STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00358682 and IN00358839. Complaint IN00358682 - Substantiated. State deficiencies related to the allegations are cited at R088, R116, R119, R121, R154, R245 and R274. Complaint IN00358839 - Substantiated. State deficiencies related to the allegations are cited at R154 and R274. Survey dates: July 28 & 29, 2021 Facility number: 001148 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed on August 6, 2021.	R 0000		

R 0088	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on interview and record review, the facility failed to ensure a licensed Administrator was obtained when the previous Administrator left his or her position. This deficiency had the potential to effect all 32 residents who resided at the facility and all 32 staff members currently working at the facility.	R 0088	R088 When previous administrator announced herintent to resign, RDO began recruiting efforts for an Interim Administrator, but receivedonly two responses. One withdrew sitingfamily matters, the other was not local andtook a position elsewhere. The only other applicants possessed no license, or even thequalifications to obtain one. With no interim candidates available, theRDO, who is an experienced ALFadministrator in multiple states, applied for a Provisional HFALicense to bridge until a new administrator could be appointed. Several weeks after sending theapplication, RDO received direction fromPLA to submit fingerprints for the background check, which was accomplishedat the earliest available appointment, two business days later. RDO has continued to follow up with PLAand on 9/1/21 was advised his applicationremains in process. Finally, RDO has continued to recruiting efforts for a currentlylicensed administrator. As soon as one isfound, he or she will be given the position.Policy statement for the appointment of newadministrators when one leaves their position. That all said, a candidate came	10/06/2021

	Finding includes: On 7/28/21 at 10:02 A.M., an interview was conducted with the Regional Director of Operations (RDO) and the Admission Coordinator/Sales/Marketing Director. The RDO indicated he had applied, in May of 2021, for an Administrative License and it was still pending, due to need of fingerprints. The RDO indicated the Management Company didn't want to hire an interim Administrator, as the facility was in the process of being sold. The RDO indicated when he wasn't present the Admission Coordinator/Sales/Marketing Director would be acting as the Administrator for the facility. The Admission Coordinator/Sales/Marketing Director indicated she did not have an Administrator's license and there had been no Administrator, for the facility, for June and July. On 7/28/21 at 1:28 PM the Regional Director of Operations indicated there was no policy regarding the appointment of an administrator or their role in the facility and the policy was whatever the state guidelines suggested. This State tag relates to Complaint IN00358682. Based on interview and record		forward during the week of 29 August 2021 who is currently operating an ALF in the Mishawka area. He has already been interviewed by RDO, COO, and is expected to move to final interview during the week of 5 September 2021. He would start 30-days after reaching an employment agreement.	

	review, the facility failed to ensure a licensed Administrator was obtained when the previous Administrator left his or her position. This deficiency had the potential to effect all 32 residents who resided at the facility and all 32 staff members currently working at the facility. Finding includes: On 7/28/21 at 10:02 A.M., an interview was conducted with the Regional Director of Operations (RDO) and the Admission Coordinator/Sales/Marketing Director. The RDO indicated he had applied, in May of 2021, for an Administrative License and it was still pending, due to need of fingerprints. The RDO indicated the Management Company didn't want to hire an interim Administrator, as the facility was in the process of being sold. The RDO indicated when he wasn't present the Admission Coordinator/Sales/Marketing Director would be acting as the Administrator for the facility. The Admission Coordinator/Sales/Marketing Director indicated she did not have an Administrator's license and there had been no Administrator, for the facility, for June and July. On 7/28/21 at 1:28 PM the Regional Director of Operations indicated there was no policy			

	regarding the appointment of an administrator or their role in the facility and the policy was whatever the state guidelines suggested. This State tag relates to Complaint IN00358682.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to develop and implement a policy & procedure related to screening newly hired employees. This deficiency affected 2 of 10 employee records reviewed. (QMA 2 and Cook 4) Finding includes: On 7/29/21 at 1:21 P.M. a review of the employee records was conducted with the Admission Coordinator. It was discovered QMA 2 (hire date 7/2/21) only had 1 reference and Cook 4 (hire date 7/10/21)	R 0116	The apparent lack of policies cited was only the result of RDO's inability to produce the requested documents during the survey.They are included with the POC.	09/05/2021

had no references completed.

