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	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODRIDGE VILLAGE	17650 GENERATIONS DR SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00387635, IN00382840, IN00380236 and IN00367315. Complaint IN00387635 - Substantiated. State Residential Findings are cited at R036, R214, R215, R217, R241, R243, R246, R275, R299, R300, R349, and R406. Complaint IN00382840 - Substantiated. State Residential Findings are cited at R036, R214, R215, R217, R241, R299, R300 and R349. Complaint IN00380236 - Substantiated. State Residential Findings are cited at R036, R214, R215, R217, R241, R243, R246, R299, R 300 and R349. Complaint IN00367315 - Substantiated. No state residential findings related to the allegations were cited. Survey dates: August 23, 24, 25, and 26, 2022 Facility number: 001148 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/6/22.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s			

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

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	legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on observation, record review and interviews, the facility failed to notify the physician of resident changes regarding medication and treatment refusals, medication omission and laboratory results for 3 residents in a sample of 23. (Residents D, G and C) Findings include: 1. During the initial tour of the facility, conducted on 8/20/2022 between 9:45 A.M. - 11:30 A.M., with Employee 18, the Admission Director, Resident D was observed to get himself up out of his bed and ambulate with a walker to the doorway area of his room. Employee 18 indicated Resident D was alert and oriented. The clinical record for Resident D was reviewed on 8/24/2022 at 2:00 P.M. Resident D was admitted to the facility with diagnoses included, but not limited to: diabetes mellitus type 2, chronic pain, major depressive disorder, cerebella stroke symptoms and anxiety disorder. The current physician's orders for Resident D included orders for the resident to receive Ozempic 4 mg/ml (milligrams per milliliter) injections once a week for diabetes. The resident was also to have his blood glucose level assessed three times a day and was to receive Humolog insulin as directed with a sliding scale dependent upon his blood glucose level. In addition, the	R 0036	**R 036- Resident Rights** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**· The Physician was notified of residents D, G and Cs refusals of care related to lab, treatments, and medications. The physician was also notified of the medication and laboratory omissions. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by deficient practice. · Facility will audit 10 resident charts weekly x 4 weeks and then 5 residents weekly until all resident charts have been reviewed. Results of audit will be reviewed with MD to ensure all adequate notifications have been addressed. **3. - What measures**	10/10/2022

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	resident was to receive Basaglar insulin injections, 30 units at bedtime. Review of the medication administration record for Resident D indicated he had only received the Ozempic injection one time in August from the 1 through the 24th. In addition, the resident was documented as having refused his blood glucose assessments 17 times from August 1 through August 24, 2022. There were no nursing notes located in Resident D's electronic record or his hard clinical record. During an interview on 8/25/2022 with Resident D's physician, who also served as the facility's medical director, she indicated no staff had notified her of Resident D's refusals nor of the inability of the facility to administer the Ozempic injections timely. She indicated Resident D had told her he was not receiving the injections timely. 2. The clinical record for Resident C was reviewed on 8/25/22 at 9:00 A.M. Resident C was admitted to the facility on 5/2/22 and was discharge from the facility on 6/20/22. Admitting diagnoses included, but were not limited to: stroke, hemipligia, anxiety, and pain. The physician's orders during the admission period included but were not limited to Baclofen (muscle relaxant) 5mg tablet by mouth 3 times daily, Lorazepam (anitanxiety) tablet 0.5 mg by mouth 2 times daily, and Cetirizine(antihistamine) 10 mg tablet 1 time daily. Review of the Medication Administration Record (MAR), dated 6/01/22 to 6/20/22, indicated Resident C did not receive Baclophen on the following dates and times: 6/07/22 morning and evening 6/19/22 evening 6/01/22 through 6/20/22, no doses were administered.		**will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Licensed staff and QMA's will be in-serviced on QMA's Scope of Practice, Staff Administered Medication emphasis on MD notification and medication omission documentation **4.** - How the corrective action(s) will be monitored to ensure the deficient practice will not **recur, i.e., what quality assurance program will be put into place; and** · Upon orientation with new licensed nursing staff, training will be provided regarding QMA's Scope of Practice, Job Description, and Staff Administered Medication. · Health Services Director or designee will monitor weekly x 4 then monthly with Health Services Review Schedule Audit tool for 6 months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	Resident C did not receive Lorazepam on the following dates and times: 6/09/22 morning 6/13/22 morning 6/15/22 morning Resident C did not receive Cetirizine on the following dates and times: 6/03/22 morning 6/06/22 morning 6/10/22 morning 6/14/22 morning There was no documentation explaining the medication omissions listed above. 3.The clinical record for Resident G was reviewed on 8/25/22 at 9:25 A.M. Resident G was originally admitted to the facility with diagnoses that included, but were not limited to: chronic obstructive pulmonary disease (COPD), heart failure, diabetes, and chronic pain. The current physician's orders included, but were not limited to: Levothyroxin (thyroid hormone replacement) 200mg tablet by mouth 1 time daily, Methoprol Suc (beta blocker used for heart failure) 25mg extended release tablet by mouth 1 time daily, Montelukast (antiinfammatory used to treat allergies) 10mg tablet by mouth 1 time daily, Trazodone (antidepressant) 25mg tablet by mouth at bedtime, Vitamin D3 2000 unit capsule by mouth 1 time daily, Clonazepam (anxiety) 0.5mg tablet by mouth 2 times daily, Acetaminophen 500mg tablet by mouth 3 times daily, Bethanechol (urinary retention) 10mg tablet by mouth three times daily, Hydromorphone (pain) 2 mg tablet by mouth 3 times daily, and Humalog kwik injection 100/ML per sliding scale three times daily for blood sugar readings which included readings of150-200 to give 1unit.			

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	Review of the Medication Administration Record (MAR), dated 7/1/22 to 7/25/22, indicated Resident G did not receive Levothroxin on the following dates and times: 8/13/22 morning Resident G did not receive Metoprol on the following dates and times: 8/13/22 morning 8/22/22 morning Resident G did not receive Montelukast on the following dates and times: 8/22/22 morning Resident G did not receive Trazodone on the following dates and times: 8/23/22 bedtime Resident G did not receive Vitamin D3 on the following dates and times: 8/22/22 morning Resident G did not receive Clonazepam on the following dates and times: 8/22/22 morning Resident G did not receive Acetaminophen on the following dates and times: 8/2/22 through 8/10/22 and 8/12/22 through 8/17/22, and 8/22/22 Noon 8/22/22 morning and evening Resident G did not receive Bethanechol on the following dates and times: 8/22/22 morning, lunch, and evening There was no documentation explaining the medication omissions listed above. On 8/23/22 at 2:15 P.M., the Administrator provided the policy titled, "RESIDENTIAL CARE POLICIES AND PROCEDURES STAFF ADMINISTERED MEDICATION," dated 3/1/2010, and indicated it was the current facility policy. The policy indicated, "...Record on the resident's Medication Sheet...Medication taken Time medication was taken Otherspecific			

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	information...Use the Medication Sheets that the community requires according to State regulation..Draw a circle around the square and initial it when the resident is observed not taking an ordered medication. Indicate on the back of the Medication Sheet the date, time andreason the medication was not taken... On 8/24/22 at 11:00 A.M. an interview with LPN 1 indicated nursing staff should document all medication administration on the Medication Administration Record. Any omissions of medication administration should be documented on the Medication Administration Record and the physician should be notified. This state residential finding relates to Complaints IN00380236, IN00382840 and IN00387635.			
R 0039 Bldg. 00	410 IAC 16.2-5-1.2(n) Residents' Rights- Deficiency (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference. Based on observation and interview, the facility failed to ensure residents were provided the opportunity to file grievances when they had concerns. This deficient practice had the potential to affect 53 of 53 residents who resident in the facility. (Resident G and H) Finding includes: On 8/23/22 at 2:30 P.M., an interview with Resident G indicated she does not know how to file a grievance with the facility and would not	R 0039	**R039- Resident Rights- Grievances** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**· The administrator met with resident G and H and reviewed grievances, grievances were recorded and appropriate follow up **2. How the facility will**	10/15/2022

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	know where to locate a grievance form. Resident G indicated she could go to the Administrator with concerns, but he is not always able to address her concerns. On 8/23/22 at 2:50 P.M., an interview with Resident H indicated the facility did not have a grievance process and was not aware of any grievance forms in the facility. Resident H indicated he would not go to the Administrator with concerns because the Administrator does not act on any concerns. On 8/25/22 at 3:12 P.M., an observation of the facility entry area indicated there was no place that held grievance forms for the residents. In an interview, at that time, the Business Office Manager indicated she was not aware of a Grievance Binder or Book. The Business Office Manager indicated the facility did not have grievance form for residents to complete with concerns. On 8/26/22 at 10:35 A.M., an interview with the Administrator indicated the facility did not have a grievance book or grievance forms. The Administrator indicated the residents did not have access to grievance forms because he had an open door policy and the residents were allowed to go to him and talk to him about their concerns. The Administrator indicated the residents did not have any current concerns and there was no record of previous concerns or follow-up. On 8/23/22 at 2:15 P.M., the policy titled, "RESIDENTIAL CARE POLICIES AND PROCEDURES GRIEVANCE PROCEDURE," was provided by the Administrator who indicated it was the current policy. The policy indicated,"...Resident/responsible party should		**identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by deficient practice. · IDT team will complete resident QIS questionnaire for all resident to determine any outstanding grievances or concerns **3. - What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Administrator educated by corporate staff on Grievance process and procedure, Grievance forms initiated and placed in centralized location for resident access · IDT team educated on Grievance process and procedure · All staff will be in serviced on Grievance process and Procedure · Administrator will hold resident council meeting and provide education to residents in Grievance process and procedure **4. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

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	complete a Grievance Report, which is available in the Nurse's Station or the Business Office...Administrator...will investigate the concern or grievance and notify resident...of...findings, actions taken and the resolution when necessitated...Grievance, Action Taken & Resolution will be noted in Assisted Living Grievance Manual on the Grievance Log..."		· Upon orientation with new licensed nursing staff, training will be provided regarding Resident rights and the Grievance process and procedure · Administrator or designee will monitor grievance log weekly x 4 then monthly to ensure resident grievances have been completed with adequate follow up for 6 months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or			

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	nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview, record review, and policy review, the facility's Administrator failed to assume full responsibility for determining, implementing, and monitoring facility policies that directed the facility operations. The cumulative effect of these systemic problems had the potential to result in the facility's inability to ensure the provision of quality health care and a clean safe environment for 53 of 53 residents who resided in the facility. Findings include: On 8/23/22 from 9:05 A.M. to 9:30 A.M., during a kitchen tour with the Dietary Manager, kitchen	R 0090	**R090 Administration and Management** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · On September 15, 2022, Trash barrels covered, scoops removed from food bins, Ice scoops stored in proper location. Floor cleaned behind appliances. · QMA 2 is no longer	10/15/2022

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	trash barrels were not covered, scoops were stored in food bins, ice cup scoop was stored on top of the ice machine, door to outside open, floors were dirty behind appliances. See R154 and R273 for additional information regarding kitchen and food storage. On 8/23/22 at 9:39 A.M. an interview with the Administrator indicated QMA 2 was the Nursing Director before 8/16/22, when Licensed Practical Nurse 2 began to work full time at the facility. The Administrator indicated he did not think a Nursing Director was the same as a Director of Nursing and that QMA 2 was never registered at the State Agency as the Director of Nursing. The Administrator indicated a QMA was not qualified to work as a Director of Nursing. See R117 for additional information regarding QMA 2. On 8/24/22 at 9:30 A.M., an employee record review was completed, and indicated that QMA 2, LPN 2, and CNA's 2, 4, and 5, did not have a 1st and 2nd step tuberculin skin test completed prior to or upon hire. See R121 for additional information regarding staff tuberculin skin test status. On 8/24/2022 at 2:10 P.M., an interview with the Administrator indicated the facility had not included evacuation practices with fire drills since 1/24/20 due to the Covid-19 pandemic. On 8/25/2022 at 1:00 P.M., the Administrator provided a copy of the Indiana State Department of Health Residential Regulations regarding required fire safety drills. Section 410 IAC 16.2-5-1.3(i)(1-2) indicated,"...(1) Fire exit drill in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas...is not required...." See R92 for		employed at the facility · LPN 2, CNA's 2, 4, 5, had tuberculin skin test initiated · Maintenance Director scheduled fire drill with local Fire Department for this community · Employees will be current with In-service for Dementia by October 10, 2022 · Employee file audit completed and scheduled job specific training to be completed with current facility staff by October 10th, 2022 · CPR class scheduled for staff · Grievance program initiated · Service plan completed with resident C, D and P · Semi Annual Evaluations completed for resident F, H, L, M, N and P · Service Plans reviewed and completed for residents C, G, M, D, F, L, N, P · Resident P with no negative effects related to PRN medication administration by QMA	

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	additional information regarding facility fire drills. On 8/25/2022 at 9:30 A.M., the Administrator provided a policy titled, "Alzheimer's and dementia care annual training requirement for comprehensive and residential care facilities", dated 6/1/2005, and indicated the policy was the one currently used by the facility. The policy indicated " ... The three-hour annual dementia specific training requirement will be based on a calendar year. The three hours annual dementia-specific training requirement begins in the year following the employee's date of hire. Upon the request of a current employee, former employee, health facility, the ISDH requests that health facilities provide a copy of an employee's dementia specific training records ...." See R119 for additional information regarding Staff orientation, job descriptions, and education. On 8/25/2022 at 11:45 A.M., an interview with the Administrator indicated that he did not have staff information regarding general or specific job orientation, or job descriptions available. The Administrator indicated there had been some dementia training. A policy was requested for job descriptions and orientation, and the Administrator indicated he could not find a policies for either. See R119 for additional information regarding staff orientation, job descriptions, and education. On 8/25/2022 at 1:10 P.M., an interview with the Administrator indicated he was unable to produce any CPR/First-aid certifications for the staff that had worked the current week. See R117 for additional information regarding CPR/First-aid certifications. On 8/26/22 at 10:35 A.M., an interview with the		· Dietary orders reviewed and sign by the physician for residents D, M, F, L and P · Pharmacist review completed for residents C, D, F, G, H, L, M, N, P and JJ · Medications carts 1, 2 and 3 were audited and corrections made · All 23 sample resident records to be reviewed for accuracy · All 53 residents' charts reviewed for accuracy of emergency contact information · All staff in servicing completed related to mask use · All house TB test blitz completed · Corporate staff to review Job Description with Administrator **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by	

