

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/14/2023
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NAME OF PROVIDER OR SUPPLIER  MELROSE ASSISTED LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP COD 7101 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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R 0000  Bldg. 00	<p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: September 13, 14, 2023</p> <p>Facility number: 014866</p> <p>Residential Census: 5</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on September 19, 2023.</p>	R 0000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p> <p>This plan of correction is submitted timely and in accordance with State and Federal Regulatory Guidelines.</p> <p>In this document, we have outlined specific actions in response to identified issues. We remain committed to providing the best care and will continue to make changes and improvements to achieve our desired results.</p> <p>The facility is requesting a desk review for compliance in these areas.</p>	
R 0216  Bldg. 00	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance</p> <p>(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:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leslie Head	Administrator	09/29/2023

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>(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 that were self-administering medications were assessed for capability to self-administer medications for 1 of 4 residents reviewed for medication administration. (Resident 5)</p> <p>Finding includes:</p> <p>On 9/14/23 at 7:46 A.M., LPN (Licensed Practical Nurse) 3 was observed to administer medications for Resident 5 in his room. Medications prepared for administration included, but were not limited to, 1 aspirin (Nonsteroidal anti-inflammatory drug and blood thinner) 81 mg (milligrams) tablet, 4 cinnamon (supplement) 500 mg capsules, 1 colestipol (cholesterol medication) 1 gm (gram) tablet, 1 ezetimibe (cholesterol medication) 10 mg tablet, 1 Farxiga (diabetes medication) 10 mg tablet, 1 fish oil (supplement) 1000 mg capsule, 1 hydrochlorothiazide (diuretic) 25 mg tablet, 1 hydroxychloroquine (immunosuppressive drug and anti-parasite) 200 mg tablet, 14 units insulin aspart (fast-acting insulin), 1 losartan (blood pressure medication) 100 mg tablet, 2 metoprolol (blood pressure medication) 50 mg tablets, 1 nabumetone (Nonsteroidal anti-inflammatory drug) 740 mg tablet, 1 sertraline (antidepressant) 50 mg tablet, and 1 spironolactone (diuretic) 25 mg tablet. LPN 3 placed the medications in a medication cup on the resident's bedside table and left the room before the resident took the medications.</p> <p>On 9/13/23 at 10:30 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but</p>	R 0216	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 9/15/23 a memo was released to all appropriate staff educating them that medication is not to be left at bedside.</p> <p>All residents had the potential to be affected by deficient practice, but after a review of all residents, no negative effects of deficient practice were found.</p> <p>The corrective action taken immediately for staff found to be deficient was education of proper medication administration. Additionally, ensure all appropriate staff are educated on proper medication administration. Inservice is being conducted. This will be completed by 10/6/23.</p> <p>To ensure that the deficient practice does not reoccur, all appropriate new employees will be educated on facility medication administration.</p> <p>The facility plans to monitor its performance to ensure that solutions are sustained by performing random audits of</p>	10/06/2023

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	<p>were not limited to, diabetes mellitus and rheumatoid arthritis.</p> <p>Current physician orders included, but was not limited to:</p> <p>Aspirin 81 mg - Give 1 tablet by mouth once daily, dated 9/6/23</p> <p>Cinnamon 500 mg - Give 4 capsules (2000 mg) by mouth once daily, dated 9/6/23</p> <p>Colestipol 1 gm - Give 1 tablet by mouth twice daily, dated 9/6/23</p> <p>Ezetimibe 10 mg - Give 1 tablet by mouth once daily, dated 9/6/23</p> <p>Farxiga 10 mg - Give 1 tablet by mouth once daily, dated 9/6/23</p> <p>Fish oil 1000 mg - Give 1 capsule by mouth twice daily, dated 9/6/23</p> <p>Hydrochlorothiazide 25mg - Give 1 tablet by mouth once daily, dated 9/6/23</p> <p>Hydroxychloroquine 200 mg - Give 1 tablet by mouth twice daily, dated 9/6/23</p> <p>Insulin aspart injection Flexpen - Inject subcutaneously as directed per sliding scale before meals and at bedtime 0 - 199 = 0 U (units), 200 - 209 = 3 U, 210 - 229 = 4 U, 230 - 249 = 5 U, 250 - 269 = 6 U, 270 - 299 = 7 U, over 300 = 8U (up to 60 units daily), dated 9/9/23</p> <p>Insulin aspart injection Flexpen - Inject 10 units subcutaneously three times daily, dated 9/8/23</p> <p>Losartan 100mg - Give 1 tablet by mouth once daily, dated 9/6/23</p> <p>Metoprolol 50mg ER (extended release) - Give 2 tablets (100 mg) by mouth every morning, dated 9/6/23</p> <p>Nabumetone 740 mg - Give 1 tablet by mouth twice daily, dated 9/11/23</p> <p>Sertraline 50mg - Give 1 tablet by mouth once daily, dated 9/11/23</p> <p>Spirolactone 25mg - Give 1 tablet by mouth twice daily, dated 9/6/23</p>		<p>medication administration passes. The DON/Administrator will conduct audits 2x per week for 4 weeks, and 1x per month for 5 months, or until total compliance is achieved.</p>	