A policy was requested regarding new hire procedures . A packet of forms titled, "Application for Employment", dated 2014, was provided, on 7/28/21 at 1:47 P.M., by the Regional Director of Operations with the indication there was no policy or procedures for the screening of newly hired employees.

This State tag relates to Complaint IN00358682.

Based on interview and record review, the facility failed to develop and implement a policy & procedure related to screening newly hired employees. This deficiency affected 2 of 10 employee records reviewed. (QMA 2 and Cook 4)

Finding includes:

On 7/29/21 at 1:21 P.M. a review of the employee records was conducted with the Admission Coordinator. It was discovered QMA 2 (hire date 7/2/21) only had 1 reference and Cook 4 (hire date 7/10/21) had no references completed.

A policy was requested regarding new hire procedures . A packet of forms titled, "Application for Employment", dated 2014, was provided, on 7/28/21 at 1:47 P.M., by the

	Regional Director of Operations with the indication there was no policy or procedures for the screening of newly hired employees. This State tag relates to Complaint IN00358682.			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (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 (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;	R 0119	Staffing crisis was most acute June and early July. This forced most of the leadership team into caregiver roles, when they would normally oversee the complete on-boarding program. Certain steps of the process were delayed in the interest of having people available to deliver care. All new hires were given two-days job shadowing orientation to familiarize them with each residents' needs. Further, all care staff hired were credentialed (HHA, CNA, or LPN) with prior health care experience. While they began working at the facility without completing in-service and training, all were very familiar with the responsibilities of the position. Recently hired team members were in process of catching up on training when the investigator arrived. In this effort, facility is following	08/31/2021

	(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 interview and record review, the facility failed to ensure 5 of 5 newly hired employees had general orientation and were in-serviced on abuse. (QMA 2, Cook 4, QMA 5, CNA 6 and LPN 7) Finding includes: On 7/29/21 at 1:21 P.M. a review of the employee records was conducted with the Admission Coordinator, due to the facility not employing a current Business Office Manager. Upon review: QMA 2 (hire date 7/2/21), Cook 4 (hire date 7/10/21, QMA 5 (hire date 6/28/21), CNA 6 (hire date		its established policies. The apparent lack of policy observed by the investigator was due to RDO's unfamiliarity with the facility and where written copies of the policies could be found to present to the investigator. See attached for examples of the policy and its application in on-boarding documents, starting with advertisements for open positions, the employment application, etc. Of the five newly hired employees, three completed all on-boarding and orientation by 08.13.0201. Two terminated employment before completing the process. Admin will audit files of newly hired employees to assure compliance with policy and regulations in preparation for Quarterly Quality Assurance meetings, with plan of action for any negative trends or non-compliance.	

7/7/21) and LPN 7 (hire date 6/15/21) had no documentation indicating they had received "general orientation" to the facility and had received no in-services regarding abuse, prior to working in the facility.

During an interview, on 7/29/21 at 1:17 P.M., the Regional Director of Operations indicated he was just trying to onboard staff and get staff working, so there was no abuse/dementia training prior to newly hired staff working with the residents.

A policy was requested regarding new hire procedures and/or in-services. A packet of forms titled, "Application for Employment", dated 2014, was provided, on 7/28/21 at 1:47 P.M., by the Regional Director of Operations with the indication there was no policy or procedures for newly hired employees.

This State tag relates to Complaint IN00358682.

Based on interview and record review, the facility failed to ensure 5 of 5 newly hired employees had general orientation and were in-serviced on abuse. (QMA 2, Cook 4, QMA 5, CNA 6 and LPN 7)

Finding includes:

