STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155762	A. BUILDING 00 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST PARK HEALTH CAMPUS	2401 SOUTH L ST RICHMOND, IN 47374

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 30, & 31 and November 1, 2, 3, and 6, 2023 Facility number: 011387 Provider number: 155762 AIM number: 200853180 Census Bed Type: SNF/NF: 44 SNF: 10 Residential: 13 Total: 67 Census Payor Type: Medicare: 14 Medicaid: 29 Other: 11 Total: 54 These deficiencies reflect/reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on November 15, 2023	F 0000	The submission of this plan of correction does not indicate an admission by Forest Park Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Forest Park Health Campus The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christina Hoff	ED	12/12/2023

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

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to promote dignity a resident by not ensuring a urinary drainage bag was not covered. This affected 1 of 2 residents reviewed for dignity. (Resident 18)	F 0550	1 Resident #18 was found to have been affected by the alleged deficient practice. 2 All residents have the potential to be affected by the alleged deficient practice.	12/08/2023

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	Findings include: An observation, on 10/31/23 at 10:35 a.m., indicated Resident 18 was lying in bed and had an uncovered urinary drainage bag that hung on the bed frame on the window side of his bed. On 11/02/23 at 11:02 a.m., Resident 18 was observed in bed and his catheter bag sat on floor with no cover on the catheter bag. On 11/02/23 at 11:04 a.m., Certified Resident Care Assistant 5 indicated it should have a dignity cover and not be on the floor and she checks it twice a day or more. She said she would get another bag that had an attached cover on it. Resident 18's record was reviewed on 11/02/23 at 1:28 p.m. The record indicated Resident 18 had diagnoses that included, but were not limited to, urinary tract infection, hypertensive heart disease with heart failure, congestive heart failure, type 2 diabetes mellitus, urinary frequency and kidney stones. Physician's orders for foley catheter included, but were not limited to: - Indwelling Urinary Catheter size 16 French with a 10 cubic centimeter balloon for benign prostatic hypertrophy with obstruction. A Significant Change Minimum Data Set assessment, dated 9/25/23, indicated Resident 18 had modified independence in cognitive status for daily decision making, and had an indwelling urinary catheter. A care plan for the catheter indicated a start date of 5/14/2021 with the problem of: "Resident uses a		3 The leadership team will preserve dignity by concealing urinary drainage bags by performing audit on 5 residents weekly x4 weeks, then every other week x2 months, then monthly x3 weeks. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	

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	Foley catheter for dx (diagnosis) of: obstructive uropathy". Interventions included but were not limited to: "Resident will be free from adverse effects from catheter use. Maintain a closed system with urinary bag below the residents bladder and cover...." A Policy for "Preserving Dignity With Indwelling Catheter" was provided on 11/6/23 at 11:53 a.m. by Clinical Nurse Support. The policy included, but was not limited to: "Overview: To preserve resident dignity by concealing urinary drainage bags...a) Keep drainage bag covered with an appropriate device...." 3.1-3(t)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse by another resident, resulting in facial bruising and bleeding for 1 of 3 residents	F 0600	1 Residents #1 and #36 were found to have been affected by the alleged deficient practice. 2 All residents have the potential to be affected by the	12/08/2023

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	reviewed for abuse. (Resident 1) Findings include: On 10/31/23 at 11:00 a.m., Resident 1 was observed to have a bruise under his right eye. Resident 1 indicated his roommate (Resident 36) hit him and they moved him to another room. Resident 1's record was reviewed on 11/01/23 at 10:24 a.m. and indicated diagnoses that included, but were not limited to, lung disease, stroke with weakness, chronic atrial fibrillation, seizure disorder, depression, insomnia, generalized weakness, and cognitive communication deficit. An Annual Minimum Data Set assessment, dated 9/7/23, indicated Resident 1 was cognitively intact, had no behaviors or moods, and did not walk. During an interview, on 11/01/23 at 10:53 a.m., Resident 1 indicated he had turned his television off about 1:30 in the morning and his roommate got mad. His roommate had his own television. When [Resident 36] hit him, it was the first time it happened, it hadn't happened before or after but he had been afraid it would happen again. Resident 36 hit him 8 to 10 times all over his face. They took Resident 36 out of his room and he didn't come back in for the rest of the night. He said his roommate had not gotten agitated before this happened but the least little thing could set him off. They had been roommates for 2 or 3 months. He had not heard of this happening to another resident. The night nurse was close by and heard the noise and came in and stopped it. He said he didn't have much pain afterwards and he had a little bleeding from the right side of his face.		alleged deficient practice. 3 Department Leaders audit and review documentation for residents that display a change and trend in behavioral documentation, department leaders will provide interventions when trends present. Audit and documentation review to be conducted on 2 residents weekly in CCM x6 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	

