STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOM AT EAGLE CREEK	5045 W 52ND ST, INDIANAPOLIS, , 46254

(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 a State Residential Licensure Survey. Survey dates: August 28 and 29, 2024. Facility number: 003915 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 10, 2024.	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement or any kind by the by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency.	
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse.	R 0053	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	08/29/2024

	Based on observation, interview, and record review, the facility failed to ensure verbal abuse was reported to the Administrator for 1 of 1 observation of resident-to-resident verbal abuse (Resident 8 and 17). Findings include: On 8/28/24 at 11:58 a.m., Resident 8 raised her voice and yelled across two tables to tell Resident 17 to, "Shut-up, you can't talk to me that way." Her face was tense and her eyebrows were down in a grimace. The two residents continued in conversation for several minutes. Three staff members were in the dining room while this event was occurring; Community Relations 9, Certified Nurse Aide (CNA) 10 and CNA 11. No one intervened. Community Relations 9 indicated she wondered what they were yelling about. Three other residents were sitting at Resident 8's table; Resident 25, whom Resident 8 was trying to talk to, Resident 30 and Resident 6. During an interview, on 8/28/24 at 12:12 p.m., Resident 8 indicated Resident 17 interrupted her conversation with Resident 25, so, she told		practice; **Executive Director or designee provided/to provide Resident Rights in-service education and reporting to Community Relations 9, Certified Nursing Aide (CNA) 10 and 11 and all current and future associates.** 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 deficient practice. Resident Rights in-service will be done upon hire and annually for all associates.** 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 **Executive Director or designee will audit the in-service binder to**	

	him to shut up. Her face was tense and her eyebrows were down during the interview. During an interview, on 8/28/24 at 12:15 p.m., Resident 17 indicated Resident 8 talked about all the wrong things. The three staff in the dining room ignored the potential verbal abuse and continued passing out lunch trays to the other residents in the dining room. Resident 8 could be heard across the room. She had been trying to talk with Resident 25. During an interview, on 8/28/24 at 12:23 p.m., the Administrator (Admin) indicated the staff in the dining room should have reported resident-to-resident verbal abuse to him. On 8/28/24 at 12:40 p.m., Resident 8's record was reviewed. She was admitted on 2/20/23. Her diagnoses included, but were not limited to, schizophrenia (serious mental condition with breakdowns in thought, emotion, and behavior) obsessive compulsive order (long-lasting disorder in which a person experiences uncontrollable and recurring thoughts), and cognitive impairment (problems with the ability to think, lean, remember, use judgment, and make		**ensure all associates have been educated on Resident Rights** By what date the systemic changes will be completed. **In-service was/will be completed on August 29th**	

decisions).

On 8/28/24 at 1:28 p.m., Resident 17's record was reviewed. He was admitted on 1/19.21.

His diagnoses included, but were not limited to, anxiety (feelings of worry and nervousness) and anemia (decreased red blood cells).

A current policy, titled, "Abuse, Neglect and Exploitation Reporting and Investigation," March, 2012, was provided by the Lead Executive Director (LED), on 8/29/24 at 8:43 a.m. A review of the policy indicated, " ...Instances or allegations of abuse ...should be treated seriously and must be reported to the Executive Director ...."

Based on observation, interview, and record review, the facility failed to ensure verbal abuse was reported to the Administrator for 1 of 1 observation of resident-to-resident verbal abuse (Resident 8 and 17).

Findings include:

On 8/28/24 at 11:58 a.m., Resident 8 raised her voice and yelled across two tables to tell Resident 17 to, "Shut-up, you can't talk to me that way." Her face was tense and her eyebrows were down in a grimace. The two residents

continued in conversation for several minutes. Three staff members were in the dining room while this event was occurring; Community Relations 9, Certified Nurse Aide (CNA) 10 and CNA 11. No one intervened. Community Relations 9 indicated she wondered what they were yelling about.

Three other residents were sitting at Resident 8's table; Resident 25, whom Resident 8 was trying to talk to, Resident 30 and Resident 6.