On 7/29/21 at 1:21 P.M. a review of the employee records

	was conducted with the Admission Coordinator, due to the facility not employing a current Business Office Manager. Upon review: QMA 2 (hire date 7/2/21), Cook 4 (hire date 7/10/21, QMA 5 (hire date 6/28/21), CNA 6 (hire date 7/7/21) and LPN 7 (hire date 6/15/21) had no documentation indicating they had received "general orientation" to the facility and had received no in-services regarding abuse, prior to working in the facility. During an interview, on 7/29/21 at 1:17 P.M., the Regional Director of Operations indicated he was just trying to onboard staff and get staff working, so there was no abuse/dementia training prior to newly hired staff working with the residents. A policy was requested regarding new hire procedures and/or in-services. A packet of forms titled, "Application for Employment", dated 2014, was provided, on 7/28/21 at 1:47 P.M., by the Regional Director of Operations with the indication there was no policy or procedures for newly hired employees. This State tag relates to Complaint IN00358682.			
R 0121	Personnel - Noncompliance	R 0121	Of the five newly hired employees referenced in the complaint, three	08/31/2021

	410 IAC 16.2-5-1.4(f)(1-4) (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		are confirmed to have received their TB screenings 06.28.2021, 07.07.2021, and 08.09.2021. The remaining two staff terminated employment before TB screening could be confirmed or accomplished.Nursing staff leadership is trained on necessity to completeall on-boarding steps before new employeesbegin work and will comply with code, "At the time of employment, or within one (1)month prior to employment, and at leastannually thereafter, employees and nonpaidpersonnel of facilities shall be screened for tuberculosis." Administrator will maintain and review each month a list of current employees' last TB screen and the due dates for follow up screenings.	

	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 loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure 3 of 5 newly hired employees had obtained the first tuberculin skin test results, prior to starting work at the facility. (QMA 2, Cook 4 and QMA 5) Finding includes: On 7/29/21 at 1:21 P.M. a review of the employee records was conducted with the Admission Coordinator. It was discovered QMA 2 (hire date 7/2/21), Cook 4 (hire date 7/10/21 and QMA 5 (hire date 6/28/21) had no documentation indicating they had been administered or started the Mantoux two-step method of testing for TB (tuberculosis). A policy was requested regarding new hire procedures-TB testing. A packet of forms titled, "Application for Employment",dated 2014, was provided, on 7/28/21 at 1:47 P.M., by the Regional Director of Operations with the indication there was no policy or			

	procedures for newly hired employees. This State tag relates to Complaint IN00358682. Based on record review and interview, the facility failed to ensure 3 of 5 newly hired employees had obtained the first tuberculin skin test results, prior to starting work at the facility. (QMA 2, Cook 4 and QMA 5) Finding includes: On 7/29/21 at 1:21 P.M. a review of the employee records was conducted with the Admission Coordinator. It was discovered QMA 2 (hire date 7/2/21), Cook 4 (hire date 7/10/21 and QMA 5 (hire date 6/28/21) had no documentation indicating they had been administered or started the Mantoux two-step method of testing for TB (tuberculosis). A policy was requested regarding new hire procedures-TB testing. A packet of forms titled, "Application for Employment",dated 2014, was provided, on 7/28/21 at 1:47 P.M., by the Regional Director of Operations with the indication there was no policy or procedures for newly hired employees.			

	This State tag relates to Complaint IN00358682.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the kitchen equipment was free from debris and maintained in good repair for 1 of 1 kitchens observed. Finding includes: During a kitchen tour on 7/28/21 from 11:40 A.M. - 12:20 P.M., the following were observed with the Dietary Manager: -The convection oven was out of commission and with no date of when it would be repaired, per the Dietary Manager. -A fan was observed, blowing toward the prep areas, stove and steam table. The fan grates and the blade was observed to have layers of dust/dirt. The dust/dirt was blowing, outward, from the grates.	R 0154	Present ownership of the building has been unableto invest funds necessary to repair or replace certain equipment in the kitchen. This includes thefreezer door and convection oven. The conventional oven under the cooktop functions normally. On 8/19, the representatives from the newownership group toured the building, and we stressed the urgent need for these issues to beresolved.The fan has been removed and not returned. Water on the floor is due to condensate line beingplugged. Bread holder, toaster, and other areas in kitchenhave been properly cleaned. RDO and other management staff are monitoring kitchen cleaningto assure it meets the standard. • Convection oven is on list of items to replace bynew ownership. (Conventional oven and cooktop are fully functional.) • Fan was removed on the day of investigator’s visitand has not been returned. • Ice buildup around the door frame was clearedand remains so, enabling the door to close properly, keeping the temperature lower.	08/05/2021