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	Administrator indicated the facility did not have a grievance book. The residents did not have grievance forms because he had an open door policy and the residents were welcome to go and talk with him about their concerns. See R39 for additional information regarding grievances. Preadmission assessments were either not completed or signed and dated, by both the resident and the facility staff for 3 of 8 residents reviewed for preadmission evaluations, (Residents, C, D, and P). See R214 for additional information regarding preadmission evaluations for Residents C, D, and P. Semiannual evaluations were not completed for 6 of 24 residents, (Resident F, H, L, M, N and P). See R215 for additional information regarding semiannual evaluations for Residents F, H, L, M, N, and P. Service Plans were completed upon admission, revised as needed, or signed and dated by the resident for 8 of 10 residents reviewed for Service Plans, (Residents C, G, M, D, F, L, N, and P). See R217 for additional information regarding Service Plans for Residents C, G, M, D, F, L, N, and P. Physician ordered medications were not administered per order for 13 of 14 records reviewed for medications. (Residents D, H, C, G, HH, BB, P, DD, S, N, Q, W, and LL). See R241 for additional information regarding medication orders for Residents D, H, C, HH, BB, P, DD, S, N, Q, W, and LL. Lack of documentation in the medical records indicating medication had been administered for 8 of 23 residents reviewed for medications,		deficient practice · Facility working through 2567 and plan of corrections for all citations and concerns. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Corporate team providing education to Administrator and IDT Team · New Health Service Director Started at facility · Facility working through 2567 and plan of corrections for all citations and concerns. · Administrator will notify regional director with facility operational concerns · Regional staff will provide oversite completing at a minimum weekly visit **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Health Services Director or designee will monitor facility plan of correction weekly x 4 then monthly for at least 6 months to ensure compliance is maintained. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance · Regional staff will provide oversite completing at a minimum	

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	(Residents F, L, N, P, Q, C, G, and D). See R243 for additional information regarding medication documentation for Residents F, L, N, P, Q, C, G, and D. PRN (as needed) medications administered by a QMA (Qualified Medication Aide) were not signed off by a licensed nurse for 1 of 16 residents reviewed for medications, (Resident P). See R246 for additional information regarding PRN medication administration for Resident P. The diet orders were not signed by the physician for 5 of 23 Residents, (Resident D, M, F, L and P). See R275 for additional information regarding the dietary orders for Residents D, M, F, L, and P. Medications were not reviewed by a pharmacist for 10 of 23 residents reviewed, (Residents C,.D, F, G, H, L, M, N, P and JJ). See R299 for additional information regarding Residents pharmacy reviews for Residents C,.D, F, G, H, L, M, N, P and JJ. Medications in the medication carts were not stored and labeled appropriately in 3 of 3 medication carts, (Medication Carts 1, 2 and 3). See R300 for additional information regarding the medication storage in Medication Carts 1, 2, and 3. Resident clinical records were not accurate and complete for 23 of 23 sampled residents. See R349 for additional information regarding the accuracy and completes of the resident's clinical records. Lack of complete emergency information, and incomplete resident information on file for 53 of 53 residents. See R356 for additional information regarding the accuracy and completes of the resident's clinical records.		weekly visit	

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	Upon entrance to the facility, on 8/23/2022 at 9: 30 A.M., only one staff member was noted to be wearing a face mask. All other staff members, including the Administrator, were not wearing a face mask and were noted to be interacting with residents in close, less than 6 foot proximity. Resident chest X-rays were not completed prior to admission for 1 of 2 residents admitted in the past year in a sample of 23. Tuberculin skin testing was not completed upon admission and annually for 23 of 23 sampled residents. Nursing staff did not follow standards of care during a medication administration observation. See R406, R408, R410, and R414 for additional information regarding infection control. On 8/26/22 at 10:35 A.M., an interview with the Administrator indicated he did not have a policy regarding his responsiblies in the facility. The Administrator indicated he did not have a job description, but indicated the Administrator was the person responsible for overseeing the daily operations of the facility. On 8/26/22 at 12:30 P.M., the Administrator provided a form titled," Health Administrator Duties and Responsibility's" and indicated as the Administrator, these would be among his duties. The form indicated,"Health Administrators ...oversee the administrative tasks of a healthcare facility ...Schedule employees based on patient needs, Oversee the organization of all patient records, stay up to date on healthcare laws and regulations ...A Healthcare Administrator, is responsible for overseeing practices and procedures within a healthcare organization ...ensuring their facility adheres to health laws and regulations ...."			

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R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview, and record review, the facility failed to ensure fire and evacuation drills were completed as directed by the facility policy. This deficient practice had the potential to affect 53 of 53 residents who resided in the facility. Finding includes: During an interview on 8/24/2022 at 1.45 P.M. with the Administrator, he indicted the facility had not conducted a fire drill that included evacuation practices in the building since January 24, 2020.	R 0092	**R 092- Admin Noncompliance – Emergency Preparedness Fire/ Evac** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by alleged deficit practice.	10/15/2022

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	The administrator indicated he had conducted monthly drills however there were two months that were incomplete (January 31, 2021 and October 28,2021). On 8/24/2022 at 2:10 P.M., an interview with Administrator indicated the facility had not included evacuation practices with fire drills for a long time because of COVID. Administrator stated "he has not contacted the fire department for follow up but is aware that it is important to do so." Documentation provided by the Administrator, dated January 24, 2020, at 2:00 P.M. from the Clay Fire Department , indicated a fire, evacuation and severe weather plan drill was conducted. In addition, there was documentation, provided by the Administrator, dated June 23,2020 at 9:20 A.M. from the Clay Fire department which indicated they had suspended routine in person fire or emergency inspections due to Covid On 8/24/22 at 2:00 P.M.,a Fire and Disaster Emergency Evaluation Drills document, was provided by the Administer and were reviewed at that time. The Reports indicated there were no occupants evacuated during the drills since January 24, 2020 A facility policy regarding fire safety and fire drills was requested on 8/25/2022 at 1:00 P.M. A copy of the residential regulations regarding the required fire safety drills was provided and no facility policy was provided. Review of the highlighted regulation indicated. "...0092 (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency...."		**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by the alleged deficient practice · Fire and evacuation drill held at facility;**/bMonthly Fire Drill log audit tool was put into place. Maintenance Assistant will provide Executive Director or designee with Fire Drill log audit for review and signature.** · **Maintenance Director scheduled fire drill with local Fire Department for this community** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Management members in-serviced on the Community's Emergency management process with emphasis on fire alarm drill and evacuation policy including Fire exit drills In facilities shall Include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of	

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			nonambulatory residents to safe areas or to the exterior of the building Is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. · Maintenance Director scheduled fire drill with local Fire Department for this community · · **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · The Administrator or designee will confirm monthly fire and evacuation drills are being conducted and complete drill audit tool monthly for 6 months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications,			

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	and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on observation, record review and interview, the facility failed to ensure they had staff CPR (cardiopulmonary resuscitation) and first aid certified for 7 out of 7 days of the schedule reviewed. In addition the facility failed to ensure one Qualified Medication Aide (QMA 2) did not refer to himself as the Nursing Director when communicating with residents and other facilities. These deficient practices had the potential to affect 53 of 53 residents who resided in the facility. Findings include: 1. A nursing schedule, dated August 21 through August 26th, indicated there was no one with CPR/ first aid certification on 7 P.M. -7 A.M. on these dates and one with CPR only on these dates from 7 A.M. - 7 P.M. On 8/24/2022 at 3 P.M., a policy related to	R 0117	**R117- Personnel CPR/ QMA Scope** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by the alleged deficient practice · QMA 2 is no longer employed at the facility **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	10/15/2022

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	employee CPR and first aid certification was requested, but one was not provided. On 8/25/2022 at 9:30 A.M., the Administrator indicated they follow the state guideline for CPR/First aid. On 8/25/2022 at 1:10 P.M., during an interview, the Administrator was unable to produce any CPR/First-aid certifications for the staff that had worked this week: LPN (Licensed Practical Nurse), QMA (Qualified Medication Assistant) 3, and 4, he indicated he had a book they are kept in, but all of them had expired and the staff should have been certified.2. On 8/23/22 at 8:00 A.M., an interview with QMA 2 indicated he was not the Director of Nursing, but had referred to himself as the Nursing Director on occasions when speaking to residents and answering the phone. QMA 2 indicated he did not think the Nursing Director was the same as a Director of Nursing. QMA 2 indicated he was the Resident Care Coordinator and not a Nursing Director nor a Director of Nursing. On 8/23/22 at 9:39 A.M., an interview with the Administrator indicated QMA 2 was the Nursing Director before 8/16/22, when Licensed Practical Nurse 2 began to work full time at the facility. The Administrator indicated he did not think a Nursing Director was the same as a Director of Nursing and that QMA 2 was never registered at the State Agency as the Director of Nursing. The Administrator indicated a QMA was not qualified to work as a Director of Nursing. On 8/26/22 at 11:00 A.M., an undated note located in Resident JJ's paper chart was provided by the LPN 2, and reviewed at that time. The note directed to an unknown entity indicated, "...This		**taken.** · All residents have the potential to be affected by deficient practice. · Audit of all staff completed to identify staff in need of CPR certification/recertification · CPR class scheduled to ensure facility staff have been CPR certified **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · During the onboarding process at the facility, BOM/designee will verify staffs CPR status and obtain copy of certificate or assist in placing staff in CPR class · Audit conducted and CPR tracking system initiated, CPR binder to be maintained with documentation with dates of certification and expiration to ensure staff remain current with this requirement · Facility staff educated on requirement for facility to ensure CPR certified staff on schedule always working in facility · Facility staff educated on QMA scope of practice with emphasis in properly identifying self during resident and family conversations and interactions	

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	is [QMA 2] Nursing Director of Woodridge. [Resident JJ] can come back after he finish [sig] your programs. Signed [QMA 2]...." On 8/26/22 at 1:00 P.M., an undated document titled, "QUALIFIED MEDICATION AIDE Scope of Practice," was provided by the Administrator and indicated this was the current QMA scope of practice policy. The policy did not give authority for a QMA to act as a Director of Nursing or as a Nursing Director. This State Residential finding is related to Complaint IN00382840.		**4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Upon orientation with new licensed nursing staff will have verification of CPR status · Administrator/designee will monitor monthly for expiring certifications and schedule subsequent training to recertify. · Administrator or designee will monitor daily schedule to ensure that CPR certified staff always present in building. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or			

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	(E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure they had staff orientation to the facility, signed job descriptions for 5 out of 5 employee files reviewed, and 4 out of 10 reviewed for dementia training. . (CNA (Certified Nursing Assistant) 2, 4, 5, QMA (Qualified Medication Assistant) 2, LPN (Licensed Practical Nurse), and housekeeper. Finding includes: An employee record review was conducted on 8/24/2022 at 10:00 A.M., and indicated CNA 2, 4, 5, QMA 2, and LPN did not have documentation indicating completion of general and job specific orientation, job description upon hire. And no dementia training provided for LPN, housekeeper, and CNA 2 & 5.	R 0119	**R119- Personnel- Job Descriptions, Orientation, Dementia Training** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by the alleged deficient practice · Job description provided and reviewed with CAN 2,4,5, and LPN · General orientation and job	10/15/2022

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	During an interview on 8/25/2022 at 11:45 A.M., the Administrator indicated that he does not have any general or specific orientation, job descriptions available, and some dementia training and there should have been. A policy was requested, and the Administrator indicated he could not find a policy for orientation or job description. On 8/25/2022 at 9:30 A.M., the Administrator provided a policy titled, "Alzheimer's and dementia care annual training requirement for comprehensive and residential care facilities", dated 6/1/2005, and indicated the policy was the one currently used by the facility. The policy indicated " ... The three-hour annual dementia specific training requirement will be based on a calendar year. The three hours annual dementia-specific training requirement begins in the year following the employee's date of hire. Upon the request of a current employee, former employee, health facility, the ISDH requests that health facilities provide a copy of an employee's dementia specific training records ...."		specific orientation was provided to CNA 2,4,5 and LPN · Dementia training was provided to LPN, Housekeeper, and CNA 2,4, and 5 · QMA 2 is no longer employed at the facility **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by deficient practice. · Audit of all staff completed to identify staff in of General Orientation · Audit of all staff completed to identity staff in need of Job Specific Orientation · Audit of staff completed to identify staff in need of Dementia Training · Weekly Training will occur to address orientation and training required until compliance of all staff achieved **3. What measures will be put into place or what systemic**	

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			changes the facility will make to ensure that the deficient practice does not recur; · Facility staff educated on orientation process, checklist, and procedures with emphasis on general orientation, Job specific orientation and dementia training · During the onboarding process at the facility, BOM/designee completely new hire check list to ensure that General and Job Specific Orientation is completed · During Orientation, Dementia Training will be completed during the orientation process · Audit of all staff completed to identify staff in of General Orientation · Audit of all staff completed to identity staff in need of Job Specific Orientation · Audit of staff completed to identify staff in need of Dementia Training · Weekly Training will occur to address orientation and training required until compliance of all staff achieved **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Upon orientation with all new hires, Administrator/ designee	

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			will complete New Hire checklist to ensure that employee has completed all required aspects of orientation · Administrator or designee will audit new hire employee files weekly x 4 then monthly x 6 to ensure that employees have received adequate orientation and training . Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight			

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	loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure employee health screens were completed for 3 out of 5 reviewed (CNA 2, 5, QMA 2 and LPN 2) and TB (tuberculosis) first and second step documentation available for 5 out of 5 employee files reviewed. (CNA (Certified Nursing Assistant) 2, 4, 5, QMA (Qualified Medication Assistant) 2, LPN (Licensed Practical Nurse) 2, Finding includes: An employee record review was completed on 8/24/2022 at 9:30 A.M., and indicated that QMA 2, LPN 2, and CNA 2, 4 and 5, did not have a 1st and 2nd step skin test completed prior to or upon hire. During an interview, on 8/24/2022 at 12:55 P.M., the Administrator indicated they could not find the TB test book, there was no documentation available to indicate the testing was completed, but it should have been. On 8/25/2022 at 1:00 P.M., the Administrator indicated they follow the CDC (Center for Disease Control and Prevention) titled, "Screening and Testing of Health Care Personnel," updated 7/28/2022, and indicated the policy was the one currently used by the facility. The policy indicated " ...All U.S. health care personnel should be screened for TB upon hire. Review result * Positive - consider TB infected, no second TST needed; evaluate for TB disease. *Negative - a second TST is needed, Retest 1 to 2 weeks after first TST result read ...." On 8/24/2022, at 11:30 A.M., a policy was requested for health screening but one was not	R 0121	**R119- Personnel- Job Descriptions, Orientation, Dementia Training** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by the alleged deficient practice · Job description provided and reviewed with CAN 2,4,5, and LPN · General orientation and job specific orientation was provided to CNA 2,4,5 and LPN · Dementia training was provided to LPN, Housekeeper, and CNA 2,4, and 5 · QMA 2 is no longer employed at the facility **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by	10/10/2022

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	provided prior to survey exit.		deficient practice. · Audit of all staff completed to identify staff in of General Orientation · Audit of all staff completed to identity staff in need of Job Specific Orientation · Audit of staff completed to identify staff in need of Dementia Training · Weekly Training will occur to address orientation and training required until compliance of all staff achieved **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Facility staff educated on orientation process, checklist, and procedures with emphasis on general orientation, Job specific orientation and dementia training · During the onboarding process at the facility, BOM/designee completely new hire check list to ensure that General and Job Specific Orientation is completed · During Orientation, Dementia Training will be completed during the orientation process · Audit of all staff completed to identify staff in of General	