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R 0246 Bldg. 00	<p>The clinical record lacked an order for self-administration of medications.</p> <p>The clinical record lacked a care plan related to self-administration of medications.</p> <p>The Physician Assessment, dated 9/1/23, indicated the resident should be supervised while taking medications.</p> <p>On 9/13/23 at 8:54 A.M., the DON (Director of Nursing) indicated there were no current residents who self-administer medication.</p> <p>On 9/14/23 at 9:58 A.M., the DON indicated that staff should not leave medications at bedside and should watch the residents take their medications.</p> <p>On 9/14/23 at 10:30 A.M., the Administrator indicated that there was not a facility policy related to self-administration of medication; however, the staff should not leave medications at bedside.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to obtain authorization from a licensed nurse prior to a Qualified Medication Aide (QMA)</p>	R 0246	What corrective action will be accomplished for those residents found to have been affected by the	10/06/2023

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	<p>administering as needed (prn) medications for 2 of 5 resident records reviewed. (Resident 2, Resident 4)</p> <p>Findings include:</p> <p>1. On 9/13/23 at 10:00 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and depression. Resident 2 was admitted 8/1/23.</p> <p>Current physician orders included, but were not limited to:</p> <p>clonazepam 1mg (milligram) at bedtime as needed, dated 8/18/23.</p> <p>cyclobenzapr 10mg three times a day as needed for muscle spasms, dated 7/28/23.</p> <p>tramadol/APAP 37.5/325 every 4 hours as needed, dated 8/10/23.</p> <p>Resident 2's Medication Administration Record (MAR) from 8/1/23 through current included the following as needed medications administered by QMA 5:</p> <p>tramadol/APAP 37.5/325 administered 9/1/23 at 6:33 P.M. Effectiveness documented by a Licensed Practical Nurse (LPN) on 9/2/23 at 5:20 A.M.</p> <p>cyclobenzapr 10mg administered 9/4/23 at 6:37 P.M. Effectiveness documented by an LPN on 9/5/23 at 5:13 A.M.</p> <p>tramadol/APAP 37.5/325 administered 9/2/23 at 9:50 P.M. Effectiveness documented by an LPN on 9/3/23 at 12:32 P.M.</p> <p>cyclobenzapr 10mg administered 9/2/23 at 9:50</p>		<p>deficient practice?</p> <p>Immediately upon findings QMA was educated on proper guidelines for PRN medication administration by a QMA.</p> <p>All residents had the potential to be affected by deficient practice, but after a review of all residents, no negative effects of deficient practice were found.</p> <p>The corrective action that is being implemented is creating QMA PRN Administration Guideline document that will be educated via an Inservice to all appropriate staff and posted at nurse's station. All appropriate staff will be Inservice by 10/6/23.</p> <p>To ensure that the deficient practice does not reoccur, all appropriate new employees will be educated on proper PRN medication administration by a QMA.</p> <p>The facility plans to monitor its performance to ensure that solutions are sustained by performing random audits of medication administration passes. The DON/Administrator will conduct audits 2x per week for 4 weeks, and 1x per month for 5 months, or until total compliance is achieved.</p>	

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	<p>P.M. Effectiveness documented by an LPN on 9/3/23 at 12:32 P.M.</p> <p>clonazepam 1mg administered 9/2/23 at 9:50 P.M. Effectiveness documented by an LPN on 9/3/23 at 12:32 P.M.</p> <p>tramadol/APAP 37.5/325 administered 9/4/23 at 6:37 P.M. Effectiveness documented by an LPN on 9/5/23 at 5:13 A.M.</p> <p>cyclobenzapr 10mg administered 9/11/23 at 9:27 P.M. Effectiveness documented by an LPN on 9/12/23 at 5:44 A.M.</p> <p>clonazepam 1mg administered 9/11/23 at 9:27 P.M. Effectiveness documented by an LPN on 9/12/23 at 5:44 A.M.</p> <p>Resident 2's clinical record lacked documentation that authorization was given by a licensed nurse prior to the QMA administering prn medications to the resident.</p> <p>2. On 9/13/23 at 10:13 A.M., Resident 4's clinical record was reviewed. Resident 4's diagnoses included, but were not limited to, diastolic heart failure.</p> <p>Current physician orders included, but were not limited to: Lorazepam 0.5 mg tablet - Give 1 tablet by mouth every 12 hours as needed for mood, dated 7/19/23</p> <p>The MAR indicated QMA 5 gave Resident 4 1 lorazepam 0.5 mg tablet on 9/11/23 at 9:23 P.M.</p> <p>The clinical record lacked documentation of approval by a nurse prior to medication administration.</p>			