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	Progress notes, for Resident 1, included, but were not limited to: Recorded as a late entry on 10/15/23 at 2:05 a.m. for the event occurring on 10/15/23 at 1:00 a.m., indicated: "Resident roommate came out of room on walker and approached this nurse at approximately 0100 and stated "I want out of my room immediately". This nurse asked resident roommate why he wanted out of his room and resident stated "That guy was running his mouth so I knocked him" (referring to this resident). This nurse went to assess this and noticed resident bleeding out of right temple. This nurse applied bandage to this resident. Resident stated "He turned my TV off and I told him to turn it back on and he hit me lots of times all over". Upon assessment of resident, no bruising was noted in any other area besides right temple on this resident. Resident pupils were PERRLA (pupils are equal, round and reactive to light and accommodation) and neuro checks were WDL (Within Defined Limits). Resident roommate at this time asked "Can I go back in my room and get my stuff". This nurse told resident no immediately and to go sit in waiting room at this time. ED [Executive Director] and DON [Director of Nursing] aware at this time. 10/15/2023 at 1:10 a.m. "slight bruise under right eye with slight swelling, redness to right side of face, and scab area to right temple with small amount bleeding, dressing applied. head to toe assessment completed with no other issues noted, residents immediately separated from each other" 10/15/2023 at 7:14 a.m.: "[Resident 1's family member] notified if (sic) incident last night, aware of bruise under right eye and redness to right side of face and scab bleeding to right temple with			

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	dressing in place, aware that roommate was removed from room...." 10/16/2023 at 12:09 p.m. "IDT (Interdisciplinary Team) Review: Resident has bruising and scab to right eye from encounter with room mate. No swelling noted by nursing staff. Will continue to monitor. Neuro checks initiated. MD and family aware." Social Services followed up with a psychosocial evaluation for Resident 1, on 10/16/23 at 1:53 p.m., 10/17/23 at 1:58 p.m., 10/19/23 at 1:38 p.m., and 10/24/2023 at 1:17 p.m., with no concerns or mood changes. The Executive Director provided a reportable incident, dated 10/15/23 at 1:01 a.m. that indicated Resident 36 "Entered the hall and told nurse he wanted his roommate to live in another room. When entering room the roommate stated he had been struck by his roommate. Type of Injury - Small bruise to the right eye. Immediate Action Taken - Residents immediately separated. Both residents assessed for injury. Physician, families, ED and DHS were notified. No new orders at this time. Preventative Measures Taken - Residents will be kept separated. Carepans (sic) will be assessed and updated. The agressor (sic) will be kept on 15 minute checks. Follow up added - Residents monitored for psychosocial effects with no adverse effect noted. 15 minute checks remained in pllace (sic) until [Resident 36] was discharged. No further resident to resident contact made." On 11/6/23 at 3:16 p.m., the Executive Director indicated this incident was reported to her immediately by a phone call when it happened. She had been on vacation and her back up			