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			Orientation · Audit of all staff completed to identity staff in need of Job Specific Orientation · Audit of staff completed to identify staff in need of Dementia Training · Weekly Training will occur to address orientation and training required until compliance of all staff achieved **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Upon orientation with all new hires, Administrator/ designee will complete New Hire checklist to ensure that employee has completed all required aspects of orientation · Administrator or designee will audit new hire employee files weekly x 4 then monthly x 6 to ensure that employees have received adequate orientation and training . Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, record review and interview the facility failed to ensure the resident environment was clean, orderly, and in a state of good repair. Finding includes: During the tour of the environment conducted on 8/24/2022 at 9:30 A.M., with the Administrator and Maintaince Supervisor, the following was noted: Room 203 had a strong pet odor permentating to the hallway, carpeting was heavily stained Room 118 carpet was heavily stained and the	R 0144	**R119- Personnel- Job Descriptions, Orientation, Dementia Training** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by the alleged deficient practice · Job description provided	10/15/2022

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	apartment had a strong cat urine odor Room 231 carpet was heavily stained and a yellow stain was noted around the base of toilet Room 231 carpet was ripped by the kitchenette area and had a bare spot measuring 2 x 4 inches by the bathroom entry way, bathroom door had a large hole in it with the frame exposed Room 116 carpet was heavily stained and carpet was coming loose from the floor Room 103 carpet was heavily stained The beauty shop had hair on floor, combs and brushes with hair in them on the counter, and a four tiered shelving unit had rusted metal on the frame. The shampoo bowl had a heavy accumulation of old dried debris and the floor was visibly soiled. The activity room had "cob" webs behind the cooking oven, crumbs in the kitchenette drawer, and multiple stained ceiling tiles. Florescent light fixtures were not to have either broken or missing covers, in the 100 hallway by the beauty shop, 100 hall resident laundry room, 100 unit equipment room, and 100 hall mechanical room, and the hallway by Room 211. There were stained, bulging and or broken ceiling tiles noted throughout the building. During an interview, conducted with the Administrator at that time, he indicated they didn't have any active water leaks. The facility laundry room hand washing sink was heavily covered with dried plaster and there were no paper towels. A policy regarding environmental cleaning and maintenance was requested on August 25th at		and reviewed with CAN 2,4,5, and LPN · General orientation and job specific orientation was provided to CNA 2,4,5 and LPN · Dementia training was provided to LPN, Housekeeper, and CNA 2,4, and 5 · QMA 2 is no longer employed at the facility **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by deficient practice. · Audit of all staff completed to identify staff in of General Orientation · Audit of all staff completed to identity staff in need of Job Specific Orientation · Audit of staff completed to identify staff in need of Dementia Training · Weekly Training will occur to address orientation and training required until compliance of all staff achieved	

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	1:00 P. M. and none was provided by the survey exit. This State Residential finding relates to Complaint IN00387635.		**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Facility staff educated on orientation process, checklist, and procedures with emphasis on general orientation, Job specific orientation and dementia training · During the onboarding process at the facility, BOM/designee completely new hire check list to ensure that General and Job Specific Orientation is completed · During Orientation, Dementia Training will be completed during the orientation process · Audit of all staff completed to identify staff in of General Orientation · Audit of all staff completed to identity staff in need of Job Specific Orientation · Audit of staff completed to identify staff in need of Dementia Training · Weekly Training will occur to address orientation and training required until compliance of all staff achieved **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place; and · Upon orientation with all new hires, Administrator/ designee will complete New Hire checklist to ensure that employee has completed all required aspects of orientation · Administrator or designee will audit new hire employee files weekly x 4 then monthly x 6 to ensure that employees have received adequate orientation and training . Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview the faculty failed to ensure the plumbing in the beauty shop compiled with state plumbing codes. Finding includes: During the environmental tour of the faculty conducted on 8/24/2022 at 9:30 A.M., the hose connected to the spray attachment was observed resting on the bottom of the shampoo bowl near the drain. The hose was noted to be kinked with a plastic circular ring and there was no anti reflux valve located near the sink to prevent contaminated water from entering the clean water system.	R 0148	**R 148- Sanitation and Safety- Beaty Shop Plumbing** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents affected by alleged deficient practice · Plumbing to beauty shop sink corrected, anti-reflex valve replaced	10/15/2022

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	A policy regarding environmental cleaning and maintenance was requested on August 25th at 1:00 P. M. and none was provided by the survey exit.		**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · Residents that visit the beauty shop have the potential to be affected by alleged deficient practice · Maintenance educated on Spray attachment for shampoo bowl · Hairdresser educated on spray attachment for shampoo bowl **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Maintenance educated on Spray attachment for shampoo bowl · Hairdresser educated on spray attachment for shampoo bowl · Maintenance staff educated on environmental rounds and repairs **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Administrator/Designee to	

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			audit environmental rounds. Rounds conducted in Beauty shop to ensure compliance with plumbing and shampoo bowl maintenance and cleaning · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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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 and interview, the facility failed to ensure the kitchen trash barrels were covered when not in use, scoops were not housed in food bins and labeled, ice cup scoops not stored on top of machinery, chemical strips used for low temp dishwasher were not expired, door to outside was closed, and floors were clean behind appliances and coverings were placed over light fixtures for 1 out of 1 kitchens inspected. Findings include: 1. During a tour of the kitchen on 8/23/2022 with the Dietary Manager from 9:05 A.M. to 9:30 A.M., the kitchen door was propped open to the outside with no staff currently working in the kitchen, two barrels one by the dishwasher area and the other on the other side of the stove were uncovered with the lids propped next to the barrels. A food bin labeled sugar was dated 1/13/2022, corn starch, breadcrumbs undated all had a scoop in them, a bin was not labeled with salt, and ice cube scoop sitting on top of machine was uncovered. Behind the stove lying on the floor were two oven mitts, dry noodle, and dirt. No hair net was worn by the dietary manager during the tour. During an interview on 8/23/2022 at 9:25 A.M., the	R 0154	**R154- Sanitation and Safety-Kitchen** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by alleged deficient practice · Trash barrels covered, scoops removed from food bins, Ice scoops stored in proper location. · Food bins cleaned and appropriately labeled · Floor cleaned behind appliances · Dishwasher strips were disposed and replaced	10/15/2022

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	dietary manager indicated that the barrels should have been covered, no scoops were to be in the food bins, appropriate labeling should have been on the outside of the bins and, the ice cube scoop should have been covered and a hair net worn when in the kitchen. They have no cleaning schedule for the kitchen but sweep and mop every evening but unable to pull out the stove and indicated it should have been swept behind appliances. 2. During an observation on 8/23/2022 at 10:15 A.M., the door from the kitchen to the outside was open, the dishwasher was running with the temperature logged as 120 degrees, a chemical test was run with expired strips dated 3/31/2018, with no log for the dishwasher testing and no covers were noted over the fluorescent light fixtures. During an interview on 8/23/2022 at 10:25 A.M., the dietary manager indicated the outside door should not have been closed, the chemical strips are expired and there was no log present on testing the machine and should have been and indicated the light fixtures have been like that since she has been here. During an interview on 8/23/2022 at 11:05 A.M., the Administrator indicated that the light fixtures have been like that since he has worked here and were not addressed in the past. On 8/23/2022 at 2:45 P.M., the Administrator provided a policy titled, " Food Identification And Storage, Dish Machine Temperatures, effectiveness of hair restraints"undated and indicted the policy was the one currently used by the facility. The policy indicated "...a. Determine the kind of dish machine the community utilizes, either a high temperature or low temperature		· Coverings were replaced for light fixtures in kitchen · Prop was removed and door was closed to the kitchen **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by alleged deficient practice · Deep clean of the kitchen was completed · Audit completed and all food labeled and dated as appropriate · Dishwasher temp log initiated · Kitchen cleaning scheduled initiated **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Dietary Manager educated on dishwasher temp log and kitchen cleaning schedule · Dietary staff educated on dishwasher temp log and kitchen cleaning scheduled · Dietary staff educated on Food labeling and Storage and	

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	machine. If it is determined that the community utilizes low temperature machine , PPM strips should be obtained from the chemical vendor. b. During each period of use; breakfast, lunch and dinner, the employee utilizing the dish machine will record the wash temperatures and level of sanitizer PPM for low temperature machines, and wash and rinse temperatures for the high temp machine utilizing the Dish Machine Temperature log. ii. Low temp machines must have a temperature of no less than 120 degrees during the wash cycle and rinse must have a minimum of 25 PPM concentration sanitizer. Except as provided in subsection (b), food employees shall wear hair restraints, such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that are designed and worn effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single use articles. Working containers holding food or food ingredients that are removed from their original packages for use in the retail food establishment, such as: (1) cooking oils, (2) flour; (3) herbs, (4) potato flakes, (5) salt; (6) spices;and (7) sugar; shall be identified with the common name of the food, except that containers holding food that can be readily and unmistakably recognized, such as dry pasta, need not be identified...." On 8/23/2022 11:15 A.M., policy was requested for light fixtures, open exit doors, cleaning of the kitchen, ice cube scoop, scoops in bins, trash barrels but one was not provided before the survey was exited.		infection control requirements for the kitchen · Dietary Manger to complete daily kitchen environmental and sanitation rounds **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Administrator. Designee to complete Kitchen sanitation rounds to ensure compliance with cleanliness and infection control practices · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by			

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	an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, record review and interview, the facility failed to ensure hot water temperatures were maintained at a safe level in 3 of 6 rooms. Finding includes: During the environmental tour, of the facility, conducted on 8/24/2022 at 9:30 A.M., the following hot water temperature were noted: Room 203- temperature 125 degrees Fahrenheit Room 208- temperature 126.1 degrees Fahrenheit Room 213 temperature 123.4 degrees Fahrenheit During an interview with the Maintenance Director, Employee 17, at that time, he indicated he had started two days prior and had not yet checked hot water temperature. Observation of the hot water heater mixing value thermostat, located in the maintenance room indicated it was set at 122 degrees Fahrenheit Employee 17 indicated he would turn down the mixing value. The Administrator indicated that no residents had been burned. No policy was provided.	R 0187	**F187- Physical Plan Standards- Hot water Temps** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by the alleged deficient practice · Water mixing value thermostat adjusted **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents had the potential to be affected by alleged deficient practice · **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	10/15/2022

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			practice does not recur; · Maintenance director educated on environmental rounds as it relates to hot water temperature checks · Maintenance director to check water temperatures **1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Administrator/ Designee to audit water temperature logs and verify water temps · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview, and record review, the facility failed to ensure preadmission assessments were either completed or signed and dated, by both the resident and the facility staff for 3 of 8 residents reviewed for preadmission evaluations, (Residents, C, D, and P). Findings include: 1. The clinical record for Resident C was reviewed on 8/24/22 at 9:40 A.M. The resident was admitted to the facility on 5/2/22 with diagnoses that included, but were not limited to: hemiplegia, stroke, anxiety, and pain.	R 0214	**R 214- Evaluation- Preadmission Assessments** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by alleged deficient practice	10/15/2022

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	There was no preadmission assessment evaluation located in the Electronic Medical Record or in Resident C's paper chart. On 8/24/22 at 11:00 A.M., an interview with Licensed Practical Nurse (LPN) 1, indicated residents admitted to the facility should have a preadmission assessment in the their medical records. LPN 1 indicated he could not find a preadmission assessment for Resident C. On 8/24/22 at 11:10 A.M., an interview with QMA 2 indicated he did not know where Resident C's preadmission assessment was, but that he thought it was completed. 2. The clinical record for Resident D was reviewed on 8/24/2022 at 10:00 A.M. Resident D was admitted to the facility on 5/9/2022 with diagnoses included, but not limited to: diabetes mellitus and hyperlipidemia. There was no preadmission assessment evaluation located on the electronic or the hard chart for Resident D. During an interview with QMA 2, the Residential Care Coordinator, on 8/24/2022 at 11:00 A.M. regarding the preadmission evaluation, he indicated he would have to look for the evaluation but he knew there was one completed because he remembered he was present with the facility's previous licensed nurse when the evaluation was completed for Resident D. On 8/25/2022 at 10:00 A.M., an undated assessment for Resident D was presented by QMA 2. The assessment was signed by Resident D but the it was unclear which type of assessment was completed, there was no indication which staff had completed the evaluation and the "Total Score" portion was left blank. In addition, the plan indicated the resident was independent with his mobility without assistive devices, had adequate vision without		· Resident C, D and P were reviewed and had assessment completed **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All newly admitted residents to the facility have the potential to be affected by alleged deficient practice · An audit of new admissions over the last sixty days completed, any resident without a preadmission evaluation completed reviewed and evaluation completed **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Admissions Director provided education on preadmission evaluation requirements · Licensed staff provided education on preadmission evaluation · Preadmission checklist to be completed prior to resident admission to the facility to be reviewed by IDT team to ensure all requirements are met **1. How the corrective**	

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	glasses, took his medications by himself, no notation was documented by the injectable medication section, was independent with blood sugar testing and insulin injections, did not require coordination of care and denied any pain. During an interview and observation with Resident D, conducted on 8/24/2022 at 1:15 P.M., he was observed to utilize a walker and wear eye glasses. He indicated the facility administered both his oral and injectable medications and had severe nerve type pain in his feet and legs. He indicated he had a tumor removed from his spinal cord and had had pain issues since the surgery. He also indicated he had came to the facility from the homeless shelter and the facility's physician had wanted him to see the neurologist and the facility had scheduled his appointment for him but it had to be rescheduled. Although an assessment was provided for Resident D on 8/25/2022 it was inaccurate and not signed by the staff member completing the assessment.3. A clinical record review was completed on 8/25/2022 at 9:28 A.M. Resident P's current diagnoses included, but were not limited to: asthma, convulsions, atrial fibrillation and left hemiparesis. The clinical record lacked a Pre Admission Evaluation prior to her admission on 11/26/2021. On 8/25/2022 at 11:47 A.M., the Pre Admission Evaluation was requested, but one was not provided. During an interview, on 8/26/2022 at 10:05 A.M., QMA 2 indicated he could not locate a Pre Admission Evaluation for Resident P.		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Health Services Director/ Designee to complete admission audit on all new admissions to ensure that preadmission checklist completed and preadmission evaluation is completed · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	On 8/24/2022 at 2:15 P.M., the Administrator provided the policy titled," Admission Health Assessment", dated 12/10/2007, and indicated the policy was the one currently use by the facility. The policy indicated"...The medical condition of each potential resident is assessed prior to admission to ensure their admission to the facility is appropriate as required by state regulations relating to residential care facilities. Following the initial assessment each resident will be assessed semi-annually and at a change in condition to ensure continued appropriate placement in Licensed Assisted Living Facility. 1. Upon admission, semi annually and with a change of condition, each resident will be assessed using the form titled" Admission Health Assessment...." This State Residential finding relates to Complaint IN00387635, IN00380236 and IN00382840.			
R 0215 Bldg. 00	410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on record review and interviews, the facility failed to ensure a semi annual evaluation was completed for 6 of 24 residents, (Resident M, H, F, L, N and P). Findings include: 1. The clinical record for Resident M was reviewed on 8/23/2022 at 3:30 P.M. Resident M was	R 0215	**R 215- Evaluation- Semi Annual Assessments** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	10/15/2022

