, or withhold cardiopulmonary resuscitative measures ...It is the responsibility of licensed nursing personnel to identify the current code status for each resident upon admission ...It is the responsibility of the Director of Nursing, or designee, to place the code status on the resident service plan ...."			
R 0379 Bldg. 00	410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency (c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record. Based on interview and record review, the facility failed to ensure a resident, (Resident K) with a diagnosis of a severe mental illness was comprehensively care planned for any special mental health needs. This deficient practice had the potential to effect 1 of 5 residents reviewed for mental health screening. Findings include:	R 0379	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident K experienced no adverse effects from the alleged deficient practice. Resident K was referred to GuideStar psych services following an audit that concluded on November 19, 2021.	01/16/2022

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	During the survey entrance conference, on 11/15/21 at 9:30 a.m., the Administrator (ADM) provided a list of residents who had a diagnosis of a major mental illness. Resident K was listed due to her diagnosis of Schizophrenia. On 11/17/21 at 9:30 a.m., Resident K's medical record was reviewed. She was admitted to the facility on 11/28/2020 with an active diagnosis of paranoid schizophrenia (a mental illness characterized by symptoms delusions and hallucinations which blur the line between what is real and what is not). A SLUMS (Saint Louis University Mental Status) Examination, (a method of screening for Alzheimer's disease and other kinds of dementia) was dated 11/3/2020 and indicated Resident K had dementia. She had a physician order for Olanzapine (an antipsychotic medication) 20 mg (milligrams) to be given once a day at bedtime. The record lacked documentation of comprehensive mental health screening. The record lacked documentation of a comprehensive care plan to address the resident's needs related to her paranoid schizophrenia. During an interview on 11/17/21 at 12:20 p.m., the Director of Nursing (DON) indicated, if a resident was admitted with a severe mental illness and received Medicaid, like Resident K, the facility should request at least two years' worth of medical records related to mental health. It was important to complete mental health screens to		2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents diagnosed with major mental illness had the potential to be affected by the alleged deficient practice. No residents experienced adverse effects from the alleged deficient practice. GuideStar psych services conducted an audit concluding on November 19, 2021 of all residents for diagnoses of major mental illness and all residents found with a diagnosis of a major mental illness were referred to GuideStar psych services. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All clinical personnel will be in-serviced on policy regarding major mental illness and process for referring those residents with a major mental illness diagnosis to an appropriate provider to develop a comprehensive care plan. DON or designee will audit all new admissions for diagnosis of major mental illness and refer to an	

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	determine what potential behaviors the resident might have like, wandering, outbursts, or agitation/aggression, then a care plan should be put in place to address those issues. The DON reviewed Resident K's record and indicated there was not comprehensive mental health screen or care plan. The DON indicated the facility should follow the state rules. A Mental Health Screening and Comprehensive Care Plan Policy was requested on 11/16/21 at 2:55 p.m., 11/17/21 at 10:15 a.m., and 11/17/21 at 12:23 p.m., but not provided. The Indiana Department of Health, Residential Regulations 410 IAC 16.2, dated 2008 indicated, "...If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record...."		appropriate provider as needed upon admission and develop comprehensive care plan related to diagnosis of major mental illness. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON will monitor any new diagnoses a minimum of 1x every other week for 2 months, 1x/month for 4 months, and as needed moving forward. When needed, DON will refer current residents with new major mental health diagnoses to an appropriate provider. Results to be reviewed at monthly QI meeting for six months and as needed.	
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,			

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	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 follow CDC (Centers for Disease Control) guidance during a pandemic and ensure resident vital signs and COVID-19 signs and symptoms were monitored for 4 of 5 residents reviewed for COVID-19 monitoring (Residents C, E, G, and P). Findings include: 1. On 11/17/21 at 10:15 a.m., Resident E's record was reviewed. A nurses note dated 11/8/21 at 10:00 a.m., indicated Resident E was transferred from the facility to a local hospital due to a dry cough. The resident was admitted to the hospital and had tested positive for COVID-19. A nurses note dated 11/11/21 at 6:02 p.m., indicated, Resident E returned to the facility, from the hospital, and would be placed in isolation due to COVID-19 positive results. A nurses note dated 11/11/21 at 8:58 p.m., indicated, Resident E would remain on isolation for 14-days and her vital signs would be checked every shift (three times a day). A nurses note dated 11/13/21 at 1:07 p.m., indicated, the resident remained in quarantine. Her vital signs were checked, and the residents denies signs and symptoms of COVID-19.	R 0407	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Residents C, E, G, and P experienced no adverse effects from the alleged deficient practice. Staff to be in-serviced on policy for Daily temperatures, vitals, and pulse Oximetry Log no later than January 16, 2022. Facility will implement daily vitals, temperatures, and Pulse Oximetry log for each resident as required by current CDC guidelines no later than December 16, 2021. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practice. No residents experienced adverse effects from the alleged deficient practice. Facility will implement daily vitals, temperatures, and Pulse Oximetry log for each resident as required by current CDC guidelines no later than December 16, 2021. 3. Describe the steps or systemic	01/16/2022