	-The freezer door edge had a dark substance on it from the bottom of the door and half way up the door. The Dietary Manager called it mold. The freezer temperature was 31 degrees. The month of July, Freezer Log of temperatures reflected the freezer temperature was never zero or below. The Dietary Manager made no comment when this was brought to her attention. -The bottom of the freezer door seal and bottom of door had been damaged, therefore there was no complete closure/seal of the freezer door. -The floor to the freezer was wet, with some slushy ice forming toward the back of the freezer. The fan near the back of the freezer had a pipe coming out of the wall. Water was observed on wall, coming from the point where the pipe was inserted into the wall. The pipe was observed to be dripping, from an area where the pipe was angled, up into the fan. The pipe was covered with electrician black tape and/or some type of insulation. -A 9 shelf bread holder was observed to have debris/bread crumbs on each shelf. Bread on the shelves were undated. -The 4 slot toaster had debris/bread crumbs between		• Frozen condensation line has been repaired andthe floor is free of ice. • Bread holder and toaster on list of daily cleaningitems. • Bread now dated with each new load. • Toaster and shelf on daily cleaning list. DSD andAdmin assuring consistent compliance through no less that twice per month inspections. Cleanliness and condition of kitchen and kitchen equipment will be reviewed in Quarterly Quality Assurance meetings, with plan of action for any negative trends or non-compliance.	

	each slot and an ant was observed near the toaster. On 7/28/21 at 4:02 P.M., the Marketing Director provided a policy titled, "Dining Service Policies & Procedures", with a revision date of 10/31/2018, and indicated the policy was the one currently used by the facility. The policy indicated "D. Receiving Deliveries 11. Indiana - date the items of the date they were received and also include the date to use them by per state regulations...H. Quality Assurance in Dining Services... 2. Kitchen & Dining Room Sanitation and Cleanliness Policy: It is the policy to ensure all food is prepared and served in a fashion to prevent food borne illness and/or cross contamination. All kitchen & dining room surfaces must be maintained in a clean and sanitary manner...b. Refrigerator & Freezer Units vi. Refrigerator and freezer units will be free of drips, leaks, rust or ice buildup...J. Fans & Vents i. Clean motorized fan grates and blades weekly by removing the grate and wiping down with detergent & water, taking care with the blades to avoid cuts or damage...k. Equipment should be kept clean at all times utilizing manufactures recommendations...m. All food holding containers will be kept clean & free from drips, spills, crumbs, dust etc. at all times...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 designate times and staff member responsible inn the course of 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*F or below ii. Freezer's must be 0*F or below...Any significant fluctuation should be reported to the Dining Services Director or management...." The State tag relates to Complaints IN00358839 and IN00358682. Based on observation, interview and record review, the facility failed to ensure the kitchen equipment was free from debris and maintained in good repair for 1 of 1 kitchens observed. Finding includes: During a kitchen tour on 7/28/21 from 11:40 A.M. - 12:20 P.M., the following were observed with the Dietary Manager:			

	-The convection oven was out of commission and with no date of when it would be repaired, per the Dietary Manager. -A fan was observed, blowing toward the prep areas, stove and steam table. The fan grates and the blade was observed to have layers of dust/dirt. The dust/dirt was blowing, outward, from the grates. -The freezer door edge had a dark substance on it from the bottom of the door and half way up the door. The Dietary Manager called it mold. The freezer temperature was 31 degrees. The month of July, Freezer Log of temperatures reflected the freezer temperature was never zero or below. The Dietary Manager made no comment when this was brought to her attention. -The bottom of the freezer door seal and bottom of door had been damaged, therefore there was no complete closure/seal of the freezer door. -The floor to the freezer was wet, with some slushy ice forming toward the back of the freezer. The fan near the back of the freezer had a pipe coming out of the wall. Water was observed on wall, coming from the point where the pipe was inserted into the wall. The pipe was observed to be dripping,			