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	admitted to the facility with diagnoses included, but not limited to: epilepsy, non pressure ulcers of the skin, glaucoma, chronic pain, major depressive disorder and hypertension, The most recent semi annual assessment, located in the hard chart was dated 4/21/2021. During an interview with QMA 2, conducted on 8/24/2022 at 1:30 A.M., he indicated the facility's previous pharmacy had notified the facility when an assessment was due but since they had changed pharmacies, the reviews had not been completed timely.2. The clinical record for Resident H was reviewed on 8/24/22 at 9:50 A.M.. Resident H was admitted to the facility on 6/08/17, with diagnoses that included, but were not limited to: dementia, and alcohol dependence. There was no semiannual assessment located in the Electronic Medical Record or in Resident H's paper chart. On 8/24/22 at 11:00 A.M., an interview with Licensed Practical Nurse (LPN) 1, indicated residents should have semiannual assessments completed and in the medical record. LPN1 indicated he was not able to locate a semiannual assessment for resident H, but that the resident should have had one completed. 8/24/22 at 11:10 A.M., an interview with Qualified Medication Assistant 2, indicated he was not able to locate a semiannual evaluation for Resident H in the residents medical record. 3. A clinical record review was completed on 8/25/2022 at 3:48 P.M. Resident F's diagnoses included, but were not limited to: epilepsy, bipolar, diabetes, Parkinson's disease and schizoaffective disorder. A Service Plan, dated 11/21/2021, was the last		· No residents were affected by alleged deficient practice · Residents, N .M,H,F,L, N and P assessments completed **2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · An audit of all residents that reside in the facility will be completed to determine semiannual assessment and service plan compliance, Facility will audit 10 resident charts weekly x 4 weeks and then 5 residents weekly until all resident charts have been reviewed and resident assessments and service plans are updated and in compliance **3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · IDT team provided education on Semi Annual evaluation and service plan requirements · Resident evaluation tracking system to be	

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	service plan completed. A request for service plans completed in February and May was requested on 8/26/2022, but none were provided. There was no new evaluations completed semi-annually. 4. A clinical record review was completed on, 8/25/2022 at 4:05 P.M. Resident L's diagnoses included, but were not limited to: diabetes, depression, bipolar, hypertension and anxiety. A Service Plan, undated, was the only service plan in the medical record. There was no new evaluations completed semi-annually. 5. A clinical record review was completed on 8/24/2022 at 1:15 P.M. Resident N's diagnoses included, but were not limited to: hypertension, atrail fibrillation, pain and congestive heart failure. A Service Plan, dated 11/21/2021, was the last service plan completed. A request for service plans completed in February and May was requested on 8/26/2022, but none were provided. There was no new evaluations completed semi-annually. 6. A clinical record review was completed on 8/25/2022 at 9:28 A.M. Resident P's current diagnoses included, but were not limited to: asthma, convulsions, atrial fibrillation and left hemiparesis. A Service Plan, dated 11/21/2021, was the last service plan completed. A request for service plans completed in February or May was requested on 8/26/2022, but none		implemented and maintained by Health Service Director/designee to ensure that all residents have scheduled semiannual evaluation scheduled and completed · Evaluation schedule will be reviewed with IDT in AM meeting **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** i. Health Services Director/ Designee to complete audit to ensure semiannual assessments and service plans are accurate and completed per schedule ii. Audit to be completed weekly x 4 then monthly x 6 to ensure compliance iii. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	were provided. There was no new evaluations completed semi-annually. On 8/24/2022 at 10:43 A.M., QMA 2 provided the policy titled," Service Plan", dated 3/22/2011, and indicated the policy was the one currently used by the facility. The policy indicated"...The service plan is completed after resident's admission and reviewed with the resident and or the responsible party within the first two weeks after admission. The comment column of the resident assessment tool may serve as the temporary service plan until the permanent service plan is completed. ...6. The Service Plan is reviewed and/or revised as appropriate following any significant changes in needs and discussed by the resident and the facility as needs or desires change. 7. Service Plans will be kept in the resident's individual charts... 13. The Service Plan is reviewed and/or revised as appropriate upon significant changes identified in the Assessment. 14. Residents/responsible parties will be notified of service plan reviews in advance of the organized meeting... 15. The interdisciplinary team, the resident, and his or her responsible party will be requested to attend/participate to complete the review...." This Residential Tag is related to Complaint IN00387635, IN00380236, and IN00382840.			
R 0217 Bldg. 00	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 services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the:			

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	(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.			
	5. A clinical record review was completed on 8/25/2022 at 3:48 P.M.. Resident F's diagnoses included, but were not limited to: epilepsy, bipolar, diabetes, Parkinson's disease and schizoaffective disorder. A service plan, dated 11/11/2021, lacked the resident/responsible party, facility staff signatures and date. A request for a service plan completed in February and or May was requested on 8/26/2022, but none were provided. 6. A clinical record review was completed on, 8/25/2022 at 4:05 P.M. Resident L's diagnoses included, but were not limited to: diabetes,	R 0217	**R 217- Evaluation- Service Plans** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected by alleged deficient practice · Residents F,L,N, P, C,G,M,D had service plans reviewed and updated	10/15/2022

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	depression, bipolar, hypertension and anxiety. A undated service plan on the clinical record, indicated the next service plan was due on 1/28/2022. The undated service plan lacked the resident/responsible party, facility staff signatures and date. A request for service plans completed in January, April and or July was requested on 8/25/2022, but none were provided. 7. A clinical record review was completed on 8/24/2022 at 1:15 P.M. Resident N's diagnoses included, but were not limited to: hypertension, atrial fibrillation, pain and congestive heart failure. A Service Plan, dated 11/19/2021, lacked the resident/responsible party and facility staff signatures A request for service plans completed in February and May was requested on 8/26/2022, but none were provided. There was no new evaluations completed semi-annually. 8. A clinical record review was completed on 8/25/2022 at 9:28 A.M. Resident P's current diagnoses included, but were not limited to: asthma, convulsions, atrial fibrillation and left hemiparesis. A service plan, dated 11/11/2021, lacked the resident/responsible party and facility staff signatures. A request for service plans completed in February and May was requested but none were provided. During an interview, on 8/26/2022 at 10:05 A.M.,		**2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · An audit of all residents that reside in the facility will be completed to determine service plan compliance, Facility will audit 10 resident charts weekly x 4 weeks and then 5 residents weekly until all resident charts have been reviewed and resident assessments and service plans are updated and in compliance **3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · IDT team provided education on service plan policy and requirements · Licensed staff will be educated on Service Plan Policy and requirements · · Resident Schedule and tracking system to be implemented and maintained by Health Service Director/designee to ensure that all residents have scheduled service plan reviews · Service Plan review schedule will be reviewed with IDT in AM meeting	

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	QMA 2 indicated he could not locate Service Plans for Residents F, L, N and P. On 8/24/2022 at 11:43 A.M., QMA 2 provided the policy titled, "Service Plan", 3/22/2011, and indicated the policy was the one currently used by the facility. The policy indicated"... 1. The service plan is completed after resident's admission and reviewed with the resident and responsible party within the first two weeks after admission. The comment column of the resident assessment tool may serve as the temporary service plan until the permanent service plan is completed. 2. The interdisciplinary team consisting of the Administrator/Designee, Clinical Director, Food Service Supervisor, Activity Director, and other appropriate staff will develop the service plan. 3. As part of the Service Plan development, all services and care required by the resident will be outlined. 4. Specific approaches and stops required for the resident will be included in the Service Plan....6. The Service Plan is reviewed and/or revised as appropriate following any significant changes in needs and discussed by the resident and the facility as needs or desires change. 7. Service Plans will be kept in the resident's individual charts... 13. The Service Plan is reviewed and/or revised as appropriate upon significant changes identified in the Assessment. 14. Residents/responsible parties will be notified of service plan reviews in advance of the organized meeting... 15. The interdisciplinary team, the resident, and his or her responsible party will be requested to attend/participate to complete the review...." This Residential Tag is related to Complaint IN00387635, IN00380236, and IN00382840.		· Service Plans will be updated as necessary for acute changes as needed in clinical morning meeting · i. Health Services Director/ Designee to complete audit to ensure service plans are accurate and completed per schedule and upon admission ii. Audit to be completed weekly x 4 then monthly x 6 to ensure compliance iii. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	Based on interview and record review, the facility failed to ensure Service Plans were completed upon admission, revised as needed, or signed and dated by the resident. 8 of 10 residents reviewed for Service Plans, (Residents C, G, M, D, F, L, N, and P). This deficient practice had the potential for negative outcomes the Resident's unidentified areas of care. Findings include: 1. On 8/24/22 at 9:40 A.M., Resident C's medical records were provided by Licensed Practical Nurse (LPN) 1 and Qualified Medication Aide (QMA) 2, and reviewed at that time. On 8/24/22 at 11:00 A.M. an interview with LPN1 indicated Resident C did not have a Service Plan. LPN1 indicated all residents should have a Service Plan in place upon admission. 2. On 8/23/22 at 10:00 A.M., Resident G's medical records were provided by Licensed Practical Nurse (LPN) 1 and Qualified Medication Aide (QMA) 2, and reviewed at that time. On 8/24/22 at 11:00 A.M. an interview with LPN1 indicated Resident G did not have a Service Plan. LPN1 indicated all residents should have a Service Plan in place upon admission. 3. The clinical record for Resident M was reviewed on 8/23/2022 at 3:30 P.M. Resident M was admitted to the facility with diagnoses, including but not limited to, epilepsy, non pressure ulcers of the skin, glaucoma, chronic pain, major depressive disorder and hypertension, The most recent semi annual assessment, located in the hard chart was dated 4/21/2021. During an			

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	interview with QMA 2, conducted on 8/24/2022 at 1:30 A.M., he indicated the facility's previous pharmacy had notified the facility when an assessment was due but since they had changed pharmacies, the reviews had not been completed timely During an interview with Resident M, conducted on 8/23/2022 at 3:30 P.M., she indicated she did not recall staff reviewing her service plan and needs with her in the past 6 months. 4. The clinical record for Resident D was reviewed on 8/24/2022 at 10:00 A.M. Resident D was admitted to the facility on 5/9/2022 with diagnoses, including but not limited to diabetes mellitus and hyperlipidemia. There was no assessment or service plan evaluation located on the electronic or the hard chart for Resident D. During an interview with QMA 2, the Residential Care Coordinator on 8/24/2022 at 11:00 A.M. regarding the evaluation, he indicated he would have to look for the evaluation but he knew there was one completed because he remembered he was present with the facility's previous licensed nurse when the evaluation was completed for Resident D. On 8/25/2022 at 10:00 A.M., an undated assessment for Resident D was presented by QMA 2. The assessment was signed by Resident D but the it was unclear which type of assessment was completed, there was no indication which staff had completed the evaluation and the "Total Score" portion was left blank. In addition, the plan indicated the resident was independent with his mobility without assistive devices, had adequate vision without glasses, took his medications by himself, no notation was			

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	documented by the injectable medication section, was independent with blood sugar testing and insulin injections and did not require coordination of care and denied any pain. During an interview and observation with Resident D, conducted on 8/24/2022 at 1:15 P.M., he was observed to utilize a walker and wear eye glasses. He indicated the facility administered both his oral and injectable medications and had severe nerve type pain in his feet and legs. He indicated he had a tumor removed from his spinal cord and had had pain issues since the surgery. He also indicated he had came to the facility from the homeless shelter and the facility's physician had wanted him to see the neurologist and the facility had scheduled his appointment for him but it had to be rescheduled. Although an assessment was provided for Resident D on 8/25/2022 it was inaccurate and not signed by the staff member completing the assessment.			
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, record review and interview, the facility failed to ensure physician ordered medications were administered per order for 13 of 14 records reviewed for medications. (Residents HH, BB, P, DD,S, N, Q, W, LL, D, H, C and G)	R 0241	**R 241- Health Services- Medications not administered / Nurse not present for Injections** **1. What corrective action(s)**	10/15/2022

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	Findings include: 1. During a Medication Administration on 8/23/2022 from 8:05 A.M. to 8:45 A.M., with QMA (Qualified Medication Aide) 5, the following was observed: At 8:05 A.M., QMA 5 pulled the medication roll from the cart for Resident HH and removed 3 packets from the roll. The medications given were: Amlodipine (blood pressure medication) 100mg (milligrams), Clopidogrel (blood thinner) 75 mg and SMZ-TMP DS (antibiotic) 800-160 mg. QMA 5 did not compare the current physician orders on the MAR to the medications that were pulled. Resident HH's medication orders also included the following: Biktarvi every am; Ferrous Sulfate (iron) 325 mg 2 tablets daily on Tuesday and Thursday; Metoprol 50 mg twice a day; Thiamin (Vitamin B-1) daily; Incruse Ellipta Aerosol powder inhale 1 puff daily (shortness of breath); Combivent Aerosol solution 20-100 MCG 1 puff every 6 hours for shortness of breath; Genovia 150-150-200-10 mg (milligrams) for HIV. None of these medications were administered during the observation. At 8:09 A.M., QMA 5 removed the pill roll for Resident BB and removed 7 packets with pills in them. QMA 5 did not compare the pill packages to the MAR. QMA 5 gave Resident BB the medication cup and Resident BB indicated that she did not take the Ferrous Sulfate pill any more. QMA 5 removed the pill from the cup and placed it on top of the medication cart.		**will be accomplished for those residents found to have been affected by the deficient practice.** · MD was notified of residents HH, BB,P,DD,S,N,Q,W,LL,D,H,C and G medication administration omissions **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · MAR to Cart audit to be completed by Pharmacy representative/ designee · Clinical Meeting agenda initiated to include reviewing all new medication orders to ensure accuracy, EMAR review for missing and refused medications, new admission reviews to ensure all admission orders transcribed accurately · Staffing patterns reviewed with facility to ensure that Licensed staff is on duty to administer injections if necessary · IDT team to complete resident interviews to determine any further medication or treatment concerns, pain	

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	Resident BB's discharge medication list, dated 3/29/2022, indicated Resident BB had the order for Ferrous Sulfate 325 mg 1 tablet three times a day. At 8:15 A.M., QMA 5 removed Resident P's medication roll for from the cart and pulled off 9 packets, and retrieved an Anura Ellipta inhaler and Fluticasone nasal spray. QMA 5 took the medications, the inhaler and the nasal spray into the dining room where Resident P was eating breakfast. Resident P put the inhaler up to her mouth and inhaled very shallow 1 time without taking a deep breath. The resident then used the nasal spray and squirted 1 spray into the right nostril and 2 squirts into the left nostril. A current Physician's Order, dated 10/3/2021, indicated Resident P was to receive Olopatadine 0.2% solution of 1 drop to both eyes twice a day. QMA 5 was not observed to not compare the medications to the current MAR, did not encourage the resident to take deep breaths prior to administering the inhaler, did not instruct the resident to do 2 sprays into both nostrils and did not administer the eye drops. At 8:28 A.M., QMA 5 removed Resident DD's 4 medication roll and pulled off 4 packages from the pill roll QMA 5 did not compare the pill packages to the MAR. Resident DD's current physician orders, dated 3/30/2022, indicated the resident was to receive Aspirin 81 mg (milligrams) every day, and Trelegy Ellipta 100 mcg-62.5 mcg-25 mcg inhalation powder - 1 puff every day. QMA 5 was not observed to administer the		concerns or any additional medical needs · Administrator and Health Services Director to meet with Medical Director to review new order process, staff to be educated **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · All Nurses and QMAs in serviced on Medication administration with return demonstration and emphasis on comparing medications to EMAR, documentations of medication refusals and PRN medications · All nurses and QMAS in serviced proper on Oral, Inhaler, and nasal spray administration · All nurses educated on admission process with emphasis on admission order verification, new admission checklist provided as tool for floor staff · All nurses and QMAs to be educated on new physician order process and procedure · All nurses and QMAs in serviced on PRN medication administration policy with emphasis on documentation in the MAR and the Narcotic count sheet · IDT educated on use of clinical meeting agenda and follow up · Health Service	