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	handled it right then, and reported it to IDOH. Review of the record of Resident 36, on 11/3/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, psychosis, age related debility, cerebrovascular disease, dementia and major depression. The Quarterly Minimum Data Set (MDS) assessment for Resident 36, dated 9/13/23, indicated the resident was severely cognitively impaired for daily decision making. The resident did not require a mobility device for ambulation. The resident required supervision only for ambulation. The progress note for Resident 36, dated 10/10/23 at 9:35 a.m., indicated the resident was upset that his roommate asked for the door to be closed. The resident begun raising his voice to room mate and stated "I know you want the door the door shut !" "So here!" (Door slamming) Spouse made aware and Nurse Practitioner (NP) made aware due to this was not in residents character. The progress note for Resident 36, dated 10/15/23 at 1:00 a.m., indicated resident came out of room on walker and approached this nurse at approximately and stated "I want out of my room immediately". This nurse asked resident why he wanted out of his room and the resident stated "That guy was running his mouth so I knocked him" (referring to his roommate). Resident roommate stated "He turned my TV off and I told him to turn it back on and he hit me lots of time all over". Upon assessment of residents roommate pupils were PERRLA (pupils equal reactive to light). Upon assessment of residents roommate, no bruising was noted in any other area besides			

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	right on resident roommate. Resident roommate pupils were PERRLA and neurological checks were within defined limits. This resident at this time asked "Can I go back in my room and get my stuff". This nurse told the resident no immediately and to go sit in waiting room at this time. Executive Director and Director Of Nursing (DON) aware at this time. The progress note for Resident 36 dated, 10/15/23 at 1:06 p.m., indicated the resident immediately taken to the lounge area and separated from roommate, head to toe skin assessment done, no new skin issues notes. The progress note for Resident 36, dated 10/15/23 at 10:17 a.m., the resident attempted to walk towards old room and reminded him that he cannot go down there. When he asked why I told him because he hit his roommate and he stated "Well he deserved it!" and asked "What the hell does that have to do with going to the dining room?" Redirected resident to the dining room. The progress note for Resident 36, dated 10/16/23 at 12:16 p.m., the resident having increased behaviors and hit another resident. Resident removed from room and put into a temporary room to keep separated from roommate. Resident on 15 minute checks until plan is established for resident increased behaviors. A Policy for "Abuse and Neglect Procedural Guidelines" was provided by the Executive Director, on 11/3/23 at 1:55 p.m. The policy included, but was not limited to: "...Purpose: Trilogy Health Services LLC (THS) has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...3.			

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	Definitions: ABUSE is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...b. PHYSICAL ABUSE - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc...i. Resident to resident abuse with or without cause...." 3.1-27(a)(1)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on interview, observations, and record review, the facility failed to promote a resident's positioning by utilizing foot pedals for a resident unable to self propel for 1 of 1 reviewed for positioning. (Resident 41) Findings include:	F 0688	1 Resident #41 was found to have been affected by the alleged deficient practice. 2 All residents have the potential to be affected by the alleged deficient practice. 3 IDT will conduct audits on	12/08/2023

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	The clinical record for Resident 41 was reviewed on 11/3/2023 at 11:45 a.m. The medical diagnoses included degenerative changes of the nervous systems and stroke. A Quarterly Minimum Data Set Assessment, dated for 8/9/2023, indicated that Resident 41 was cognitively impaired and needed substantial assistance for propel his wheelchair. An observation on 10/31/2023 at 10:53 a.m. indicated that Resident 41 was sitting in his wheelchair with it tilted back, his feet were dangling off of the ground with no foot pedals in place. An observation on 11/1/2023 at 2:35 p.m. indicated that Resident 41 was sitting in his wheelchair with it tilted back, his feet were dangling off of the ground with no foot pedals in place. An interview with the Director of Health Services on 11/2/2023 at 1:09 p.m. indicated that the chair was not made for foot pedals. An interview with the Clinical Support Nurse on 11/2/2023 at 1:15 p.m. indicated that the facility did not have a policy regarding foot pedals. She indicated that they are waiting for the manufacture guidelines, the resident does not self-propel, and are they would be ordering foot pedals for the chair if they were made. The manufacture guidelines provided by the Clinical Support Nurse on 11/2/2023 at 2:35 p.m. included a picture of the wheelchair with foot pedals as well as safe usage guidance for use to the wheelchair with foot pedals. She indicated they would be ordering some foot pedals for the		residents with limited ROM/ Do not experience reduction in ROM and appropriate devices are provided for resident's needs related to mobility. IDT will audit 3 residents 3x week x4 weeks, then every other week x2 months, then monthly for 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	