	from an area where the pipe was angled, up into the fan. The pipe was covered with electrician black tape and/or some type of insulation. -A 9 shelf bread holder was observed to have debris/bread crumbs on each shelf. Bread on the shelves were undated. -The 4 slot toaster had debris/bread crumbs between each slot and an ant was observed near the toaster. On 7/28/21 at 4:02 P.M., the Marketing Director provided a policy titled, "Dining Service Policies & Procedures", with a revision date of 10/31/2018, and indicated the policy was the one currently used by the facility. The policy indicated "D. Receiving Deliveries 11. Indiana - date the items of the date they were received and also include the date to use them by per state regulations...H. Quality Assurance in Dining Services... 2. Kitchen & Dining Room Sanitation and Cleanliness Policy: It is the policy to ensure all food is prepared and served in a fashion to prevent food borne illness and/or cross contamination. All kitchen & dining room surfaces must be maintained in a clean and sanitary manner...b. Refrigerator & Freezer Units vi. Refrigerator and freezer units will be free of drips, leaks, rust or ice			

	buildup...J. Fans & Vents i. Clean motorized fan grates and blades weekly by removing the grate and wiping down with detergent & water, taking care with the blades to avoid cuts or damage...k. Equipment should be kept clean at all times utilizing manufactures recommendations...m. All food holding containers will be kept clean & free from drips, spills, crumbs, dust etc. at all times...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 designate times and staff member responsible inn the course of 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*F or below ii. Freezer's must be 0*F or below...Any significant fluctuation should be reported to the Dining Services Director or management...." The State tag relates to Complaints IN00358839 and IN00358682.			

R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on record review and interview, the facility failed to ensure a QMA (Qualified Medication Assistant) had completed the Insulin Administration Education Module before the QMA injected insulin into 4 of 5 residents who received subcutaneous injections of insulin. (Resident F, H, J and K) Findings include: During an interview, on 7/28/21 at 12:25 P.M., QMA 2 indicated he had not administered/injected insulin at the facility and was currently in an insulin training program. QMA 2 indicated he would need to get a certification and then he needed to complete a test, through the state. 1. On 7/29/21 at 10:05 A.M., a review of the clinical record for Resident F was conducted. The resident's diagnosis included, but were not limited to: type 2 diabetes mellitus. The July Medication Administration Record (MAR) indicated the following	R 0245	QMA 2 has been advised of state and facilitypolicies for medication administration. He is also warned any further non-compliance with result indisciplinary action, up to and including termination of employment. Compliance will of all medication administrationpractices will be audited by HealthServices Coordinator and/or Resident Care Coordinator and Administrator, in preparationfor review during each Quarterly Quality Assurance meeting, with plan of action for any negative trends or non-compliance.	08/05/2021

	administration instructions: Humalog inject subcutaneously (under the skin), 20 units, always, with meals, plus sliding scale. 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-250=8 units, 351-400=10 units, greater than 400 notify MD. The July Medication Administration Record (MAR) indicated, on 7/11/21, Resident F's Blood sugar, at lunch time, was 203. The resident received Humalog 24 units, subcutaneously, administered by QMA 2, and documented with QMA's initials. 2. On 7/29/21 at 10:25 A.M., a review of the clinical record for Resident H was conducted. The resident's diagnoses included, but were not limited to: diabetes and chronic kidney disease. The July MAR indicated the following insulin orders: "...Insulin ASPA [Novolog] Flexpen inject 15 units sub Q [subcutaneous] three times daily with meals...Levemir [insulin] 70 units sub Q (subcutaneous) twice a daily..." The July MAR indicated on, 7/18/21 at A.M., Lunch and P.M., the resident received Novolog insulin-15 units, from QMA 2 and on 7/20/21 at A.M., the Novolog-15 units was administered by QMA 2. In			

addition, QMA 2 administered Levemir 70 units, subcutaneously, on 7/18/21 at A.M. and P.M., and again, on 7/20/21 at A.M. All dates and times were documented as administered by QMA 2.

3. On 7/29/21 at 10:42 A.M., a review of the clinical record for Resident J was conducted. The resident's diagnoses included, but were not limited to: diabetes and hypertension.

The July MAR indicated the following insulin orders: "...Insulin ASPA [Novolog] Flexpen inject sub Q [subcutaneous] three time daily per scale: 150-189=1 unit 190-229=2 unit 230-269=3 units 270-309=4 units 310-349=6 units 350-389=8 units 30-429=10 units 430-469=10 units & call MD [Medical Doctor]...."