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R 0247 Bldg. 00	<p>On 9/14/23 at 9:58 A.M., the Director of Nursing (DON) and Administrator indicated QMAs should call a nurse for prior authorization before administering prn medications. At that time, the Administrator indicated the facility did not have a policy related to QMAs administering prn medications, but did indicate when a QMA administered prn medications, they should contact a nurse prior to administration, as well as the nurse to assess and document effectiveness.</p> <p>"Qualified Medication Aide Scope of Practice" was retrieved on 9/14/23 from the Indiana Government website. The Scope of Practice included, but was not limited to the following: "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident 's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty"</p> <p>410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The</p>						

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	<p>physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medication was prepared according to manufacturer instructions to prevent medication errors for 1 of 4 residents reviewed for medication administration (Resident 5). An insulin pen was not primed prior to insulin administration.</p> <p>Finding includes:</p> <p>On 9/14/23 at 7:46 A.M., LPN (Licensed Practical Nurse) 3 was observed preparing an insulin aspart (fast-acting insulin) flexpen for Resident 5. Resident 5's blood sugar was 226. LPN turned the dose selector to 14 units. At that time, LPN 3 indicated the pen did not need to be primed before injection. LPN 3 injected the prepared insulin into Resident 5's abdomen.</p> <p>On 9/13/23 at 10:30 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and rheumatoid arthritis.</p> <p>Current physician orders included, but was not limited to:</p> <p>Insulin aspart injection Flexpen - Inject subcutaneously as directed per sliding scale before meals and at bedtime 0 - 199 = 0 U (units), 200 - 209 = 3 U, 210 - 229 = 4 U, 230 - 249 = 5 U, 250 - 269 = 6 U, 270 - 299 = 7 U, over 300 = 8U (up to 60 units daily), dated 9/9/23</p> <p>Insulin aspart injection Flexpen - Inject 10 units subcutaneously three times daily, dated 9/8/23</p>	R 0247	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Immediately upon findings of deficient practice, appropriate staff was educated on how to properly administer insulin via a flexpen.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents that are insulin dependent had the potential to be affected by deficient practice.</p> <p>The corrective action that is being implemented is an Inservice from our pharmacy and education to all appropriate staff on the proper way to administer insulin via a pen, additionally the need for pens to be primed.</p> <p>To ensure that the deficient practice does not recur, all new employees will be educated to always check the manufactures recommendations when administering insulin via a pen to ensure proper administration is being conducted.</p> <p>The facility plan to monitor its performance to make sure that</p>	10/12/2023

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R 0273  Bldg. 00	<p>On 9/14/23 at 10:33 A.M., the manufacturer's insert for the insulin aspart indicated "to avoid injecting air and to ensure proper dosing turn the dose selector to select 2 units".</p> <p>On 9/14/23 at 9:58 A.M., the DON (Director of Nursing) indicated that all insulin pens should be primed before injection administration.</p> <p>On 9/14/23 at 10:30 A.M., the Administrator indicated there was no facility policy related to insulin administration; however, staff should always prime the insulin pen prior to injection administration.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food containers and kitchen utensils were stored and sanitized appropriately in 2 of 2 kitchen observations.</p> <p>Findings include:</p> <p>On 9/13/23 at 8:46 A.M., the following was observed in the kitchen: on a silver prep table 3 bowls of corn flakes dated 9/6 1 bowl of oat rings dated 9/4</p> <p>On 9/13/23 at 9:03 A.M., the following was observed in the walk in freezer: french fries were open and not dated</p>	R 0273	<p>solutions are sustained by the DON conducting random audits of insulin administration to ensure all staff are administering properly and following manufactures recommendations. The audits will be conducted 2x per week for 4 weeks, and 1x per month for 5 months, or until total compliance is achieved.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility immediately completed a full walk through of food storage areas and disposed of all unlabeled foods, and thoroughly cleaned all shelves.</p> <p>All residents had the potential to be affected by deficient practice.</p> <p>The following corrective action was taken; All staff were in-serviced on proper labeling and storing of food, proper storage of ice scoop, and</p>	10/06/2023