During an interview, on 8/28/24 at 12:12 p.m., Resident 8 indicated Resident 17 interrupted her conversation with Resident 25, so, she told him to shut up. Her face was tense and her eyebrows were down during the interview.

During an interview, on 8/28/24 at 12:15 p.m., Resident 17 indicated Resident 8 talked about all the wrong things.

The three staff in the dining room ignored the potential verbal abuse and continued passing out lunch trays to the other residents in the dining room. Resident 8 could be heard across the room. She had been trying to talk with Resident 25.

During an interview, on 8/28/24 at 12:23 p.m., the Administrator

(Admin) indicated the staff in the dining room should have reported resident-to-resident verbal abuse to him.

On 8/28/24 at 12:40 p.m., Resident 8's record was reviewed. She was admitted on 2/20/23.

Her diagnoses included, but were not limited to, schizophrenia (serious mental condition with breakdowns in thought, emotion, and behavior) obsessive compulsive order (long-lasting disorder in which a person experiences uncontrollable and recurring thoughts), and cognitive impairment (problems with the ability to think, lean, remember, use judgment, and make decisions).

On 8/28/24 at 1:28 p.m., Resident 17's record was reviewed. He was admitted on 1/19.21.

His diagnoses included, but were not limited to, anxiety (feelings of worry and nervousness) and anemia (decreased red blood cells).

A current policy, titled, "Abuse, Neglect and Exploitation Reporting and Investigation," March, 2012, was provided by the Lead Executive Director (LED), on 8/29/24 at 8:43 a.m. A review of the policy indicated, " ...Instances or allegations of

	abuse ...should be treated seriously and must be reported to the Executive Director ...."			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with	R 0120	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Executive Director or designee** **provided/to provide Personnel Noncompliance in-service education to Housekeeping 12, QMA 13, 14, 17, Activity Director, LPN 16 and all current and future associates.** 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 deficient practice.** **Associate Training in-service will be done upon hire and annually for all associates.**	09/25/2024

	dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure a new hire and ongoing in-service/training program included the minimum requirements for Resident's Rights, Abuse/Neglect, and Dementia training for 6 of 6 employee records reviewed. This deficient practice had the potential to effect 53 of 53 residents who resided in the facility. Findings include: On 38/29/24 at 10:00 a.m., six randomly selected employee records were reviewed. Housekeeper (HK) 12 was hired on 3/7/24. The record lacked documentation of having job-specific orientation, and having been provided		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 **Executive Director or designee will audit the in-service binder to ensure all associates have been educated upon hire and annually** By what date the systemic changes will be completed. **In-service was/will be completed on/by September 25th**	

Resident's Rights and/or Abuse/Neglect training upon hire before she started working.

Qualified Medication Aide (QMA) 13 was hired on 7/16/24. The record lacked documentation of having job-specific orientation and having been provided Resident's Rights and/or Abuse/Neglect training upon hire before she started working.

QMA 14 was hired on 7/5/24. The record lacked documentation of having job-specific orientation, and having been provided Resident's Rights and/or Abuse/Neglect training upon hire before she started working.

The Activity Director (AD) was hired on 12/10/19 and his record lacked documentation he had received annual education related to Resident's Rights.

Licensed Practical Nurse (LPN) 16 was hired on 9/6/11 and her record lacked documentation she had received annual education related to Resident's Rights.

QMA 17 was hired on 9/15/22 and her record lacked documentation she had received annual education related to Resident's Rights, and a minimum of 3 hours of Dementia-specific training.