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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
	A nurses note dated 11/15/21 at 8:10 p.m., indicated Resident E's vital signs were checked at that time, and the resident was not in any acute distress. A nurses note dated 11/17/21 at 1:05 a.m., indicated facility staff had left a voicemail with the resident's son to update him on his mother's condition. The resident was doing well. No complaints of pain or shortness of breath. Her vitals were monitored regularly, and she had no fever. Meals were delivered to the resident's apartment by staff while the resident remained on a 14-day quarantine after hospitalization with diagnosis of COVID-19 positive. A nurses note dated 11/17/21 at 9:41 a.m., indicated, Resident E remained on quarantine. Her vital signs were checked, and within normal limits. Resident E complained of chest congestion, dizziness, and discomfort related to a hernia. Resident E's vital signs record for 11/11/21 to 11/17/21 was reviewed. The record indicated, Resident E had blood pressure (BP), heart rate/ pulse (HR), temperature, Respiratory rate (RR), and pulse ox (pulse oximetry, oxygen saturation) checked once for the dates reviewed. On 11/16/21, resident E had her vital signs checked twice. On 11/17/21 at 11:37 a.m., the Administrator (Admin) provided a document titled, "Current Quarantine List". The document indicated, Resident E's quarantine period began on 11/10/21 and was scheduled to end on 11/24/21. 2. On 11/17/21 at 9:54 a.m., Resident G's record was reviewed. A nurses note dated 11/11/21 at 11:17 p.m.,		changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. Staff to be in-serviced on policy for Daily Temperatures, Vitals, and Pulse Oximetry Log no later than December 30, 2021. Facility will implement daily vitals, temperatures, and Pulse Oximetry log for each resident as required by current CDC guidelines no later than January 16, 2022. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. Director of Nursing or designee will monitor Daily temperatures, vitals, and pulse Oximetry log a minimum of three (3) times per week for four (4) weeks, two (2) times per week for four (4) weeks, and once (1) per week for four (4) weeks, then as needed. Results will be reviewed at monthly QI meeting for three (3) months and on an as needed basis between monthly meetings.	

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		A. BUILDING 00 B. WING	11/17/2021

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	indicated, Resident G arrived at the facility on that date for admission. The note lacked documentation regarding the resident's isolation status, vital signs, or COVID-19 symptom monitoring. A nurses note dated 11/11/21 at 11:24 p.m., indicated Resident G's blood pressure was rechecked due to being elevated on the admission BP check. The resident's vital signs were checked. The resident denied complaint of a headache or any discomfort. The note lacked documentation regarding the resident's isolation status or COVID-19 symptom monitoring. A nurses note dated 11/13/21 at 1:01 p.m., indicated Resident G's vital signs were checked. The resident was afebrile (without fever) and denied shortness of breath or cough. The note lacked documentation regarding the resident's isolation status. A nurses note dated 11/14/21 at 12:32 p.m., indicated Resident G continued on quarantine with meals delivered to the resident's apartment. The resident had no complaints, and her vital signs were within normal limits. A nurses note dated 11/15/21 at 8:09 p.m., indicated, Resident G's vital signs were taken, and no acute distress was observed. The note lacked documentation regarding the resident's isolation status. A nurses note dated 11/16/21 at 1:35 p.m., indicated a PPD (a test to detect the immunity developed against tuberculosis causing bacteria) was placed in the resident's right forearm. The note lacked documentation regarding the resident's isolation status, vital signs, or COVID-19 symptom monitoring.			

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	Resident G's vital signs record for 11/11/21 to 11/17/21 was reviewed. The record indicated on: 11/17/21: BP, HR, temperature, RR, Pulse Ox checked once. 11/16/21: BP, HR, temperature, RR checked three times. Pulse ox checked twice. 11/15/21: BP and RR checked once. HR, temperature, and pulse ox checked three times. 11/14/21: BP and RR checked once. HR, temperature, and pulse ox checked three times. 11/13/21: BP and RR checked once. HR, temperature, and pulse ox checked three times. 11/12/21: No documented vital signs 11/11/21: BP, HR, temperature, RR, Pulse Ox checked twice. On 11/17/21 at 11:37 a.m., the Administrator (Admin) provided a document titled, "Current Quarantine List". The document indicated, Resident G's quarantine period began on 11/11/21 and was scheduled to end on 11/25/21. 3. On 11/15/21 at 10:43 a.m., Resident C was observed and interviewed. He indicated the facility used to check his vital signs, but that had stopped about 3 weeks ago. On 11/16/21 at 10:00 a.m., Resident C's record was comprehensively reviewed. Vital signs records indicated, Resident C had his HR, temperature, and pulse ox checked on: 10/26/21, 10/24/21, 10/23/21, 10/7/21, 10/3/21, 10/2/21, 10/1/21, 9/30/21, 9/24/21, and 9/21/21. He had his blood pressure checked on 9/25/21 and 9/21/21. 4. On 11/15/21 at 3:03 p.m., Resident P was observed and interviewed. He indicated the			