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	aspirin and the inhaler to Resident DD. At 8:30 A.M., QMA 5 removed 3 packets from Resident S's pill roll: Eliquis (anticoagulant) 5 mg, Gabapentin (nerve pain) 300 mg, and Metoprolol 100 mg. QMA 5 indicated she was not sure what medications the resident was on due to she just returned from the hospital recently. QMA 5 did not compare the medications pulled from the cart to the MAR. Resident S's current physician orders indicated the resident was to receive Acetaminophen 325 mg 2 tablets daily. A clinical record review was completed on 8/24/2022 at 1:15 P.M. Resident N's diagnoses included, but were not limited to: hypertension, atrial fibrillation, pain and congestive heart failure. Resident N's current physician orders, dated from 2/25/2022 to 7/22/2022, included the following medication orders: Lyrica (nerve pain medication) 25 mg 1 tablet three times a day. Lactulose (laxative) 20 ml (milliliters) twice a day. Albuterol Sulfate (breathing aid) 2.5 mg/3 ml via nebulizer every 6 hours. Nicotine patch (smoking cessation) 24 hr/14 mg apply 1 patch daily. Fluticasone nasal spray suspension 1 spray both nostrils twice a day. Fentanyl (narcotic pain patch) patch 12 mcq every 12 hours. The MAR (Medication Administration Record) dated 8/1/2022 through 8/31/2022, indicated the following medications were not administered to		Director/Designee to complete medication pass observations with staff to ensure compliance **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Health Services Director/ Designee to complete daily medication administration audit to ensure medication compliance · Health Services Director/ Designee to complete clinical morning meeting agenda review and follow up related to new orders, new admission review · Health Services Director/ Designee to review daily staffing schedules to ensure licensed nurse staffing levels are appropriate · Health Services Director. Designee to complete medication administration observation audits · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	Resident N. Fentanyl pain patch, Nicotine patch, Fluticasone nasal spray, Lactulose solution, Lyrica, and the Albuterol Neb solution. 2. During an interview, on 8/24/2022 at 11:23 A.M., Resident Q indicated she was not receiving her medications. A clinical record review was completed on 8/24/2022 at 3:58 P.M. Resident Q's diagnoses included, but were not limited to: anxiety, hypertension, insomnia, pain and depression. Resident Q's current physician orders, dated 8/17/2022, indicated new orders to: discontinue the Cymbalta (anti depressant) 30 mg twice a day order and start Cymbalta 30 mg every day x 14 days the discontinue the order. Increase Zoloft (anti depressant) to 50 mg every day. The August MAR, dated 8/1/2022 through 8/31/2022, lacked the documentation to show the Cymbalta and or the Zoloft had been given since the new order was received on 8/17/2022. 3. During an interview, on 8/25/2022 at 1:50 P.M., Resident W walked up to the front office and indicated he was waiting for his noon medications. A clinical record review was completed on 8/25/2022 at 2:59 P.M. Resident W's diagnoses included, but were not limited to: depression, diabetes, hypothyroidism, pain, and bipolar. A current physician's order, dated 8/17/2022, indicated Resident W was to receive Norco 5/325 mg 1 tablet every am, and 1 tablet every 6 hours PRN (as needed) for pain.			

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	The August MAR indicated Resident W had not received the Norco pain pill from 8/17/2022 through 8/20/2022. Resident W's Individual Resident Control Medication Record Sheet indicated there were 15 Hydrocodone pills sent to the facility on 8/18/2022. An entry was made, on 8/21/2022 at 5:00 P.M., indicating that only 1 Hydrocodone pill had been administered. During an interview, on 8/25/2022 at 2:45 P.M., QMA 6 indicated Resident W only received the Norco pain pill one time on 8/21/2022. 4. A clinical record review was completed on 8/5/2022 at 9:05 A.M. Resident LL's diagnoses included, but were not limited to: diabetes, heart issues, depression and pain. During an anonymous interview, on 8/25/2022 at 2:22 P.M., the staff person indicated Resident LL had informed them of not getting their pain patches. The August MAR (Medication Administration Record), dated 8/1/2022 through 8/31/2022, indicated on 8/15/2022 the Lidocaine 5% pad was documented as refused. The back page lacked the documentation to show the resident had refused the patch. The MAR lacked any initials indicating the patch was administered from 8/16/22 through 8/24/2022. The medication cart was observed on 8/26/2022 at 10:57 A.M., with QMA 6. She provided a box of Lidocain patches with Resident W's pharmacy label on it. 5. During the initial tour of the facility, conducted on 8/20/2022 between 9:45 A.M. - 11:30 A.M., with Employee 18, the Admissions			

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	Director, Resident D was observed to get himself up out of his bed and ambulate with a walker to the doorway area of his room. Employee 18 indicated Resident D was alert and oriented. The clinical record for Resident D was reviewed on 8/24/2022 at 2:00 P.M. Resident D was admitted to the facility with diagnoses included, but not limited to: diabetes mellitus type 2, chronic pain, major depressive disorder, cerebella stroke symptoms and anxiety disorder. The current physician's orders for Resident D included an order, initiated on 5/15/2022, for the resident to receive Ozempic 4 mg/ml injections once a week for diabetes. Review of the medication administration record for Resident D indicated he had only received the Ozempic injection one time in August from the 1st through the 24th. The July Medication Administration Record was not available for review. The June Medication Administration Record did not have any documented doses of the Ozempic medication given. During an interview on 8/25/2022 with Resident D's physician, who also served as the facility's medical director, she indicated no staff had notified her of Resident D's refusals nor of the inability of the facility to administer the Ozempic injections timely. She indicated Resident D had told her he was not receiving the injections timely. She indicated she was concerned the resident was not receiving his medication as ordered and her orders were not being noted and transcribed timely and correctly. She indicated she had rewritten medication and insulin orders on 8/18/2022 because the medication aides had informed her there were no insulin orders for a sliding scale for Resident D even though they			

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	were included in the resident's admission orders in May. During an interview with Resident D, conducted on 8/24/2022 at 1:15 P.M., he indicated he was not receiving his Ozempic injection because there was no licensed nurse available to administer the medication. He indicated the nurse, LPN 1 was supposed to come every Monday to administer the medication but often did not show up to give the injection. In addition, Resident D indicated he did not always receive his pain medications timely. He indicated he was supposed to get his oral pain medication twice a day but yesterday he did not receive any pain medication until 2:00 A.M. He indicated he was in so much pain he was reduced to crawling on the floor and crying in pain. Review of the physician's orders indicated on 8/18/2022 the physician had increased his oral pain medication, Hydrocodone 5/325 mg (milligram) from once a day to twice a day. Review of the medication administration record for Resident D for August 2022 confirmed the resident did not receive his morning dose of Hydrocodone, nor did he receive any of his doses of Gabapentin on 8/22/2022. Review of physician orders, dated 7/22/2022 and signed by the physician indicated Resident D was also to receive a Fentanyl patch 12 mg every 72 hours. There was no documentation the resident had received the pain medication patches at all in August 2022. In addition, there were physician orders, dated 6/2/2022 for the resident to receive physical and occupational therapy due to his back pain. The order was not noted by a nurse. 6. During a Medication Administration observation on			

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	8/23/2022 at 7:56 A.M., with QMA (Qualified Medication Aide) 3, the QMA was observed giving Resident H a small white paper pill cup with 1 Oxycod/apap 5-325mg tablet. Resident H was observed taking the Oxycod/apap in the paper pill cup into the dining room and out of sight of QMA 3, having never taken the medication. QMA 3 signed the Control Medication Record Sheet indicating she had given 1 Oxycod/apap 5-325 Mg and the medication had been administered. In an interview at that time with QMA 3, the QMA indicated the Resident H preferred to take the Oxycod/apap to the dining room and have it with his breakfast. QMA 3 indicated she did not watch the resident actually take the medication. On 8/26/22 at 8:20 A.M., QMA 2 provided Resident H's medical records which were reviewed at that time. The Physician's Order Sheet dated 1/08/21, indicated an order for, "OXYCOD/APAP TAB 5-325 MG - BID [2 times daily] - 0.5 EA [each] - PO [by mouth] - TAKE ONE-HALF TABLET BY MOUTH TWICE DAILY." Review of Resident H's Individual Resident Control Medication Record Sheets dated 8/11/22 through 8/26/22 indicated, "Oxycod/apap Tab 5-325 Mg Take one-half tablet by mouth twice daily Quantity Remaining: 30 EA," Review of the of the Dosage Documentation column on the Resident H's Individual Resident Control Medication Record Sheet, indicated from 8/12/22 to 8/26/22, the Resident had been given 1 full Oxycod/apap Tab 5-325, rather than "ONE-HALF," as ordered by the physician. On 8/24/22 at 11:00 A.M., an interview with LPN 1 indicated nursing staff should always watch the resident's take their medication since the resident's do not self-administer their medications.			

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	7. The clinical record for Resident C was reviewed on 8/25/22 at 9:00 A.M. Resident C was admitted to the facility on 5/02/22 and was discharge from the facility on 6/20/22. Admitting diagnoses included, but were not limited to: stroke, hemiplegia, anxiety, and pain. The physician's orders during the admission period included but were not limited to Baclofen 5 mg tablet by mouth 3 times daily, Lorazepam tablet 0.5 mg by mouth 2 times daily, and Cetirizine 10 mg tablet 1 time daily. Review of the Medication Administration Record (MAR), dated 6/01/22 to 6/20/22, indicated Resident C did not receive Baclophen on the following dates and times: 6/07/22 morning and evening 6/19/22 evening 6/01/22 through 6/20/22, no doses were administered. Resident C did not receive Lorazepam on the following dates and times: 6/09/22 morning 6/13/22 morning 6/15/22 morning Resident C did not receive Cetirizine on the following dates and times: 6/03/22 morning 6/06/22 morning 6/10/22 morning 6/14/22 morning There was no documentation explaining the medication omissions listed above. 8. The clinical record for Resident G was reviewed on 8/25/22 at 9:25 A.M. Resident G was originally admitted to the facility with diagnoses that included but were not limited to chronic			

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	obstructive pulmonary disease (COPD), heart failure, diabetes, and chronic pain. The current physician's orders included, but were not limited to: Levothyroxin (thyroid hormone replacement) 200 mg tablet by mouth 1 time daily, Methoprol (heart failure)Suc 25 mg extended release tablet by mouth 1 time daily, Montelukast (allergies/asthma) 10 mg tablet by mouth 1 time daily, Trazodone (antidepressant) 325mg tablet by mouth at bedtime, Vitamin D3 2000 unit capsule by mouth 1 time daily, Clonazepam (antianxiety) 0.5 mg tablet by mouth 2 times daily, Acetaminophen (pain) 500 mg tablet by mouth 3 times daily, Bethanechol (urinary retention) 10 mg tablet by mouth three times daily, Hydromorphone (narcotic pain med) 2 mg tablet by mouth 3 times daily, and Humalog kwik injection 100/ML per sliding scale three times daily for blood sugar readings which included readings of 150-200 to give 1 unit. Review of the Medication Administration Record (MAR), dated 7/1/22 to 7/25/22, indicated: Resident G did not receive Levothyroxin on the following dates and times: 8/13/22 morning Resident G did not receive Metoprol on the following dates and times: 8/13/22 morning 8/22/22 morning Resident G did not receive Montelukast on the following dates and times: 8/22/22 morning Resident G did not receive Trazodone on the following dates and times: 8/23/22 bedtime Resident G did not receive Vitamin D3 on the following dates and times: 8/22/22 morning Resident G did not receive Clonazepam on the			

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	following dates and times: 8/22/22 morning Resident G did not receive Acetaminophen on the following dates and times: 8/2/22 through 8/10/22 and 8/12/22 through 8/17/22, and 8/22/22 Noon 8/22/22 morning and evening Resident G did not receive Bethanechol on the following dates and times: 8/22/22 morning, lunch, and evening There was no documentation explaining the medication omissions listed above. On 8/23/2022 at 2:15 P.M., the Administrator provided the policy titled, "Staff Administered Medications", dated 12/8/2011, and indicated the policy was the one currently used by the facility. The policy indicated"... 1. Wash you hands thoroughly with soap and water. 2. Unlock the medication cart and read the resident's Medication Sheet. The Medication Sheets must be reviewed each time the medications are administered to make certain that changes have not been made or medications discontinued. 3. Remove the resident's medication container/package. All medication labels must include: resident's name, name of medication, dose, directions, physician's name, and expiration date of medication, dispensing pharmacy name and prescription number. 4. Read the label on each bottle/packet. Read the label when removing the bottle/packet from the med cart and compare it with the resident's Medication Sheet. If there is a discrepancy in the directors between the label and an individual Medication Sheet verify against the physician's order to make sure the Medication Sheet correctly reflects the physician order...." This State Residential finding relates to Complaints IN00387635, IN00380236 and			

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R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. 9. During the initial tour of the facility, conducted on 8/20/2022 between 9:45 A.M. - 11:30 A.M., with the Admission Director, Employee 18, Resident D was observed to get himself up out of his bed and ambulate with a walker to the doorway area of his room. Employee 18 indicated Resident D was alert and oriented. The clinical record for Resident D was reviewed on 8/24/2022 at 2:00 P.M. Resident D was admitted to the facility with diagnoses, including but not limited to: diabetes mellitus type 2, chronic pain, major depressive disorder, cerebella stroke symptoms and anxiety disorder. The current physician's orders for Resident D included an order, initiated on 5/15/2022, for the resident to receive Ozempic 4 mg/ml injections once a week for diabetes. Review of the medication administration record for Resident D indicated he had only received the Ozempic injection one time in August from the 1 through the 24 of August. The July Medication Administration Record was not available for review. The June Medication Administration record did not have any documented doses of the Ozempic medication given and only had two days	R 0243	**R 243 Health Services – MAR not signed** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · MD was notified of residents F,L,N,P,Q,C,G and D medication administration omissions **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	10/15/2022

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	of the ordered medications documented as having been administered. The ordered insulin was not documented as given on the medication administration records. The May blood glucose tracking forms for Resident D for the Humolog insulin had only one before breakfast blood sugar level and insulin documented on 5/20/2022. During an interview on 8/25/2022 with Resident D's physician, who also served as the facility's medical director, she indicated no staff had notified her of Resident D's refusals nor of the inability of the facility to administer the Ozempic injections timely. She indicated Resident D had told her he was not receiving the injections timely. She indicated she was concerned the resident was not receiving his medication as ordered and her orders were not being noted and transcribed timely and correctly. She indicated she had rewritten medication and insulin orders on 8/18/2022 because the medication aides had informed her there were no insulin orders for a sliding scale for Resident D even though they were included in the resident's admission orders in May. During an interview with Resident D, conducted on 8/24/2022 at 1:15 P.M., he indicated he was not receiving his Ozempic injection because there was no licensed nurse available to administer the medication. He indicated the nurse "Joe" LPN 1 was supposed to come every Monday to administer the medication but often did not show up to give the injection. In addition, Resident D indicated he did not always receive his pain medications timely. He indicated he was supposed to get his oral pain		**taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · MAR to Cart audit to be completed by Pharmacy representative/ designee · Clinical Meeting agenda initiated to include reviewing all new medication orders to ensure accuracy, EMAR review for missing and refused medications, new admission reviews to ensure all admission orders transcribed accurately · Staffing patterns reviewed with facility to ensure that Licensed staff is on duty to administer injections if necessary · IDT team to complete resident interviews to determine any further medication or treatment concerns, pain concerns or any additional medical needs · Administrator and Health Services Director to meet with Medical Director to review new order process, staff to be educated **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · All Nurses and QMAs in serviced on Medication administration with return	