	During an interview on 11:10 a.m., the Lead Executive Director (ED) indicated a monthly in-service training was provided for all staff who were responsible for ensuring their participation. He did not know who should follow up to ensure all staff had participated. The ED indicated there was no comprehensive 6-hour dementia-specific training for new hires to complete within the first 6 months of employment, but that dementia training was a part of the scheduled monthly in-service training on a rotation, but that it did not add up to 6 hours. The ED indicated there was no policy related to new and ongoing hire education, but the facility followed the Residential Regulations. Based on interview and record review, the facility failed to ensure a new hire and ongoing in-service/training program included the minimum requirements for Resident's Rights, Abuse/Neglect, and Dementia training for 6 of 6 employee records reviewed. This deficient practice had the potential to effect 53 of 53 residents who resided in the facility. Findings include:			

	On 38/29/24 at 10:00 a.m., six randomly selected employee records were reviewed. Housekeeper (HK) 12 was hired on 3/7/24. The record lacked documentation of having job-specific orientation, and having been provided Resident's Rights and/or Abuse/Neglect training upon hire before she started working. Qualified Medication Aide (QMA) 13 was hired on 7/16/24. The record lacked documentation of having job-specific orientation and having been provided Resident's Rights and/or Abuse/Neglect training upon hire before she started working. QMA 14 was hired on 7/5/24. The record lacked documentation of having job-specific orientation, and having been provided Resident's Rights and/or Abuse/Neglect training upon hire before she started working. The Activity Director (AD) was hired on 12/10/19 and his record lacked documentation he had received annual education related to Resident's Rights.			

	Licensed Practical Nurse (LPN) 16 was hired on 9/6/11 and her record lacked documentation she had received annual education related to Resident's Rights. QMA 17 was hired on 9/15/22 and her record lacked documentation she had received annual education related to Resident's Rights, and a minimum of 3 hours of Dementia-specific training. During an interview on 11:10 a.m., the Lead Executive Director (ED) indicated a monthly in-service training was provided for all staff who were responsible for ensuring their participation. He did not know who should follow up to ensure all staff had participated. The ED indicated there was no comprehensive 6-hour dementia-specific training for new hires to complete within the first 6 months of employment, but that dementia training was a part of the scheduled monthly in-service training on a rotation, but that it did not add up to 6 hours. The ED indicated there was no policy related to new and ongoing hire education, but the facility followed the Residential Regulations.			
R 0151	Sanitation & Safety Standards -Noncompliance	R 0151	What corrective action(s) will be accomplished for those	09/27/2024

	410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on interview and record review, the facility failed to ensure pets were vaccinated for the safety of all residents in the building for 2 of 2 pets records reviewed. This deficiency had the potential to effect 53 of 53 residents residing in the building. Findings include: After entrance conference, the facility provided information for the pets in the building. Resident 14 had a cat and Resident 4 had a cat. A review Resident 14's pet documentation indicated her cat's last rabies vaccination was on 7/8/2020. The local veterinary clinic document indicated the next rabies vaccination was due on 7/8/2023. A review of Resident 4's pet documentation indicated her cat's last rabies vaccination was on 8/19/23. The rabies vaccination certificate indicated the next rabies vaccination was due on 8/18/24. A current policy titled, "Pets (Community & Visiting)," dated		residents found to have been affected by the deficient practice; **Executive Director will review pet documentation for R14 and R4 pets.** 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, associates and visitors have the potential to be affected by the deficient practice.** 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 **Executive Director or designee will audit the pet documentation binder to ensure all pets have current documentation and reviewed annually**	

	September, 2011, was provided by the Lead Executive Director (LED), on 8/29/24 at 8:43 a.m. A review of the policy indicated, " ...The Executive Director, or designee, will be responsible for the oversight and delegation of all pet care including, but not limited to ...medical/veterinarian needs ...." Based on interview and record review, the facility failed to ensure pets were vaccinated for the safety of all residents in the building for 2 of 2 pets records reviewed. This deficiency had the potential to effect 53 of 53 residents residing in the building. Findings include: After entrance conference, the facility provided information for the pets in the building. Resident 14 had a cat and Resident 4 had a cat. A review Resident 14's pet documentation indicated her cat's last rabies vaccination was on 7/8/2020. The local veterinary clinic document indicated the next rabies vaccination was due on 7/8/2023. A review of Resident 4's pet documentation indicated her cat's last rabies vaccination was on 8/19/23. The rabies vaccination certificate indicated the next rabies vaccination was		By what date the systemic changes will be completed. **In-service was/will be completed on/by September 27th**	