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	facility did not check his vital signs regularly. On 11/16/21 at 11:08 a.m., Resident P's record was comprehensively reviewed. Vital signs records indicated, Resident P had his HR, temperature, and pulse ox checked on 10/9/21, 10/6/21, 10/5/21, 10/3/21, 10/2/21, 10/1/21, and 9/30/21. On 9/25/21, his BP, temperature, and pulse ox were checked. During an interview on 11/16/21 at 1:50 p.m., the Director of Nursing (DON) indicated, all residents in the facility should have a daily check of HR, temperature, and pulse ox. All residents are also screened for COVID-19 signs and symptoms. People on quarantine get those vital signs and COVID-19 signs and symptoms checked three times a day. That is documented and kept on paper. On 11/17/21 at 12:06 p.m., records for Residents C, E, G, and P were reviewed with the DON. She indicated the records reflected all the documentation available for the residents reviewed. The DON indicated, it was the facility expectation to check vital signs and COVID-19 signs and symptoms for residents in isolation or quarantine at least 3 times a day. Staff should document the vital signs and the symptom monitoring in the resident record. On 11/17/21 at 10:45 a.m., the Administrator provided a policy titled, "Universal Screening Policy", dated last revised 8/2021. She indicated this was the current policy in use by the facility at that time. The policy indicated, "All residents shall have a Daily Wellness Check completed on a specified schedule ...Residents who are suspected, symptomatic, and/ or confirmed to			

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	have COVID-19 shall have the Daily Wellness Check completed every three times a day. During the Daily Wellness Check, the following is monitored, including but not limited to: temperature, pulse oximetry [oxygen saturation], pulse [HR], and signs & symptoms of COVID-19 or COVID-19 like illness ...The Daily Temperature & Pulse Ox Log shall also be updated at the time of Daily Wellness Check completion." CDC guidance, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", dated 9/10/21, indicated, "Evaluate Residents at least Daily: Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. Actively monitor all residents upon admission and at least daily for fever (temperature 100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry ... Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection ... Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection." 410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance			
R 0410				

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Bldg. 00	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure first and second step tuberculous (infectious bacterial disease) screens were complete for 3 of 5 residents reviewed for admission screenings (Resident B, K, and E), and failed to provide second step tuberculous admission screenings for 2 of 5 residents reviewed for second step tuberculous screenings (Resident L and D). Findings include: 1. On 11/17/21 at 12:10 p.m., Resident B's medical record was comrehensively reviewed and the record lacked documentation for her required admission first and second step tuberculous screenings. She was admitted on 5/10/21.	R 0410	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Residents B, K, E, L, and D experienced no adverse effects from the alleged deficient practice. Residents B, K, E, D, and L will receive first step TB test on December 17, 2021. Residents B, K, E, D, and L will received their second step TB test 1-3 weeks after the first step per polic. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct	01/16/2022

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	2. On 11/17/21 at 12:13 p.m., Resident L's medical record was comprehensively reviewed and his immunization record indicated on 10/19/21 he received, "step 1 of 2 steps," of the required tuberculous screenings. No second step was found in his paper or EMR. He was admitted on 10/23/21. 3. On 11/17/21 at 9:30 a.m., Resident K's medical record was reviewed. She was admitted to the facility on 11/28/2020. The record lacked documentation that an admission Tuberculosis (TB) skin test had been initiated or completed. 4. On 11/16/21 at 10:00 a.m., Resident D's medical record was reviewed. Resident D was admitted on 2/1/21. An initial TB skin test was placed on 2/2/21, but the record lacked documentation the two-step TB test had been completed. TB skin test documentation was requested on 11/16/21 at 2:55 p.m., 11/17/21 at 10:15 a.m., and 11/17/21 at 12:23 p.m., but not provided. On 11/16/21 at 1:50 p.m., the Administrator (ADM) provided a copy of current facility policy titled, "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," dated, 9/21. The policy indicated, "Residents and employees of health care communities have been identified as a high-risk group for re-activation of laten TB infection, acquisition of TB infection and potential spread of TB within the community... a health screen is required for each resident: the screen will include a Mantoux tuberculin test unless a		the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practice. No residents experienced adverse effects from the alleged deficient practice. DON will complete first step TB tests on all residents currently in the facility by date of December 20, 2021. All residents currently in the facility will receive second step TB tests 1-3 weeks after first step per policy. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All licensed nursing personnel will be in-serviced on TB administration policy no later than January 16, 2022. DON or designee will be responsible for ensuring all new residents receive two-step TB test appropriately, and that all current residents receive annual TB tests appropriately. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON or designee will be responsible for ensuring	

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	previously positive reaction can be documented. Tuberculosis screening shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours an annually thereafter. The result step in 7-21 days...."		compliance on all current and new resident TB tests. DON will monitor all new admissions within 3 days of admission to ensure completion of first step TB test, then again 1-3 weeks later to ensure completion of second-step of TB test. DON will be responsible for monitoring annual TB tests for current residents annually. Results to be reviewed at monthly QI meeting for six months. and as needed.	