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	wheelchair and the resident would have a hospice evaluation next week. 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, observations, and record review, the facility failed to promote a safe environment by safeguarding perineal cleaner for a resident with a history of placing non-edible items in her mouth and potentially ingesting jewelry cleaner for 1 of 4 residents reviewed for accidents. (Resident 29) Findings include: The clinical record for Resident 29 was reviewed on 11/1/2023 at 1:40 p.m. The medical diagnoses included dementia and stroke. A Quarterly Minimum Data Set Assessment, dated 10/2/2023, indicated that Resident 29 was cognitively impaired and was a supervision assistance for walking with a walker. A care plan, dated for 9/27/2022, indicated that Resident 29 would place non-edible food items in her mouth.	F 0689	1 Resident #29 was affected by the alleged deficient practice. 2 All residents have the potential to be affected by the alleged deficient practice. 3 DHS/ADHS/ED/designee will conduct random audits on 5 residents x3 days a week for 4 weeks, then 2 days a week x8 weeks then weekly times x3 months to ensure the residents remain free of environmental hazards. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	12/08/2023

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	The Profile Care Guide, dated for 3/23/2022, indicated that Resident 29 would "...ingest non edible food items..." A nursing progress note, dated 7/26/2023, indicated "...This writer entered room, staff reported that resident had Jewelry cleaner in had and had something in her mouth. When this writer entered bathroom res[ident] was found to be swishing mouth out and proceeded to spit into the toilet. Staff informed writer that she did swallow some of this. This writer call Poison control [sic]..." A nursing progress note, dated 7/31/2023, indicated "Resident confused of what a trash can is used for. Resident removed trash from trash can and placed on bedside table. Resident was then noted trying to eat things from said trash..." A nursing progress note, dated 10/29/2023, indicated Resident 29 was having paranoia with staff, was unable to be redirected, and was yelling. An observation on 11/1/2023 at 1:28 p.m. indicated that Resident was sitting in her room on her bed with a bottle of light green liquid labeled as perineal cleaner to her right on the bedside table. Resident was very hard of hearing and confused. She indicated she did not know what that was, she then got up with her walker and began to walk around her room. An interview with LPN 3 on 11/1/2023 at 2:05 p.m. indicated that Resident 29 does have behaviors. She has good and bad days but had recently been yelling and wandering. The resident has a history of eating things she is not supposed to.			

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	155762	A. BUILDING 00 B. WING	11/06/2023

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	An interview with the Clinical Support Nurse on 11/1/2023 at 2:35 p.m. indicated that she was not sure if the resident was a risk for accidental ingestion, but she would not keep the perineal cleaner on the bedside table. A nurse practitioner note, dated for 11/1/2023, indicated that Resident 29 was seen for "...evaluations of risk for possibly ingesting non-food substances..." and that she "...does have significant dementia therefore risk of this will always be present as with any dementia patient..." A material safety data sheet was provided by the facility for the perineal cleaner on 11/2/2023 at 2:00 p.m. First-aid measures indicated if the substance was ingested, "...Dilute by giving a large amount of water. Allow vomiting to occur, then get medical attention..." An interview on 11/6/2023 at 2:00 p.m. with Clinical Support Nurse indicated that they do not have a policy for perineal cleaner left at bedside. 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-			

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	(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review the facility failed to ensure a resident's catheter bags or tubing were not touching the floor to prevent infection for 1 of 3 residents reviewed for catheter use. (Resident 18) Findings include: On 11/02/23 at 11:02 a.m., Resident 18 was observed in bed and his catheter bag sat on floor with no cover on the catheter bag. On 11/02/23 at 11:04 a.m., Certified Resident Care Assistant 5 indicated it should have a dignity cover and not be on the floor and she checks it twice a day or more. She said she would get	F 0690	1 Resident #18 was found to have been affected by the alleged deficient practice. 2 All residents have the potential to be affected by the alleged deficient practice. 3 The DHS or designee will conduct an audit of catheters to be free from resting/sitting on the ground surface~~.~~ ~~A~~uditing will include 3 like residents x4 weeks, then every other week x2 months then monthly for 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus	12/08/2023