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	medication twice a day but yesterday he did not receive any pain medication until 2:00 A.M. He indicated he was in so much pain he was reduced to crawling on the floor and crying in pain. Review of the physician's orders indicated on 8/18/2022 the physician had increased his oral pain medication, Hydrocodone 5/325 from once a day to twice a day. Review of the medication administration record for Resident D for August 2022 confirmed the resident did not receive his morning dose of Hydrocodone, nor did he receive any of his doses of Gabapentin on 8/22/2022. Review of physician orders, dated 7/22/2022 and signed by the physician indicated Resident D was also to receive a Fentanyl patch 12 mg every 72 hours. There was no documentation the resident had received the pain medication patches at all in August 2022. In addition, there were physician orders, dated 6/2/2022 for the resident to receive physical and occupational therapy due to his back pain. The order was not noted by a nurse. On 8/23/2022 at 2:15 P.M., the Administrator provided the policy titled, "Staff Administered Medications", dated 12/8/2011, and indicated the policy was the one currently used by the facility. The policy indicated"... 1. Wash you hands thoroughly with soap and water. 2. Unlock the medication cart and read the resident's Medication Sheet. The Medication Sheets must be reviewed each time the medications are administered to make certain that changes have not been made or medications discontinued. 3. Remove the resident's medication container/package. All medication labels must include: resident's name, name of medication, dose, directions, physician's name, and expiration date of medication,		demonstration and emphasis on comparing medications to EMAR, documentations of medication refusals and PRN medications · All nurses and QMAS in serviced proper on Oral, Inhaler, and nasal spray administration · All nurses educated on admission process with emphasis on admission order verification, new admission checklist provided as tool for floor staff · All nurses and QMAs to be educated on new physician order process and procedure · All nurses and QMAs in serviced on PRN medication administration policy with emphasis on documentation in the MAR and the Narcotic count sheet · IDT educated on use of clinical meeting agenda and follow up · Health Service Director/Designee to complete medication pass observations with staff to ensure compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Health Services Director/ Designee to complete daily medication administration audit to ensure medication compliance · Health Services Director/ Designee to complete clinical	

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	dispensing pharmacy name and prescription number. 4. Read the label on each bottle/packet. Read the label when removing the bottle/packet from the med cart and compare it with the resident's Medication Sheet. If there is a discrepancy in the directors between the label and an individual Medication Sheet verify against the physician's order to make sure the Medication Sheet correctly reflects the physician order... On 8/24/2022 at 2:15 P.M. the Administrator provided the policy titled, "Preparation for Medication Administration- Controlled Medications", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... d. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record: 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose, completed after the medication is actually administered...." On 8/24/2022 at 2:15 P.M., the Administrator provided the policy titled, "Controlled Substance Storage", dated 5/10/2018, and indicated the policy was the one currently used by the facility. The policy indicated..."D. A controlled substance accountability record is prepared by the pharmacy/ facility for all Schedule II, III, IV and V medications. The following information is completed on the accountability form upon dispensing or receipt of a controlled substance or use of a controlled substance from the emergency supply: 1) Name of resident, if applicable. 2) Prescription number, if applicable. 3) Name, strength, and dosage form of medication. 4) Date received. 5) Quantity received. 6) Name of person receiving medication supply. E. At each shift		morning meeting agenda review and follow up related to new orders, new admission review · Health Services Director/ Designee to review daily staffing schedules to ensure licensed nurse staffing levels are appropriate · Health Services Director. Designee to complete medication administration observation audits including narcotic monitoring · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented...." This Residential Tag is related to Complaint IN00387635, IN00380236, and IN00382840. 7.The clinical record for Resident C was reviewed on 8/25/22 at 9:00 A.M. Resident C was admitted to the facility on 5/02/22 and was discharge from the facility on 6/20/22. Admitting diagnoses included but were not limited to stroke, hemiplegia, anxiety, and pain. The physician's orders during the admission period included but were not limited to Baclofen 5 mg tablet by mouth 3 times daily, Lorazepam tablet 0.5 mg by mouth 2 times daily, and Cetirizine 10 mg tablet 1 time daily. Review of the Medication Administration Record (MAR), dated 6/01/22 to 6/20/22, indicated Resident C did not receive Baclophen on the following dates and times: 6/07/22 morning and evening 6/19/22 evening 6/01/22 through 6/20/22, no doses were administered. Resident C did not receive Lorazepam on the following dates and times: 6/09/22 morning 6/13/22 morning 6/15/22 morning			

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	Resident C did not receive Cetirizine on the following dates and times: 6/03/22 morning 6/06/22 morning 6/10/22 morning 6/14/22 morning There was no documentation explaining the medication omissions listed above. 8. The clinical record for Resident G was reviewed on 8/25/22 at 9:25 A.M. Resident G was originally admitted to the facility with diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease (COPD), heart failure, diabetes, and chronic pain. The current physician's orders included but were not limited to Levothyroxin 200 mg tablet by mouth 1 time daily, Methoprol Suc 325mg extended release tablet by mouth 1 time daily, Montelukast 10 mg tablet by mouth 1 time daily, Trazodone 325mg tablet by mouth at bedtime, Vitamin D3 2000 unit capsule by mouth 1 time daily, Clonazepam 0.5 mg tablet by mouth 2 times daily, Acetaminophen 500 mg tablet by mouth 3 times daily, Bethanechol 10 mg tablet by mouth three times daily, Hydromorphone 2 mg tablet by mouth 3 times daily, and Humalog kwik injection 100/ML per sliding scale three times daily for blood sugar readings which included readings of 150-200 to give 1 unit. Review of the Medication Administration Record (MAR), dated 7/1/22 to 7/25/22, indicated Resident G did not receive Levothyroxin on the following dates and times: 8/13/22 morning Resident G did not receive Metoprol on the following dates and times: 8/13/22 morning			

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	8/22/22 morning Resident G did not receive Montelukast on the following dates and times: 8/22/22 morning Resident G did not receive Trazodone on the following dates and times: 8/23/22 bedtime Resident G did not receive Vitamin D3 on the following dates and times: 8/22/22 morning Resident G did not receive Clonazepam on the following dates and times: 8/22/22 morning Resident G did not receive Acetaminophen on the following dates and times: 8/2/22 through 8/10/22 and 8/12/22 through 8/17/22, and 8/22/22 Noon 8/22/22 morning and evening Resident G did not receive Bethanechol on the following dates and times: 8/22/22 morning, lunch, and evening There was no documentation explaining the medication omissions listed above. On 8/24/22 at 11:00 A.M. an interview with LPN 1 indicated nursing staff should document all medication administration on the Medication Administration Record. Any omissions of medication administration should be documented on the Medication Administration Record and the physician should be notified. Based on record review, observation and interview, the facility failed to document in the medical record indicating a medication had been administered for 8 of 23 residents reviewed for medications. (Residents F, L, N, P, Q, C, G, and D)			

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	Findings include: 1. A clinical record review was completed on 8/25/2022 at 3:48 P.M.. Resident F's diagnoses included, but were not limited to: epilepsy, bipolar, diabetes, Parkinson's disease and schizoaffective disorder. A current MAR (Medication Administration Record), dated 8/2022, indicated Resident F did not receive the following medications: 8/15/2022 Invega injection 234/1.5. All of the following medications were not documented as received on 8/22/2022: Aspirin 81 mg daily, Lantus insulin 15 units daily, Mag Oxide 400 mg daily, Nitrofuran Mono Macr 100 mg daily, Benztropine 2 mg twice a day, Carbamazepine 200 mg twice a day, Novolog sliding scale three times a day. 2. A clinical record review was completed on, 8/25/2022 at 4:05 P.M. Resident L's diagnoses included, but were not limited to: diabetes, depression, bipolar, hypertension and anxiety. The following medications were not documented as received on 8/22/2022: Gabapentin 600 mg twice a day, Lamotrigine 100 mg twice a day, Metformin 1000 mg in the evening Carbo/Levo 25-100 mg at 2:00 P.M. On 8/23/2022 the following medications were not documented as received: Lisinopril 2.5 mg daily, Divalpoex 250 mg daily, Aspirin 81 mg daily, Amantadine 100 mg daily, Ferrous Sulfate 325 mg daily, Metformin 1000 mg twice daily, Metoprol 50 mg daily, and Tamsulosin 0.4 mg daily. 3. A clinical record review was completed on 8/24/2022 at 1:15 P.M. Resident N's diagnoses included, but were not limited to: hypertension, atrial fibrillation, pain and congestive heart failure.			

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	The following medications were not documented as received on 8/22/2022: Furosemide 20 mg at noon, Potassium Chloride 20 meq daily, and Warfarin 2 mg daily. The following medications were not documented as received from 8/1/2022 through 8/26/2022: Nicotine 14 Gm patch daily, Fluticasone nasal spray twice daily, Lactulose 20 ml twice a day, Albuterol Nebulizer treatments 4 times a day. 4. A clinical record review was completed on 8/25/2022 at 9:28 A.M. Resident P's current diagnoses included, but were not limited to: asthma, convulsions, atrial fibrillation and left hemiparesis. The following medications were not documented as received on 8/22/2022: Metoprol 50 mg twice daily, Mucinex 600 mg twice daily, Olopatadine solution eye drops twice daily, Potassium Chloride 20 meq twice daily, hydralazine 10 mg three times a day with a line drawn through the lunch time and no documentation from 8/1/ to 8/26/2022, Anoro Ellipt inhaler daily, Cetirizine 10 mg daily, Fluticasone spray daily, Furosemide 40 mg daily, Metolazone 2.5 mg daily, Diltiazem 60 mg twice a day, Eliquis 5 mg twice daily, Levetiraceta 500 mg twice daily and Losartan 50 mg twice daily. 5. A clinical record review was completed on 8/24/2022 at 3:58 P.M. Resident Q's diagnoses included but were not limited to: anxiety, hypertension, insomnia, pain and depression The following medications were not documented as received: Zoloft 50 mg daily and Cymbalta 30 mg 8/20 through 8/25/2022. 6. During an interview, on 8/24/2022 at 11:23 A.M.			

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	Resident Q indicated she was not receiving her medications. A clinical record review was completed on 8/24/2022 at 3:58 P.M. Resident Q's diagnoses included but were not limited to: anxiety, hypertension, insomnia, pain and depression. Resident Q's current narcotic medication orders, dated 7/15/2022, indicated the resident was to receive a Fentanyl (narcotic pain) patch 25 mcg (micro grams) apply one patch every 3 days. The Individual Resident Control Medication Record Sheet for the Fentanyl indicated the resident did not received the Fentanyl patch from 8/1/2022 through 8/24/2022. The August MAR (Medication Administration Record), dated 8/1/2022 through 8/31/2022, indicated Resident Q had received the Fentanyl patch every day from 8/1/2022 to 8/21/2022. An unopened box of Fentanyl patches, dated 8/18/2022, for Resident Q was observed in the medication cart on 8/26/2022 at 10:04 A.M. Resident Q's non-narcotic medication orders, dated 8/17/2022, indicated a new order for: discontinue the Cymbalta (anti-depressant) 30 mg twice a day, and start Cymbalta 30 mg every day x 14 days then discontinue the order, and increase Zoloft (anti-depressant) to 50 mg every day The August MAR, dated 8/1/2022 through 8/31/2022, lacked the documentation to show the Cymbalta and or the Zoloft had been given since the new order was received on 8/17/2022. A review of Resident Q's Individual Resident			

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	Control Medication Record Sheet for Clonazepam (anti-anxiety) 0.5 mg (milligrams) twice a day, the amount listed on 8/23/2022 at 10:40 A.M. was 22 remaining. The actual medication card had 21 pills remaining. The count sheet had not been signed off after the medication was administered to Resident Q. A Resident Individual Control Medication Record Sheet for Oxycodone (narcotic pain) 5/325 mg 1 three times a day, the amount listed on 8/23/2022 at 10:41 A.M. was 18 pills remaining. The actual medication card had 17 pills remaining. The count sheet had not been signed off after the medication was administered. During an interview, on 8/26/2022 at 10:04 A.M., QMA 3 indicated the Fentanyl box had 5 patches and had not been opened, and the narcotics should have been signed off after giving the medications.			
R 0246 Bldg. 00	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 record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Aide) were signed off by a licensed nurse for 1 of 16 residents reviewed for medications, (Resident	R 0246	**R 2 46- Health Services PRN Medications given by QMA**	10/15/2022

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	P). Findings include: A clinical record review was completed on 8/25/2022 at 9:28 A.M. Resident P's current diagnoses included, but were not limited to: asthma, convulsions, atrial fibrillation and left hemiparesis. A current MAR (Medication Administration Record) dated, 8/1 through 8/31/2022, indicated Resident P had received a PRN (as need) medication of Acetaminophen (pain reliever) 325 mg (milligrams) one time on the following dates: 8/6, 8/11, 8/15, 8/18, 8/19 and 8/20/2022. On the back side of the MAR were the instructions for: d. PRN Med. Reason given and results should be noted on Nurses's Medication Notes. The back page was blank and lacked any documentation to say why the as needed medication was administered or the documentation to show that an authorization from a Licensed Nurse for the as needed medication was obtained. The Nurses's Notes, dated 8/6/2022 through 8/20/2022, lacked the documentation to show the licensed Nurse had been notified. During an interview, on 8/24/2022 at 11:00 A.M., QMA 2 indicated the QMAs are supposed to call the LPN when they give a PRN medication. They then chart it on the back of the MAR or in the progress notes. During an interview, on 8/24/2022 at 11:10 A.M., the Director of Nursing, indicated PRN (as needed) medications- all need to be cleared by him		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident P had no negative effects related to alleged deficient practice **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents in the facility have the potential to be affected · LPNs and QMAs to be in serviced on QMA scope of practice with emphasis on PRN administration process **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · LPNs and QMAs to be in serviced on QMA scope of practice with emphasis on PRN	

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	and then he would tell the QMA to document it and then to document the follow up. He indicated he had only received 1 call from July 3rd 2020 to August 15, 2020, and the QMA's had not been calling him for PRN medication. On 8/25/22 at 1:00 P.M., the Administrator provided a form titled QUALIFIED MEDICATION AIDE Scope of Practice which indicatied, "The following tasks are within the scope of practice for the QMA unless prohibited by facility policy:... (11) Administer previously ordered pro re nata (PRN) [as needed] 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 residnt 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..." This Federal Tag is related to Complaint IN00387635 and IN00380236.		administration process · Health Service Director to review PRN medication usage using the clinical morning meeting agenda **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** i. Health Services Director/Designee to complete PRN medication audit to ensure that all PRN medications received appropriate nurse follow up ii. Audit to be completed weekly x 4 then monthly x 6 to ensure compliance iii. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to maintain appropriate temperatures for the freezer and refrigerator, label open containers, ensure rubber gaskets were clean and intact, and utensils were not uncovered for 1 out of 1 kitchen	R 0273	**R 273 Food and Nutritional Services temperature logs, labeling containers,**	10/15/2022