	due on 8/18/24. A current policy titled, "Pets (Community & Visiting)," dated September, 2011, was provided by the Lead Executive Director (LED), on 8/29/24 at 8:43 a.m. A review of the policy indicated, " ...The Executive Director, or designee, will be responsible for the oversight and delegation of all pet care including, but not limited to ...medical/veterinarian needs ...."			
R 0242	Health Services - Offense 410 IAC 16.2-5-4(e)(2) (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on record review and interview, the facility failed to monitor a resident's blood pressure prior to administering a blood pressure medication as ordered by the physician for 1 of 5 residents medications reviewed (Resident 52). Findings include: On 8/28/24 at 12:54 p.m., Resident 52's record was reviewed. He had the following	R 0242	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Executive Director and Director of Operations provided/to provide in-service education to WD and Nursing.** 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**	09/20/2024

	diagnoses which included but were not limited to anemia, congestive heart failure (CHF), chronic kidney disease (CKD), coronary artery disease (CAD), diabetes mellitus (DM), hyperlipidemia (HLD), and hypertension (HTN). Resident 52 had orders for nifedipine extended release (ER) 30 milligrams (mg) daily, hold if systolic blood pressure was less than 100. Resident 52's record lacked documentation that blood pressures were obtained prior to administering the medication for the month of August 2024. The Wellness Director (WD) indicated she would fix the order to ensure staff obtained blood pressures prior to administering the medication. A policy titled; "Alert Charting" was provided by the Lead Executive Director (ED) on 8/29/24 at 8:43 a.m. The policy indicated to check for any undesired effects. Based on record review and interview, the facility failed to monitor a resident's blood pressure prior to administering a blood pressure medication as ordered by the physician for 1 of 5 residents medications reviewed (Resident 52).		**to be affected by the deficient practice.** 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 **Wellness Director will audit the Alert Charting Log on an ongoing basis.** **By what date these systemic changes will be complete. September 20th**	

	Findings include: On 8/28/24 at 12:54 p.m., Resident 52's record was reviewed. He had the following diagnoses which included but were not limited to anemia, congestive heart failure (CHF), chronic kidney disease (CKD), coronary artery disease (CAD), diabetes mellitus (DM), hyperlipidemia (HLD), and hypertension (HTN). Resident 52 had orders for nifedipine extended release (ER) 30 milligrams (mg) daily, hold if systolic blood pressure was less than 100. Resident 52's record lacked documentation that blood pressures were obtained prior to administering the medication for the month of August 2024. The Wellness Director (WD) indicated she would fix the order to ensure staff obtained blood pressures prior to administering the medication. A policy titled; "Alert Charting" was provided by the Lead Executive Director (ED) on 8/29/24 at 8:43 a.m. The policy indicated to check for any undesired effects.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f)	R 0273	What corrective action(s) will be accomplished for those	09/20/2024

	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure the dietary staff had their hair covered, had clean air conditioning vents in the kitchen over the prep table while food was being prepared and had appropriate dates on food for 1 of 1 observations of the kitchen. This deficiency had the potential to affect 53 of 53 resident served meals from the kitchen. Findings include: During a kitchen tour, on 8/28/24 at 10:28 a.m., the Dietary Manger (DM) had a face mask under his chin with his facial hair exposed. The round white ceiling fan was observed with dust hanging on it in strings, and a wide band of brown dust on the ceiling and wall. During an interview, on 8/28/24 at 10:30 a.m., Cook 6 indicated he was concerned with the dust hanging from the ceiling vent. He was observed plating Jello desserts under the dusty ceiling fan. He indicated his lunch was under the prep table, where he		residents found to have been affected by the deficient practice; **Executive Director provided/to** **provide in-service education on Infection Control to Dietary Manager, Cook 6** **and all current and future dietary associates.** 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 deficient practice.** 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 **Dietary Manager will audit the Dietary Weekly Cleaning binger and documentation**	