The MAR indicated on 7/11/21 at LU (lunch) the residents blood sugar was 334 and QMA 2 administered Novolog 6 units subcutaneously to Resident J, and was documented with QMA's initials.

4. On 7/29/21 at 11:00 A.M., a review of the clinical record for Resident K was conducted. The resident's diagnoses included, but were not limited to: type 2 diabetes mellitus with hyperglycemia and chronic pain.

	The July MAR indicated the following insulin orders:"...Novolog Flexpen 100 unit/ml [milliliters] inject 4 units subcutaneously before meals plus sliding scale\. 150-22=2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 400 or greater call MD [Medical Doctor]...." The Mar indicated on 7/11/21 at LU (lunch) the resident's blood sugar was 345 and QMA 2 administered 8 units of Novolog subcutaneously to Resident K and was documented with QMA 2's initials. During an interview, on 7/29/21 at 11:10 AM the Resident Care Coordinator indicated QMA 2 should not of been giving insulin injections, as he had not completed the QMA Insulin Administrator course. On 7/28/21 at 1:21 P.M., the Regional Director of Operations provided a booklet titled, "General Policies & Procedures", revised on 10/11/2017, and indicated "specific policy and procedures" were whatever the state guidelines were. Within the booklet, on page 6, titled "Determining Health Services Staffing Ratios Policy" the document read as follows: "...It is the policy of the Community that it must have qualified			

caregivers, sufficient in number, to meet the 23-hour scheduled and unscheduled needs of the residents...Caregivers provide services for residents that include assistance with activities of daily living, medication administration, resident-focused activities, supervisors, and support...."

This State tag relates to Complaint IN00358682.

Based on record review and interview, the facility failed to ensure a QMA (Qualified Medication Assistant) had completed the Insulin Administration Education Module before the QMA injected insulin into 4 of 5 residents who received subcutaneous injections of insulin. (Resident F, H, J and K)

Findings include:

During an interview, on 7/28/21 at 12:25 P.M., QMA 2 indicated he had not administered/injected insulin at the facility and was currently in an insulin training program. QMA 2 indicated he would need to get a certification and then he needed to complete a test, through the state.

1. On 7/29/21 at 10:05 A.M., a review of the clinical record for Resident F was conducted. The resident's diagnosis included, but were not limited to: type 2

diabetes mellitus.

The July Medication Administration Record (MAR) indicated the following administration instructions: Humalog inject subcutaneously (under the skin), 20 units, always, with meals, plus sliding scale. 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-250=8 units, 351-400=10 units, greater than 400 notify MD.

The July Medication Administration Record (MAR) indicated, on 7/11/21, Resident F's Blood sugar, at lunch time, was 203. The resident received Humalog 24 units, subcutaneously, administered by QMA 2, and documented with QMA's initials.

2. On 7/29/21 at 10:25 A.M., a review of the clinical record for Resident H was conducted. The resident's diagnoses included, but were not limited to: diabetes and chronic kidney disease.

The July MAR indicated the following insulin orders: "...Insulin ASPA [Novolog] Flexpen inject 15 units sub Q [subcutaneous] three times daily with meals...Levemir [insulin] 70 units sub Q (subcutaneous) twice a daily..."

The July MAR indicated on, 7/18/21 at A.M., Lunch and P.M., the resident received

	Novolog insulin-15 units, from QMA 2 and on 7/20/21 at A.M., the Novolog-15 units was administered by QMA 2. In addition, QMA 2 administered Levemir 70 units, subcutaneously, on 7/18/21 at A.M. and P.M., and again, on 7/20/21 at A.M. All dates and times were documented as administered by QMA 2. 3. On 7/29/21 at 10:42 A.M., a review of the clinical record for Resident J was conducted. The resident's diagnoses included, but were not limited to: diabetes and hypertension. The July MAR indicated the following insulin orders: "...Insulin ASPA [Novolog] Flexpen inject sub Q [subcutaneous] three time daily per scale: 150-189=1 unit 190-229=2 unit 230-269=3 units 270-309=4 units 310-349=6 units 350-389=8 units 30-429=10 units 430-469=10 units & call MD [Medical Doctor]...." The MAR indicated on 7/11/21 at LU (lunch) the residents blood sugar was 334 and QMA 2 administered Novolog 6 units subcutaneously to Resident J, and was documented with QMA's initials. 4. On 7/29/21 at 11:00 A.M., a review of the clinical record for Resident K was conducted. The			