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	inspected. Finding includes: During the tour of the kitchen on 8/23/2022, with the Dietary Manager at 9:05 A.M. to 9:30 A.M., there was difficulty opening the walk-in freezer as there was a buildup of ice on the torn gasket, ice on the freezer floor, outside the temperature read 8 degrees and the inside thermometer read 28 degrees. The fan on the inside was not running. The walk-in refrigerator had an opened plastic package covered with foil and pepperoni both undated. The Reach-in refrigerator had an outside temperature of 46 degrees and no thermometer inside, contents of jelly were stored in a metal container covered with foil, 3/4 jug of barbeque sauce was gone and 3 bundles of American cheese slices wrapped in plastic wrap all undated, serving utensils in a plastic bin on a lower shelf uncovered. During an interview on 8/23/2022 at 9:30 A.M., the Dietary Manager indicated that the freezers temperature should have been below 0, the packages of meat, cheese, jelly, and barbeque sauce should have been labeled with an open date, the reach-in refrigerators temperature should have been below 41 degrees and serving utensils should have been covered. On 8/23/2022 at 2:45 P.M., the Administrator provided a policy titled, "3. Equipment: Refrigerator & Freezer Temperature Policy: It is the policy to provide safe food that is stored at the proper temperatures at all times. All food temperatures will be in the safe zone and will be monitored in the course of each shift utilizing the Refrigerator & Freezer Temperature log. Procedure: a. The Dining Services Director will		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · Freezer door gasket repaired · Freezer defrosted and new thermometer installed · Fan Reported and operating properly at this time · Refrigerator items cleaned and all items labeled and dated appropriately · Refrigerator and Freezer logs initiated · Utensil cleaned and stored appropriately **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by alleged deficient practice · Deep clean of the kitchen was completed · Audit completed and all food labeled and dated as	

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	designate times and staff member responsible in the course 0 each shift to check the temperature of each refrigerator and/or freezer b. Utilizing the thermometer installed in the equipment, check to ensure the following: i. Refrigerator's must be 41 degrees Fahrenheit or below. ii. Freezer's must be 0 degrees Fahrenheit or below, c. Enter each reading in the Refrigerator & Freezer Temperature log. d. Any significant fluctuations should be reported to the Dining services Director or management....." On 8/23/2022 at 11:15 A.M. polices requested for food and utensil storage was requested but not provided prior to the survey exit.		appropriate · Dishwasher temp log initiated · Kitchen cleaning scheduled initiated **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Dietary Manager educated on Refrigerator and freezer temp log and kitchen cleaning schedule · Dietary staff educated on Refrigerator and freezer temp log and kitchen cleaning scheduled · Dietary staff educated on Food labeling and Storage and infection control requirements for the kitchen · Dietary staff educated storage of utensils · Dietary Manger to complete daily kitchen environmental and sanitation rounds **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Administrator. Designee to complete Kitchen sanitation rounds to ensure compliance with cleanliness and infection control practices including food storage, labeling, temperature checks, logs and utensil storage	

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			· Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
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 record review and interviews, the facility failed to ensure there were diet orders, signed by the physician for 5 of 23 Residents. (Resident M, D, F, L and P) Findings include: 1. The clinical record for Resident M was reviewed on 8/23/2022 at 3:30 P.M. Resident M was admitted to the facility with diagnoses, including but not limited to, epilepsy, non pressure ulcers of the skin, glaucoma, chronic pain, major depressive disorder and hypertension. Review of the current physician orders for Resident M indicated there was no diet order. During an interview with QMA 2, the Residential Care Coordinator, conducted on 8/24/2022 at 11:00 A.M. he indicated he did not know where the diet orders for Resident M were located but he indicated he would "look" for them. QMA 2 was queried on 8/24/2022 at 3:00 P.M., again on 8/25/2022 at 3:00 P.M. and on 8/26/2022 at 10:00 A.M. and there was no diet order located for Resident M.	R 0275	**R 275- Food and Nutritional Services- Diet Orders signed** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Residents M, D,F,L and P had diet orders reviewed and signed by the physician **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents in the facility have the potential to be affected by alleged deficient practice · Whole House audit	10/15/2022

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	2. The clinical record for Resident D was reviewed on 8/24/2022 at 10:00 A.M. Resident D was admitted to the facility on 5/9/2022 with diagnoses, including but not limited to diabetes mellitus and hyperlipidemia. The admission physician orders for Resident D did not include an order for the resident's diet. QMA 2, the Residential Care Coordinator was interviewed on 8/24/2022 at 11:00 A.M. regarding the resident's diet order. He indicated he would look for the order. The diet order was requested again on 8/24/2022 at 3:00 P.M., on 8/25/2022 at 11:00 A.M. and 3:00 P.M. and on 8/26/2022 at 11:00 A.M. and no diet order was located for Resident D.3. A clinical record review was completed on 8/25/2022 at 3:48 P.M. Resident F's diagnoses included, but were not limited to: epilepsy, bipolar, diabetes, Parkinson's disease and schizoaffective disorder. Resident F's physician orders, dated 9/15/2021, lacked a diet order and no more recent physician orders were noted on the medical record. On 8/25/2022 at 11:47 A.M., Resident F's current physician orders were requested, but none were provided on 8/25/22 or 8/26/2022. 4. A clinical record review was completed on, 8/25/2022 at 4:05 P.M. Resident L's diagnoses included, but were not limited to: diabetes, depression, bipolar, hypertension and anxiety. Resident L's physician orders, dated 2020, lacked any type of diet order and no more recent physician orders were noted on the medical record. On 8/25/2022 at 11:48 A.M., Resident L's current physician orders were requested, but none were provided on 8/25/22 or 8/26/2022.		completed to verify diet accuracy and physician signature **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** o IDT team provided education on new admission reviews to include verification of Diet Order o Licensed educated on admission checklist to include verification of Diet Order o IDT will review diet orders during semi annual assessments and during service plan reviews **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** i. Health Service Director to complete Audit to ensure Diet orders are in place and have been signed by the physician ii. Audit to be completed weekly x 4 then monthly x 6 to ensure compliance iii. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	5. A clinical record review was completed on 8/25/2022 at 9:28 A.M. Resident P's current diagnoses included, but were not limited to: asthma, convulsions, atrial fibrillation and left hemiparesis. Resident P's physician orders, dated 9/15/2021, lacked any type of diet order and no more recent physician orders were noted on the medical record. On 8/25/2022 at 11:47 A.M., Resident P's current physician orders were requested, but none were provided on 8/25 or 8/26/2022. A policy was requested for diet orders and reviewing but one was not provided. This State Residential finding relates to Complaint IN00387635.			
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interviews, the facility failed to ensure medications were reviewed by a pharmacist for 10 of 23 residents reviewed. (Residents C,.D, F, G, H, L, M, N, P and JJ) Findings include: During reviews of clinical records for all 23 sampled residents, conducted on 8/23/22 - 8/26/2022, there were no pharmacy medication reviews documented for Residents C, D, F, G, H, L, M, N, P and JJ) .	R 0299	**R 299 Pharmaceutical Services – No Pharmacy Recommendations** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · Residents C,D,F,G,H,L,M,N,P and JJ had	10/15/2022

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	During an interview with QMA 2, the Resident Care Coordinator, on 8/24/2022 at 9:40 A.M., he indicated the facility had changed pharmacy providers and he did not think the new pharmacy was conducting routine pharmacy reviews for residents. He indicated he would look for any reviews. There were no pharmacy reviews located by QMA 2. On 8/23/2022 at 2:15 P.M., the Administrator provided the policy titled," Pharmacy Recommendations", dated 12/28/2008, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. The Pharmacist will review the drug regimen of each resident at least every sixty (60) days. 2. A written report of individual resident regimen recommendations, along with recommendations regarding pharmaceutical services will be provided to the Administrator, or designee. 3. All pharmacy recommendations requiring a physician's action will be brought to the attention of the appropriate physician in a timely manner (three to five business days). 4. If a physician is not in agreement with and declines the recommendation, this will be documented in the medical record...." This State Residential finding relates to Complaints IN00387635, IN00380236 and IN00382840.		medications reviewed by pharmacist **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents in the facility have the potential to be affected by alleged deficient practice · Pharmacy contacted and review requested of all residents that reside in the facility. Pharmacy completing reviews and will ensure all residents reviewed over next sixty days · Pharmacy report/ recommendation tracking system implemented · Health Service Director and Administrator to meet with facility pharmacy consultant to review Pharmacy recommendations policy **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** o IDT team provided education pharmacy consultant reviews o Pharmacy to send reports to Health Services Director and Administrator after visits and follow up to be given to physician for	

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			review o Health Serv ice Director/Designee to maintain Pharmacy review/ report tracking system **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** i. Health Service Director to complete Audit to ensure that Pharmacy reports and recommendation orders are in place and have been reviewed, completed and signed by the physician ii. Audit to be completed weekly x 4 then monthly x 6 to ensure compliance iii. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently			

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	accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on record review, observation and interview, the facility failed to date medications when opened, failed to separate oral medications and topical creams, and failed to have pharmacy labels in 3 of 3 medication storage areas observed. (Medication Carts 1, 2 and 3) Findings include: 1. During a medication storage observation on hall 3 medication cart, on 8/23/2022 at 9:16 A.M., with QMA 2 (Qualified Medication Aide) the following was observed: An opened Lidocaine package with a patch in it not labeled or a resident name. An Albuterol inhaler medication not in a box with a name [residents name] written on it with no pharmacy label. A Symbicort inhaler with no pharmacy label and not in the box it was delivered in. A Trelegy inhaler without a pharmacy label and un boxed. A Breo Ellipta inhaler without a pharmacy label. An opened and undated Fluticasone nasal spray for Resident P. One Lispro and Lantus insulin pen without a pharmacy label or resident name. An opened undated and un labeled Fluticosone nasal spray for Resident N. A tube of Diclofence Sod. cream for topical use in with the oral medications. An opened bottle of Magnesium pills undataed and without a pharmacy label. A small package with one Rivastigmin transdera (dementia treatment) patch, with the letters A D written on the outside of the package, not labeled and not named. A paper medication cup with a small pill inside and stapled together with " Don't Touch [resident name]" written with a black marker.	R 0300	**R 300- Pharmacy – Med Storage** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · Medications carts 1, 2 and 3 were audited and corrections made **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · Medication Cart Audit completed and corrections for labeling and storage completed. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · All nurses educated medication storage	10/15/2022

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	On 8/23/2022 at 9:49 A.M., QMA (Qualified Medication Aide) 2 indicated the medications should be labeled, dated when opened and the medications that was held or was refused, is put back in the medication drawer and at the end of the week on Friday they will be returned or destroyed when there can be another witness present. 2. During a medication storage observation on Hall 2, on 8/23/2022 at 10:38 A.M., with QMA 2 the following was observed: 2 loose pills in drawer 2 and 3; An opened bottle of pills with no pharmacy label and or date opened. An opened bottle of Equate not labeled with AM written on the cap. An opened bottle of Sentry Senior vitamins with no label or name. An opened, undated, and not labeled bottle of Omeprazole. A bottle of Atropine eye drops in with the oral medications. Three opened and undated bottles of Miralax. Opened and undated containers of Potassium Chloride, Methadone Syrup, lacteals, and Paratroop nasal spray. Four insulin pens with no pharmacy label. A medication cup with 2 Tylenol tablets with no resident identifiers. During an interview, on 8/23/2022 at 10:50 A.M., AMA 2 indicated the medications should be labeled, dated when opened, separated by routes and the Tylenol pills should not be in the cart like that. 3. During a medication storage observation on Hall 1 Medication Cart, at 8:00 A.M., with QMA 3, the following was observed: Assure Prism glucose test strips 50/bottle was opened. The container was not labeled with a resident's name, there was no open date on the container and no use by date on the container; 1 bottle of opened Refresh Tear Drops with no open or discard date on the bottle.		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Health Services Director/ Designee to complete medication cart audit to ensure storage and labeling of medication cart is appropriate · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	An interview with QMA 3 at this time indicated all medications and medication supplies should be labeled with the resident's name and should also be labeled with the open and expiration dates. On 8/24/2022 at 2:15 P.M. the Administrator provided the policy titled, "Medication Storage in the Facility", dated 5/10/2018, and indicated the policy was the one currently used by the facility. The policy indicated"...C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams,vaginal products, etc. Eye medications are stored separately per facility policy...." This State Residential finding relates to Complaints IN00387635, IN00380236 and IN00382840.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review and interview, the facility failed to ensure clinical records were accurate and complete for 23 of 23 sampled residents. This potentially affected all 53 residents in the facility.	R 0349	**R 349 – Clinical Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	10/15/2022

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	Findings include: During the survey process, conducted on 8/23/22 - 8/26/2022, clinical records were noted to be missing documentation such as current evaluations and service plans, pharmacy medication reviews, current physician's orders, accurate medication administration records, accurate and complete emergency file information, current diet orders, current resident weight documentation, nursing notes, physician progress notes, narcotic count records and immunization documentation, including Tuberculin testing and assessments. Physician's Orders were observed in an open paper holder in the nurse's station that were over 3 months old and had not been transcribed and implemented. There were stacks of Medication Administration Records from June 2022 on the floor in front of the bookcase holding Resident charts. The electronic charting system had very little documentation implemented for each resident. During an interview with QMA 2, the Resident Care Coordinator, he indicated the facility only had a nurse working on an as needed basis until 8/24/2022 when the as needed nurse, LPN 1 agreed to come back and work on a consistent basis. In addition, QMA 2 indicated the current pharmacy took all the Medication Administration Records back after the month was completed, even though stacks of records were noted on the floor. QMA 2 indicated the facility had stopped completing narcotic count sheet records in December 2021 because it was too time consuming. QMA 2 indicated he had requested assistance from the facility's new corporation and		· No residents with reported negative outcomes related to clinical records noncompliance **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · New Health Service Director (LPN was on board at the facility) · Administrator, Health Service Director, and Regional Operator to review staffing patterns, trends and IDT team to review delegation of duties as it relates to clinical records **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Administrator, Health Service Director, and Regional Operator to review staffing patterns, trends, and IDT team to review delegation of duties as it relates to clinical records	

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	had been told they were doing "a good job" and no assistance was provided. The policy regarding the maintenance of clinical records was requested on 8/25/2022 and 8/26/2022. The policy regarding destruction of clinical records was provided multiple times. In addition, a highlighted copy of the Residential regulation and a clinical chart content list was provided. There was no policy provided regarding the facility's policy and procedure regarding maintenance of active and closed clinical records in the building. This State Residential finding relates to Complaints IN00382840, IN00387635 and IN00380236.		· Electronic Health Record (PCC) training to be reviewed with facility staff · Education for Facility staff on Cheat sheets created for documentation and copies provided to staff · Clinical Morning Meeting agenda and follow up initiated · Facility Chart Audits to be completed by RN or LPN staff 4 resident charts weekly weekly until all resident charts have been reviewed- Chart Reviews will be comprehensive and review orders, service plans, assessments, medications etc. · New Admission Checklist to be utilized for floor staff and IDT to complete IDT admission review to capture accurate clinical information **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Chart Audits to be completed by RN or LPN staff 4 resident charts weekly until all resident charts have been reviewed- Chart Reviews will be comprehensive and review orders, service plans, assessments, medications etc. · Audit to be completed weekly until current census	