	was working. On 8/28/24 at 10:32 a.m., the inside top of the microwave had dark debris. The DM indicated it was rust and the facility needed a new microwave. He pulled a piece of the rust out of the microwave to be observed. On 8/28/24 at 10:36 a.m., the DM indicated foods should have had an open date and an expiration date. The three-door refrigerator was observed. Date stickers were observed on the food with an area for when the food was opened and when it would become expired. The foods without expiration dates were packages and containers of boiled eggs, oatmeal, applesauce, mashed potatoes, ham and turkey luncheon meat. A container of shredded cheese was observed with an open date of 8/7/24 and an expiration date of 10/14/24. The DM indicated the 10/14/24 date was an error because shredded cheese did not last that long. A plastic bag of wet shredded lettuce was removed from the refrigerator, the DM indicated it had no dates and would be exposed of. On 8/28/24 at 10:41 a.m., three containers of Sterno (heat fuel cans), one was rusty, and two containers of dish machine detergent and one container of dish machine rinse aid were observed in the dry storage area		**on a weekly basis.** By what date the systemic changes will be completed. **In-service was/will be completed on/by September 20th**	

	with the food. The DM indicated they should not be in the dry storage with the food. On 8/28/24 at 10:47 a.m., the dish room's round air conditioning vent was observed to be dirty with dust build-up and had a wide brown band of dust on the ceiling around it. On 8/28/24 at 10:53 a.m., a second square vent was observed in the dish room. It was observed to be dirty with dust build-up. During an interview, on 8/29/24 at 8:45 a.m., the Lead Executive Director (LED) indicated the facility's kitchen followed the Indiana Retail Food Establishment Sanitation Requirements. A policy titled, "Infection Control - Food Storage," dated September, 2011, was provided by the LED, on 8/20/24 at 8:43 a.m. A review of the policy indicated, " ...It is the policy of the Dining Services Department that food storage occurs in a strictly defined manner as outlined in the procedures below. These procedures are designed to prevent the transmission of disease-carrying organisms ...Food storage areas are to be toured three (3) times daily by the Dietary Service Director, or designee, to review compliance ...Leftovers are			

	placed in containers that allow chilling in a short period of time. The are covered, labeled and dated ...." A document titled, "Dietary Aid Weekly Cleaning Schedule 2018," was provided by the Administrator (Admin), on 8/29/24 at 9:15 a.m. A review of the cleaning schedule indicated, " ...Check use by dates on all products ...date all products ...." A current policy, titled, "Infection Control - Environment," dated September, 2011, was provided by the LED, on 8/29/24 at 8:43 a.m. A review of the policy indicated, " ...It is the policy of the Dining Services Department to adhere to a strict environmental sanitation program for the purpose of preventing the transmission of disease-carrying organisms ...Walls, floors, and storage areas are routinely cleaned with appropriate sanitizing compounds ...." Based on observation, interview, and record review, the facility failed to ensure the dietary staff had their hair covered, had clean air conditioning vents in the kitchen over the prep table while food was being prepared and had appropriate dates on food for 1 of 1 observations of the kitchen. This deficiency had the potential to affect 53 of 53 resident			

served meals from the kitchen.

Findings include:

During a kitchen tour, on 8/28/24 at 10:28 a.m., the Dietary Manger (DM) had a face mask under his chin with his facial hair exposed.

The round white ceiling fan was observed with dust hanging on it in strings, and a wide band of brown dust on the ceiling and wall.

During an interview, on 8/28/24 at 10:30 a.m., Cook 6 indicated he was concerned with the dust hanging from the ceiling vent. He was observed plating Jello desserts under the dusty ceiling fan. He indicated his lunch was under the prep table, where he was working.

On 8/28/24 at 10:32 a.m., the inside top of the microwave had dark debris. The DM indicated it was rust and the facility needed a new microwave. He pulled a piece of the rust out of the microwave to be observed.