	resident's diagnoses included, but were not limited to: type 2 diabetes mellitus with hyperglycemia and chronic pain. The July MAR indicated the following insulin orders:"...Novolog Flexpen 100 unit/ml [milliliters] inject 4 units subcutaneously before meals plus sliding scale\. 150-22=2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 400 or greater call MD [Medical Doctor]...." The Mar indicated on 7/11/21 at LU (lunch) the resident's blood sugar was 345 and QMA 2 administered 8 units of Novolog subcutaneously to Resident K and was documented with QMA 2's initials. During an interview, on 7/29/21 at 11:10 AM the Resident Care Coordinator indicated QMA 2 should not of been giving insulin injections, as he had not completed the QMA Insulin Administrator course. On 7/28/21 at 1:21 P.M., the Regional Director of Operations provided a booklet titled, "General Policies & Procedures", revised on 10/11/2017, and indicated "specific policy and procedures" were whatever the state guidelines were. Within the booklet, on page 6, titled			

	"Determining Health Services Staffing Ratios Policy" the document read as follows: "...It is the policy of the Community that it must have qualified caregivers, sufficient in number, to meet the 23-hour scheduled and unscheduled needs of the residents...Caregivers provide services for residents that include assistance with activities of daily living, medication administration, resident-focused activities, supervisors, and support...." This State tag relates to Complaint IN00358682.			
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3) (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a	R 0274	Facility is in process of having all cooking staffcomplete the ServeSafe training program before theend of September 2021. DSD and Admin will assure any new cooks joiningthe staff will also complete ServeSafe training within first 30-days of employment.	09/30/2021

minimum of one (1) year of experience in some aspect of institutional food service management.

(C) A graduate of a dietetic technician program approved by the American Dietetic Association.

(D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management.

(E) An individual with training and experience in food service supervision and management.

(2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis.

(3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.

Based on interview and record review, the facility failed to ensure the Dietary Manager/Supervisor had a certificate in food service and sanitation standards, this had the potential to effect all 32 residents who received food from the kitchen at the facility.

Finding includes:

On 7/28/21 at 11:40 A.M., the Dietary Manager indicated she was the person in charge of the kitchen.

On 7/28/21 at 3:24 P.M., the Dietary Manager indicated she did not have a ServSafe certificate or any other certificate for safe food handling, nor did anyone else working in the kitchen.

During an interview, on 7/29/21 at 10:37 A.M., the Marketing Director indicated the the Dietary Manager and Dietary Aides do not have a certificate, for safe food handling, in their employee files.

On 7/28/21 at 4:02 P.M., the Marketing Director provided a policy titled, "Dining Service Policies & Procedures", with a revision date of 10/31/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...F. Dinning Services Staff Expectations Policy 1. Safe Food Handling Certification Policy: There will be at least one staff member per cooking shift whom is certified in sanitation and food safety. ServSafe, a nationally recognized program in food safety, is the minimum certification required for all Dining Services Directors and designated Cooks for the dining

	services department. Once a certification has been obtained, the employee is to provide a copy to the Community Administrator who will then place the copy in the employee's personnel file...." The State tag relates to Complaints IN00358839 and IN00358682. Based on interview and record review, the facility failed to ensure the Dietary Manager/Supervisor had a certificate in food service and sanitation standards, this had the potential to effect all 32 residents who received food from the kitchen at the facility. Finding includes: On 7/28/21 at 11:40 A.M., the Dietary Manager indicated she was the person in charge of the kitchen. On 7/28/21 at 3:24 P.M., the Dietary Manager indicated she did not have a ServSafe certificate or any other certificate for safe food handling, nor did anyone else working in the kitchen.			

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The State tag relates to Complaints IN00358839 and IN00358682.

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