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	<p>On 9/13/23 at 9:06 A.M., the following was observed in the walk in refrigerator: carrots in bag were open and not dated potatoes were in a box and not dated strawberries open lid container but not dated 1 small jar of maraschino cherries not dated 1 container of white vinegar open but not dated 1 green container was dated but not labeled with the contents 2 cartons of 4 scrambled eggs were open and not dated</p> <p>On 9/13/23 at 9:15 A.M., the following was observed in the food preparation area: the spice rack ledge was sticky</p> <p>On 9/13/23 at 9:17 A.M., the following was observed in the kitchen refrigerator: 3 pitchers of unlabeled, orange colored fluid covered with plastic, 1 was dated 9/13/23 while the other 2 were not dated.</p> <p>On 9/13/23 at 9:20 A.M., the following was observed by the ice machine: ice scoop was laying on table next to ice machine uncovered</p> <p>On 9/14/23 at 8:11 A.M., the following was observed in kitchen: on a silver prep table 3 bowls of corn flakes dated 9/6 1 bowl of oat rings dated 9/4</p> <p>On 9/14/23 at 8:29 A.M., the following was observed in the food preparation area: the spice rack ledge was sticky</p> <p>On 9/13/23 at 8:45 A.M., the following was observed by the ice machine:</p>		<p>educated on newly created cleaning sheets.</p> <p>To ensure that the deficient practice does not recur, cleaning schedules have been created and will need to be signed off on daily to ensure completion. All appropriate staff will be educated on food labeling, storage of food items, and how to properly use the ice scoop.</p> <p>The facility plans to monitor its performance to make sure that solutions are sustained by the creation of cleaning sheets being brought to weekly manager meeting to ensure that they are being completed. Administrator or designee will conduct walk throughs of kitchen 2x per week for 4 weeks, and 2x per month for 5 months, or until total compliance is achieved.</p>	

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R 0410 Bldg. 00	<p>ice scoop was laying on soda machines next to ice machine uncovered</p> <p>During an interview on 9/14/23 at 10:15 A.M., a kitchen worker indicated all food in containers should be labeled with contents and dated with preparation date.</p> <p>During an interview on 9/14/23 at 10:17 A.M., the dietary manager indicated the ice machine must be washed and sanitized after each use.</p> <p>On 9/14/23 at 10:27 A.M., a current policy "Dietary Sanitation and Safety" dated 7/1/23 was by the Administrator but did not indicated labeling or sanitization.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/14/2023
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NAME OF PROVIDER OR SUPPLIER  MELROSE ASSISTED LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP COD 7101 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	<p><b>a diagnosis.</b> Based on interview and record review, the facility failed to ensure admission Tuberculin testing was completed or documented for 1 of 5 residents. (Resident 5)</p> <p>Finding includes:</p> <p>On 09/13/23 at 10:30 AM, Resident 5's clinical record was reviewed. Resident 5 was admitted on 9/7/2023. Diagnoses included type 2 Diabetes Mellitus and Rheumatoid Arthritis.</p> <p>The clinical record lacked Tuberculin(TB) test results since admission. Documentation containing the Tuberculin testing administration and results was requested and unable to be provided.</p> <p>During an interview on 9/14/23 at 12:59 P.M., the Administrator indicated all residents should have a TB test on admission and a TB test for Resident 5 was not documented.</p> <p>A policy titled Infection Control, dated 5/20/2023, was provided on 9/14/2023 at 1:11 P.M., and indicated "2. A tuberculin skintest shall be completed within three months prior to admission or upon admission and read at forty-eight to seventy-two hours. The results shall be read in millimeters of induration with the date given, date read and by whom administered and read."</p>	R 0410	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On 9/15/23 a nurse administered first step PPD to resident found to be affected by deficient practice. Administration of test and results were documented in said residence chart within appropriate time frame.</p> <p>No other residents were found to be affected by deficient practice.</p> <p>The corrective action taken was that educating the DON and staff on how to properly add PPD first and second step orders into the facilities EMR system. This will ensure there is proper documentation of PPD being administered and read in the regulated time frame.</p> <p>Additionally, multiple staff nurses have become TB certified, which allows us to have multiple staff members who can give and read PPD test ensure all new incoming admissions can receive their first and second step administration of PPD and read with an adequate time frame.</p> <p>The facility plan to monitor its performance to make sure that solutions are sustained by DON will audit all new admissions orders to ensure PPD have been</p>	10/06/2023
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-039

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NAME OF PROVIDER OR SUPPLIER  MELROSE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7101 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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			<p>administered and all documentation is completed.</p> <p>Administrator will audit all new admission charts weekly to ensure all PPD's are administered and properly documentation within proper time frame. Audits will be conducted for 6 months or until total compliance is achieved.</p>		