On 8/28/24 at 10:36 a.m., the DM indicated foods should have had an open date and an expiration date. The three-door refrigerator was observed. Date stickers were observed on the food with an area for when the food was opened and when it would become expired. The foods without expiration dates

	were packages and containers of boiled eggs, oatmeal, applesauce, mashed potatoes, ham and turkey luncheon meat. A container of shredded cheese was observed with an open date of 8/7/24 and an expiration date of 10/14/24. The DM indicated the 10/14/24 date was an error because shredded cheese did not last that long. A plastic bag of wet shredded lettuce was removed from the refrigerator, the DM indicated it had no dates and would be exposed of. On 8/28/24 at 10:41 a.m., three containers of Sterno (heat fuel cans), one was rusty, and two containers of dish machine detergent and one container of dish machine rinse aid were observed in the dry storage area with the food. The DM indicated they should not be in the dry storage with the food. On 8/28/24 at 10:47 a.m., the dish room's round air conditioning vent was observed to be dirty with dust build-up and had a wide brown band of dust on the ceiling around it. On 8/28/24 at 10:53 a.m., a second square vent was observed in the dish room. It was observed to be dirty with dust build-up. During an interview, on 8/29/24 at 8:45 a.m., the Lead Executive Director (LED) indicated the			

	facility's kitchen followed the Indiana Retail Food Establishment Sanitation Requirements. A policy titled, "Infection Control - Food Storage," dated September, 2011, was provided by the LED, on 8/20/24 at 8:43 a.m. A review of the policy indicated, " ...It is the policy of the Dining Services Department that food storage occurs in a strictly defined manner as outlined in the procedures below. These procedures are designed to prevent the transmission of disease-carrying organisms ...Food storage areas are to be toured three (3) times daily by the Dietary Service Director, or designee, to review compliance ...Leftovers are placed in containers that allow chilling in a short period of time. The are covered, labeled and dated ...." A document titled, "Dietary Aid Weekly Cleaning Schedule 2018," was provided by the Administrator (Admin), on 8/29/24 at 9:15 a.m. A review of the cleaning schedule indicated, " ...Check use by dates on all products ...date all products ...." A current policy, titled, "Infection Control - Environment," dated September, 2011, was provided by the LED, on 8/29/24 at 8:43 a.m. A review of the policy indicated, " ...It is the policy of			

	the Dining Services Department to adhere to a strict environmental sanitation program for the purpose of preventing the transmission of disease-carrying organisms ...Walls, floors, and storage areas are routinely cleaned with appropriate sanitizing compounds ...."			
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview, and record review, the facility failed to ensure all medications were secure for a resident who self-administered her medications for 1 of 1 observation (Resident 4). Findings include: On 8/28/24 at 12:50 p.m., an observation of Resident 4's door being unlocked and only pulled to the thresh hold and not latched closed. During an interview, on 8/28/24 at 1:30 p.m., Resident 4 indicated she self-administered two medications: famotidine 20 milligrams (mg) twice a day and	R 0295	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 4’s medication has been stored in a secure location in apartment. Wellness Director or designee will check residents who self-administer medications regularly.	09/29/2024

	levothyroxine 75 micrograms (mcg) daily. She provided the weekly pill container she used and the blister packages from where the medication originated. Neither were locked up. She indicated she felt her apartment was safe and did not lock her apartment when she went for meals or when she went outside to smoke. A current policy, titled, "Medication Storage - Resident (Self)," dated May, 2012, was provided by the Lead Executive Director (LED), on 8/29/24 at 8:43 a.m. A review of the policy indicated, " ...The purpose of this policy is to allow for self-administration and self-storage in a safe manner ...A resident may keep medications in the apartment ...provided the conditions for self-administration have been met ...An apartment will be considered secure if the resident locks the door when out, and keeps the medication in a locked drawer or cabinet ...." Based on observation, interview, and record review, the facility failed to ensure all medications were secure for a resident who self-administered her medications for 1 of 1 observation (Resident 4). Findings include:		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 same deficient practice. All Wellness Associates will be in-serviced on Medication Storage by Executive Director or designee. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Executive Director or designee will provide/provided in-service education on Medication Storage to all associates. Wellness associates will check regularly that resident’s doors remain locked or medications are in a secure area in apartment from other residents. How the corrective action(s) will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance	