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			reviewed and will be reviewed monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
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 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 record review, observation and interview, the facility failed to ensure an emergency information file was accurate and complete with all required resident information for 53 of 53 residents. Finding includes: On 8/25/2022 at 10:28 A.M., the Administrator provided 4 emergency binders. The binders	R 0356	**R 356 – Clinical Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents with reported negative outcomes related to clinical records noncompliance	10/15/2022

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	contained 23 of the 53 residents residing in the facility. The following information was observed missing: 30 face sheets out of 53 residents. 21 of 23 face sheets lacked the name of the funeral home preference. 2 of 23 face sheets lacked the hospital preference. 8 of 23 lacked a photo of the resident. 23 of the 23 residents lacked a current copy of their Advanced Directives. A policy on emergency resident information was requested on 8/25/2022. During an interview, on 8/25/2022 at 1:12 P.M., the Administrator indicated he could not provide a policy for the emergency binder.		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · New Health Service Director (LPN was on board at the facility) · Administrator, Health Service Director, and Regional Operator to review staffing patterns, trends and IDT team to review delegation of duties as it relates to clinical records **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · Administrator, Health Service Director, and Regional Operator to review staffing patterns, trends, and IDT team to review delegation of duties as it relates to clinical records · Electronic Health Record (PCC) training to be reviewed with facility staff · Education for Facility staff	

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			on Cheat sheets created for documentation and copies provided to staff · Clinical Morning Meeting agenda and follow up initiated · Facility Chart Audits to be completed by RN or LPN staff 4 resident charts weekly weekly until all resident charts have been reviewed- Chart Reviews will be comprehensive and review orders, service plans, assessments, medications, emergency contact, photos etc. · New Admission Checklist to be utilized for floor staff and IDT to complete IDT admission review to capture accurate clinical information **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Chart Audits to be completed by RN or LPN staff 4 resident charts weekly until all resident charts have been reviewed- Chart Reviews will be comprehensive and review orders, service plans, assessments, medications etc. · Audit to be completed weekly until current census reviewed and will be reviewed monthly x 6 to ensure compliance · Results of the audits will be	

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			reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review and interview, the facility failed to ensure infection control measures were implemented and maintained to ensure a safe, sanitary environment was provided to prevent infection transmission. This deficient practice had the potential to affect 53 of 53 residents who reside in the facility. Finding includes: Upon entrance to the facility, on 8/23/22 at 9:30 A.M., only one staff member was noted to be wearing a face mask. All other staff members including the Administrator, were not wearing face masks and were noted to be interacting with residents in close proximity, less than 6 feet. During an interview, with the Administrator, conducted on 8/23/22 at 11:00 A.M., he indicated	R 0406	**F 406- Infection Control – COVID, Mask Use, COVID etc.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected · QMA 2 is no longer employed at the facility **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	10/15/2022

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	the facility was not currently following their own policy and procedure regarding COVID-19. He indicated they were following the current CDC (Centers for Disease Control) guidelines. The Administrator indicated the facilities current COVID 19 policy was not reflective of what the staff were doing regarding wearing masks. During the survey process, conducted through 8/23/22 through 8/26/22, QMA 2, the Resident Care Coordinator and the staff member designated as responsible for the Infection Control system was asked multiple times for a copy of the COVID 19 resident and staff line list records. The QMA indicated he had the documentation in a folder but did not produce any documentation regarding a COVID 19 line list for review. When queried, QMA 2 indicated he thought a dietary employee tested positive for COVID a month or two ago. He indicated any employee testing positive for COVID was to be off work for 5-7 days and then if they retested negative they could come back to work. He indicated any resident with signs and or symptoms of COVID was immediately tested and placed in isolation if they tested positive. He did not know what type of isolation was utilized but indicated staff were to wear gowns, gloves, face shields and an N95 mask when entering the room of a COVID positive resident. The resident was also to quarantine for 5 days and if they tested negative on day 5, their quarantine was over. He indicated if the roommate would be tested and if they tested negative, they would be moved to a different room. When asked if they did any contact tracing ad additional testing when they had a positive resident or staff member, QMA 2 indicated only if they had symptoms. QMA 2 indicated he reported any COVID positive resident or employee to the Administrator and the Administrator was responsible for reporting the		**taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · Health Services Director on boarded and is responsible for COVID 19-line listings, tracking, monitoring etc. · Infection control Surveillance initiated · COVID Vaccination Audit completed for all residents and staff § COVID vaccination tracking system implemented · COIVD monitoring orders initiated in PCC · Infection control practices reviewed in orientation and during routine in servicing · Audit of all staff TB/Tuberculin testing to be completed as noted in R 121 § `TB tracking system initiated for staff. TB tracking system to be maintained with documentation with § Facility staff educated on TB tracking system, 1st, 2nd step and annual PPD requirements for staff **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · All nurses educated on COVID monitoring, reporting, s/sx,	

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	infection to the " State". During an interview with QMA2, conducted on 8/25/22 at 2:00 P.M., he indicated he was not currently completing any infection surveillance since the " new company" had purchased the facility in October 2021. He indicated the staff administering medications were to take resident temperatures with every medication pass. There was no system to document this assessment and he was not sure the nursing staff were taking the required temperatures. When quarried about the vaccination program for employees and residents, QMA 2 provided a 2 page list of residents and staff that had vaccinations completed in the last 12 months. The list was not in any particular order and had resident and staff vaccinations together on the same document. In addition, QMA 2 indicated he had just received the document from the pharmacy, they had completed all the immunizations in the building but he was uncertain if all of the residents and staff were up to date with their vaccines. He indicated staff were to document vaccinations in the electronic clinical records for residents but they weren't currently being documented because staff had not had training with the new electronic charting system. QMA 2 indicated staff were educated regarding infection control, isolation and hand washing during the initial orientation process. It was unclear who provided the initial orientation inservicing. QMA 2 indicated LPN 1, who had been a PRN nurse and worked another job in a different facility, had been responsible for all employee and resident TB (Tuberculosis) Mantoux skin testing. QMA 2 indicated he would notify LPN 1 of the need in the building for a Mantoux test to be		isolation practices etc. · All staff in service on PPE/ Mask use in the facility · Upon orientation with all new hires, Administrator/ designee will complete New Hire checklist to ensure that employee has completed all required aspects of orientation including PPD testing/screening / Vaccination Records and infection control training · Health Services Director on boarded and is responsible for COVID 19-line listings, tracking, monitoring etc. · Infection control Surveillance initiated · COVID Vaccination Audit completed for all residents and staff · COVID vaccination tracking system implemented · COIVD monitoring orders initiated in PCC · Infection control practices reviewed in orientation and during routine in servicing · Audit of all staff TB/Tuberculin testing to be completed as noted in R 121 · `TB tracking system initiated for staf **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

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	administered and he would come to the building to provide the test. When asked for any documented TB Mantoux test performed in the past year, QMA 2 indicate the documentation was in a folder and that he had lost the folder. There was no documentation located in the clinical records or employee files regarding the required tuberculin skin testing. Review of the facilities policy and procedure regarding COVID 19 indicated it had not been updated since May 28, 2020. In addition, review of the facilities policy and procedure, titled " Surveillance for Infections" included the following: "...3. Infections that will be included in routine surveillance include those with: a. Evidence of transmissibility in a healthcare environment. b. Available processes's and procedures that prevent or reduce the spread of the infection. c. Clinically significant morbidity or mortality associated with infection (e.g. Pneumonia, UTI's C. Difficile) and d. Pathogens associated with serious outbreaks. (e.g. invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza)...5. Nursing staff. This State Residential finding relates to Complaint IN00387635.		§ Upon orientation with all new hires, Administrator/ designee will complete New Hire checklist to ensure that employee has completed all required aspects of orientation including PPD testing/screening / Vaccination Records and infection control training § Administrator or designee will audit new hire employee files weekly x 4 then monthly x 6 to ensure that employees have completed PPD testing/screening Vaccination Records and infection control training § Health Services Director /Designee to audit PPD tracking monthly to ensure all 1st, 2nd step, and Annual PPDs / screening completed as required § Health Services Director/Designee to audit COVID vaccination tracker monthly to ensure all residents and staff records are up to date · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interviews, the facility failed to ensure a chest x-ray was completed prior to admission for 1 of 2 residents admitted in the past year in a sample of 23. Findings include: The clinical record for Resident D was reviewed on 8/24/2022 at 10:00 A.M. Resident D was admitted to the facility on 5/9/2022 with diagnoses, including but not limited to diabetes mellitus and hyperlipidemia. There was a copy of a physical form completed prior to the resident's admission to the facility, but there was no chest xray documented on the form or on a separate diagnostic center form. During an interview with QMA 2, the Resident Care Coordinator on 8/25/2022 at 3:00 P.M. he indicated a physician from the homeless shelter had provided the preadmission physical documentation for Resident D and QMA 2 was unaware of the lack of chest x-ray documentation or admission tuberculin testing, utilizing the two step method.	R 0408	**F 408- Infection Control CXR for residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected · Resident D had CXR completed, and MD was notified **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · PPD/ CXR audit completed for residents at the facility · PPD testing/ CXR or screening scheduled for all identified residents **What measures will be put into**	10/15/2022

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			place or what systemic changes the facility will make to ensure that the deficient practice does not recur; · IDT team educated on preadmission requirements of CXR prior to admission · Nursing staff in service on PPD testing/ Screening · IDT educated on use of IDT admission review tool to ensure CXR was obtained and PPD was initiated. · Audit of all staff TB/Tuberculin testing to be completed for residents in the facility · `TB tracking system initiated for resident tracking. TB tracking system to be maintained by Health Service Director/Designee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** § Health Services Director/Designee to audit new admissions to the facility to ensure that PPD/ CXR/ Screenings have been completed as required · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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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
R 0410 Bldg. 00	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 a diagnosis. Based on record review and interview, the facility failed to ensure tuberculin skin testing was completed upon admission and annually for 23 of 23 sampleted residents. (Resident B, C, D, F, G, H, K, L, M N, P, Q, S, T, V, W, BB, CC, DD, FF, GG, HH, KK and JJ) Findings include: During the survey, conducted on 8/23/22 -	R 0410	**F 410- Infection Control PPD/CXR** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · No residents were affected	10/15/2022

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		A. BUILDING 00 B. WING	08/26/2022

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	8/26/2022, the clinical records for Residents B, C, D, F, G, H, K, L, M, N, P, Q, S, T, V, W, BB, CC, DD, FF, GG, HH, KK and JJ) were reviewed. There was no documentaiton in the clinical reords regarding tuberculin skin testing. During an interview with QMA 2, the Resident Care Coordinator, conducted on 8/25/2022 at 3:00 P.M., he indicated all of the facility resident tuberculin skin testing documentation was in a folder but he could not locate the folder. He indicated the PRN (as needed) nurse LPN 1 would come to the building to perform the testing when QMA 2 let him know of the need. The folder was requested on all days of the survey but was never located and provided by QMA 2. Review of the facility policy and procedure, titled, "Tuberculin Screening", provided by the Administrator on 8/25/2022 at 9:30 A.M., indicated the following was included: "...2. A tuberculin skin test shall be completed within three (3) months prior to the admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induriation with the date give, date read and by whom administered and read. 3. Residents who have not had a documented neggative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method....."		· Residents B,C,D,F,G,H,K,L,M,N,P,Q,S,T,V, W,BB,CC,DD,FF,GG,HH,KK and JJ had PPD screening/ Testing completed as appropriate **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · PPD/ CXR audit completed for residents at the facility · PPD testing/ CXR or screening scheduled for all identified residents **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · IDT team educated on preadmission requirements of CXR prior to admission · Nursing staff in service on PPD testing/ Screening · IDT educated on use of IDT admission review tool to ensure CXR was obtained and PPD was initiated. · Audit of all staff TB/Tuberculin testing to be completed for residents in the facility	

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			· TB tracking system initiated for resident tracking. TB tracking system to be maintained by Health Service Director/Designee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** § Health Services Director/Designee complete PPD audit to ensure that PPD/ CXR/ Screenings have been completed as required · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation and interview, the facility failed to follow standards of care during a medication administration observation. (QMA 5) Finding includes: During an Administration of Medication	R 0414	**F 414- Infection Control QMA Medication Pass** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	10/15/2022

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	observation, on 8/16/2022 from to 8:05 A.M. to 8:45 A.M., the following was observed: 1. QMA 5 retrieved medication packets from the medication cart for Resident BB. QMA tried to open the packets with her hands, but they did not open. She then placed the corner of the pill packet in her mouth and ripped the packet open and placed the pill into the medication cup. QMA 5 ripped open the other 6 packets with her teeth and placed the pills into the medication cup, with 1 pill landing on the top of the medication cart. QMA 5 with a bare hand picked up the pill and placed it into the medication cup. QMA 5 then administered the medications to the resident. The QMA did not any complete of hand hygiene. 2. On 8/23/2022 at 8:15 A.M., QMA 5 retrieved the medication packets for Resident P. When ripping open a medication packet a pill fell onto the floor. QMA 5 picked up off the floor bare handed and placed the pill into the medication cup. She then ripped open the remaining packets one at a time and place the medications into the medication cup. She administered the medications to Resident P. QMA 5 did not complete any type of hand hygiene. 3. At 8:28 A.M., QMA 5 retrieved medications for Resident DD. With an ungloved hand, she removed a pill from the package and placed the pill on top of the package on the medication cart. QMA 5 administered the medications to the resident and completed no hand hygiene. 4. At 8:32 A.M. QMA 5 removed Resident CC's medications from the cart. She dropped a pill on top of the medication cart, and with an ungloved hand picked up the pill and placed it into the medication cup. QMA 5 did not complete any		· QMA 5 was educated on medication administration prior to retuening to the floor to pass medications **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents to the facility have the potential to be affected by alleged deficient practice · All Nurses and QMAs educated on Medication administration with emphasis on handwashing **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** · All Nurses and QMAs in serviced on Medication administration with return demonstration and emphasis on comparing medications to EMAR, documentations of medication refusals and PRN medications · Health Service Director/Designee to complete medication pass observations with	

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	type of hand hygiene. During an interview, on 8/23/2022 at 8:45 A.M., QMA 5 indicated she should not have used her mouth to open the pill packets and may be used scissors instead. She indicated the medications should not have been picked up off the floor and given and should not have given the pills dropped on the medication cart, and she should have washed her hands and or used hand gel in between the residents. On 8/23/2022 at 2:15 P.M. the Administrator provided a policy titled," Staff Administered Medication", dated 3/1/2010, and indicated the policy was the one currently used by the facility. The policy indicated"...1. Wash your hands throughly with soap and water. ... 5.... Use a paper medicine cup, not your hands...."		staff to ensure compliance **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** · Health Services Director/ Designee to complete daily medication administration audit to ensure medication compliance · Health Services Director. Designee to complete medication administration observation audits to ensure proper infection control process in place · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	