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	another bag that had an attached cover on it. Resident 18's record was reviewed on 11/02/23 at 1:28 p.m. The record indicated Resident 18 had diagnoses that included, but were not limited to, urinary tract infection, type 2 diabetes mellitus, urinary frequency and kidney stones. Physician's orders for foley catheter included: - Indwelling Urinary Catheter size 16 French with a 10 cubic centimeter balloon for benign prostatic hypertrophy with obstruction. A Significant Change Minimum Data Set assessment, dated 9/25/23, indicated Resident 18 was moderately cognitively impaired and had an indwelling urinary catheter. A care plan for the catheter indicated a start date of 5/14/2021 with the problem of: "Resident uses a Foley catheter for dx (diagnosis) of: obstructive uropathy". Interventions included but were not limited to: "Resident will be free from adverse effects from catheter use. Maintain a closed system with urinary bag below the residents bladder and cover...." A Policy for "Preserving Dignity With Indwelling Catheter" was provided on 11/6/23 at 11:53 a.m. by the Clinical Support Nurse. The policy included, but was not limited to: "Overview: To preserve resident dignity by concealing urinary drainage bags...c) Urinary drainage bags and catheter tubing should be kept from touching the floor surface." 3.1-41(a)(2)		Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	
R 0000				

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Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: November 6, 2023 Facility number: 011387 Residential Census: 13 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 15, 2023	R 0000	The submission of this plan of correction does not indicate an admission by Forest Park Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Forest Park Health Campus The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			

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	Based on observation, interview, and record review, the facility failed to ensure the physicians' orders were followed regarding administration of a gastrostomy tube feeding for 1 of 5 residents reviewed for medication administration. (Resident R5) Findings include: An observation was conducted, on 11/6/23 at 11:37 a.m., of medication administration for Resident R5 by Qualified Medication Assistant (QMA) 5. QMA 5 proceeded to take a large container labeled Glucerna 1.2 and poured 8 ounces of such in a clear cup. Resident R5 took such cup and administered the feeding solution through his gastrostomy tube. The container labeled Glucerna 1.2 was already opened and did not contain an open date. QMA 5 indicated "it must have been over the weekend" and stated she did not open the container of Glucerna 1.2 originally. QMA 5 put the date for this last Saturday, 11/4/23, on the container. The clinical record for Resident R5 was reviewed on 11/6/23 at 1:25 p.m. The diagnoses included, but were not limited to, muscle wasting and atrophy, diabetes mellitus, and arthropathy. A service plan, revised 8/31/23, indicated Resident R5 "requires set up, cues, and/or encouragement - Cutting up food, location of items due to vision or mobility and/or needs to be encouraged to eat or drink". A physician order, dated 10/9/23, indicated to administer Glucerna via gastrostomy tube at 357 milliliters (ml) at lunch and supper. Staff was to provide moral support and supervision.	R 0091	1 Resident R5 was found to have been affected by the alleged deficient practice. 2 All residents have the potential to be affected by the alleged deficient practice. 3 Department leaders will ensure opened Glucerna without dates will be disposed of and new Glucerna will be provided prior to administration. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	12/08/2023

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	The administration of Glucerna to Resident R5 by QMA 5 did not align with the physicians' orders. A follow-up interview with QMA 5, on 11/6/23 at 1:40 p.m., indicated Resident R5 received Glucerna at 8 ounces (237 milliliters) via gastrostomy tube three times daily. A policy titled "Food Labeling and Dating Policy", revised 3/18/19, was provided by Clinical Support Nurse 12 on 11/6/23 at 2:08 p.m. The policy indicated the following, " ...Any food product removed from its original container, has a broken seal, has been processed in any way must have a label ...." A policy titled "Assisted Living Physician's Orders Guidelines", revised 8/11/16, was provided by Clinical Support Nurse 10 on 11/6/23 at 2:19 p.m. The policy indicated the following, " ...Purpose ...To provide guidelines for obtaining and follow through of physician orders ...."			