	On 8/28/24 at 12:50 p.m., an observation of Resident 4's door being unlocked and only pulled to the thresh hold and not latched closed. During an interview, on 8/28/24 at 1:30 p.m., Resident 4 indicated she self-administered two medications: famotidine 20 milligrams (mg) twice a day and levothyroxine 75 micrograms (mcg) daily. She provided the weekly pill container she used and the blister packages from where the medication originated. Neither were locked up. She indicated she felt her apartment was safe and did not lock her apartment when she went for meals or when she went outside to smoke.		program will be put into place; Wellness associate will check residents who self-administer weekly and report to ED. By what date the systemic changes will be completed; 9/29/24 and on going.	

	A current policy, titled, "Medication Storage - Resident (Self)," dated May, 2012, was provided by the Lead Executive Director (LED), on 8/29/24 at 8:43 a.m. A review of the policy indicated, " ...The purpose of this policy is to allow for self-administration and self-storage in a safe manner ...A resident may keep medications in the apartment ...provided the conditions for self-administration have been met ...An apartment will be considered secure if the resident locks the door when out, and keeps the medication in a locked drawer or cabinet ...."			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the	R 0301	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 21, 41, 52, 25, 29, 9, 8, 34, 20 and 46 medications have been dated and labeled and stored properly. 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	09/30/2024

	prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, record review, and interview, the facility failed to store medications safely, failed to date medications, failed to label medication bottles, insulins, inhalers, and eye drops for 1 of 3 medication carts observed and 1of 1 insulin basket observed for medication labeling (Residents 21, 41, 52, 25, 29, 9, 8, 34, 20, and 46). Findings include: 1. On 8/28/24 at 11:00 a.m., the second-floor medication cart was observed. It had topical creams (six tubes) triamcinolone and hydrocortisone in the top drawer with inhalers and eye drops. 2. Resident 21 had a Novolog (insulin) pen in the insulin basket without a date to indicate when it was opened. 3. Resident 41 had a Lantus (insulin) pen and Humalog (insulin) pen not dated to indicate when it was opened. 4. Resident 52 had two pens of Novolin 70/30 not dated to indicate when they were		to be affected by the same deficient practice. All associates will be or has been in-serviced by the Wellness Director or designee on Medication Storage/Labeling. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Wellness Director or designee will audit the med cart weekly for 1 month and then biweekly on going. How the corrective action(s) will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place; Wellness Director or designee will Audit medication carts bi weekly on going. By what date the systemic changes will be completed; 9/30/24 and ongoing.	

opened.

5. Resident 25 had a pen of Tresiba (insulin) that was dated 5/25/24. It was expired.

6. Resident 29 had a pen of Lantus (insulin) that was not dated to indicate when it was opened.

7. Resident 9 had a Basaglar (insulin) pen that was not dated to indicate when it was opened.

8. Resident 8 had a bottle of artificial tears that was undated. She had a bottle of glucosamine chondroitin that only had her name on it and no label.

9. Resident 34 had a bottle of fluticasone propionate (nasal spray for allergies) without a date to indicate when it was opened.

10. Resident 20 had a bottle of fluticasone propionate without a date to indicate when it was opened.

11. Resident 46 had an inhaler, Breo Ellipta (inhaler for the lungs), with no date to indicate when it was opened.

12. Resident 25 had an inhaler Proair HFA 90mcg (inhaler for the lungs) with no date to indicate when it was opened.

During an interview with Licensed Practical Nurse (LPN),

on 8/28/24 at 11:55 a.m., she indicated the insulin pens should be dated.

A policy titled, "Storing General Medications," was provided by the Lead Executive Director (ED) on 8/29/24 at 8:43 a.m. The policy lacked information regarding the dating of medications, labeling of medications and storage of topical creams separate from eye drops and inhalers.

Based on observation, record review, and interview, the facility failed to store medications safely, failed to date medications, failed to label medication bottles, insulins, inhalers, and eye drops for 1 of 3 medication carts observed and 1of 1 insulin basket observed for medication labeling (Residents 21, 41, 52, 25, 29, 9, 8, 34, 20, and 46).

Findings include:

1. On 8/28/24 at 11:00 a.m., the second-floor medication cart was observed. It had topical creams (six tubes) triamcinolone and hydrocortisone in the top drawer with inhalers and eye drops.

2. Resident 21 had a Novolog (insulin) pen in the insulin basket without a date to indicate when it was opened.

3. Resident 41 had a Lantus

	(insulin) pen and Humalog (insulin) pen not dated to indicate when it was opened. 4. Resident 52 had two pens of Novolin 70/30 not dated to indicate when they were opened. 5. Resident 25 had a pen of Tresiba (insulin) that was dated 5/25/24. It was expired. 6. Resident 29 had a pen of Lantus (insulin) that was not dated to indicate when it was opened. 7. Resident 9 had a Basaglar (insulin) pen that was not dated to indicate when it was opened. 8. Resident 8 had a bottle of artificial tears that was undated. She had a bottle of glucosamine chondroitin that only had her name on it and no label. 9. Resident 34 had a bottle of fluticasone propionate (nasal spray for allergies) without a date to indicate when it was opened. 10. Resident 20 had a bottle of fluticasone propionate without a date to indicate when it was opened. 11. Resident 46 had an inhaler, Breo Ellipta (inhaler for the lungs), with no date to indicate when it was opened.			

	12. Resident 25 had an inhaler Proair HFA 90mcg (inhaler for the lungs) with no date to indicate when it was opened. During an interview with Licensed Practical Nurse (LPN), on 8/28/24 at 11:55 a.m., she indicated the insulin pens should be dated. A policy titled, "Storing General Medications," was provided by the Lead Executive Director (ED) on 8/29/24 at 8:43 a.m. The policy lacked information regarding the dating of medications, labeling of medications and storage of topical creams separate from eye drops and inhalers.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.	R 0407	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Wellness Director provided/to provide Infection Control in-service to all associates. 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	09/19/2024

	(4) Reporting communicable disease to public health authorities. Based on observation and interview, the facility failed to implement an infection control program to analyze patterns of know infection symptoms for the facility which had the potential to affect 53 of 53 residents. Findings include: On 8/28/24 and 8/29/24, the facility was observed for residents with infection control precautions in place. On 8/28/24 at 1:53 p.m., the infection control program was discussed with the Wellness Director (WD). She indicated she was monitoring for COVID which she had residents currently diagnosed with COVID. She indicated another nurse was supposed to be managing the program, but she found out that she was not managing the program. She indicated she had to get the program going again. During an interview with the Lead Executive Director (ED) on 8/29/24 at 11:00 a.m., he indicated he did not know the program was not being performed. He indicated there was no policy for the infection control program. Based on observation and		affected by the same deficient practice. Wellness Director will implement Infection Control Binder What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Wellness Director will bring Infection Control Binder to stand up meeting weekly to discuss with ED. How the corrective action(s) will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place; Wellness Director will bring Infection Control binder to Ed weekly for review. By what date the systemic changes will be completed; 9/19/24 and ongoing.	

interview, the facility failed to implement an infection control program to analyze patterns of know infection symptoms for the facility which had the potential to affect 53 of 53 residents.

Findings include:

On 8/28/24 and 8/29/24, the facility was observed for residents with infection control precautions in place.

On 8/28/24 at 1:53 p.m., the infection control program was discussed with the Wellness Director (WD). She indicated she was monitoring for COVID which she had residents currently diagnosed with COVID. She indicated another nurse was supposed to be managing the program, but she found out that she was not managing the program. She indicated she had to get the program going again.

During an interview with the Lead Executive Director (ED) on 8/29/24 at 11:00 a.m., he indicated he did not know the program was not being performed. He indicated there was no policy for the infection control program.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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

SIGNATURE		