STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS PLACE	4200 WYNTREE DR, NEWBURGH, , 47630

(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: November 25, 26, 2024 Facility number: 004903 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 1, 2024.	R 0000		
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	R 092 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	12/26/2024

	alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to attempt to told a fire and disaster drill in conjunction with the local fire department at least every six months. Finding includes: On 11/25/24 at 10:30 A.M., facility fire drills were reviewed. The most recent fire drill that indicated the fire department was notified was on 4/18/24. The fire department did attend that fire drill. On 11/25/24 at 12:46 P.M., the Administrator provided a current		employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 On 12/6/2024, Executive Director (ED) conducted an audit of fire drills. No concerns identified. 2 On 12/6/2024, ED conducted an audit for inviting	

	non-dated Fire Drill policy. The policy did not indicate how often the fire department should be invited to fire drills, but indicated facility policy was to notify the fire department annually (in the second quarter) and invite to attend. The policy did indicate the facility would comply with regulations which included inviting the fire department at least every six months. Based on interview and record review, the facility failed to attempt to told a fire and disaster drill in conjunction with the local fire department at least every six months. Finding includes: On 11/25/24 at 10:30 A.M., facility fire drills were reviewed. The most recent fire drill that indicated the fire department was notified was on 4/18/24. The fire department did attend that fire drill. On 11/25/24 at 12:46 P.M., the Administrator provided a current non-dated Fire Drill policy. The policy did not indicate how often the fire department should be invited to fire drills, but indicated facility policy was to notify the fire department annually (in the second quarter) and invite to attend. The policy did indicate the facility would comply with regulations which included inviting the fire department at		the local fire department to facility fire drills semi-annually. Identified concerns were corrected at time of findings. 3 ED provide in-service to staff on policy of fire drills and regulation including inviting the fire department at least every six months. 4 The Executive Director is responsible for sustained compliance. The ED, or designee, will review Fire Drills for proper regulatory requirements weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	

	least every six months.			
R 0121	Personnel - Noncompliance 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	R 0121	R 121 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 this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures:	12/26/2024

	complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure a newly hired employee was screened for TB (tuberculosis) prior to resident contact for 1 of 2 newly hired employees. A new employee, unable to get the TB skin test due to an allergy, did not get a chest x-ray prior to having contact with the residents. (Care Manager 7) Finding includes: On 11/26/24 at 8:34 A.M., the employee records were reviewed and indicated Care Manager 7 was hired on 11/1/24. The file lacked documentation of a 2 step TB skin test or chest x-ray being completed prior to or upon hiring. During an interview on 11/26/24 at 11:53 A.M., the Administrator indicated Care Manager 7		1 On 12/2/2024, Executive Director (ED) conducted an observational audit of employee TB screenings. Staff member identified was sent for chest x-ray on 12/4/24. No residents were affected. 2 On 12/6/2024, ED conducted an observational audit of all employee TB screenings. No concerns were identified. 3 ED provide in-service to DHW and Nursing staff on TB staff policy for each newly hired care staff member to be screened regarding exposure to or symptoms of TB after an employment offer has been made and prior to the employee's duty assignments. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will review new hire TB screenings weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three	

	required a chest x-ray and could not have a skin test done because of an allergy to the skin test procedure. At that time, he indicated Care Manager 7 had been in contact with residents. On 11/26/24 at 1:16 P.M., a current Staff TB Policy, dated 6/10/24, was provided by the Director of Nursing (DON) and indicated " ... Each newly hired care staff member will be screened regarding exposure to or symptoms of TB after an employment offer has been made and prior to the employee's duty assignments. TB test must be completed at the time of employment or within one (1) month prior to employment ... 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 ... " Based on interview and record review, the facility failed to ensure a newly hired employee was screened for TB (tuberculosis) prior to resident contact for 1 of 2 newly hired employees. A new employee, unable to get the TB skin test due to an allergy, did not get a chest x-ray prior to having contact with the residents. (Care Manager 7)		consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	

	Finding includes: On 11/26/24 at 8:34 A.M., the employee records were reviewed and indicated Care Manager 7 was hired on 11/1/24. The file lacked documentation of a 2 step TB skin test or chest x-ray being completed prior to or upon hiring. During an interview on 11/26/24 at 11:53 A.M., the Administrator indicated Care Manager 7 required a chest x-ray and could not have a skin test done because of an allergy to the skin test procedure. At that time, he indicated Care Manager 7 had been in contact with residents.			

	On 11/26/24 at 1:16 P.M., a current Staff TB Policy, dated 6/10/24, was provided by the Director of Nursing (DON) and indicated " ... Each newly hired care staff member will be screened regarding exposure to or symptoms of TB after an employment offer has been made and prior to the employee's duty assignments. TB test must be completed at the time of employment or within one (1) month prior to employment ... 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 ... "			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to	R 0246	R 246 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 this Plan of Correction	12/26/2024

	ensure as needed (prn) medications were administered by a Qualified Medication Aide (QMA) only upon authorization by a licensed nurse for 2 of 7 resident records reviewed. (Resident 5, Resident 7) Findings include: 1. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease. Current physician orders included, but were not limited to: acetaminophen 325mg (milligrams) every six hours as needed. hydroxyzine 25mg every six hours as needed. ondansetron 4mg three times a day as needed. loperamide 2mg every six hours as needed. Resident 5's MAR (Medication Administration Record) for October and November 2024 included, but were not limited to, the following prn medications administered by a QMA without prior authorization from a licensed nurse: acetaminophen 325mg given on 10/2/24 at 9:59 A.M., 10/15/24 at 12:10 P.M., and 10/18/24 at		does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 Resident 5 and Resident 7 suffered no negative effects related to these findings. QMA’s and Nurses to be in-serviced on obtaining appropriate authorization for each PRN administration and proper documentation of PRN administration in the nursing notes indicating the time and date on 12/13/24 2 On 12/10/2024, Director of Health and Wellness	

	10:36 A.M. hydroxyzine 25mg given on 10/2/24 at 10:00 A.M., and 10/18/24 at 10:36 A.M. ondansetron 4mg given on 10/15/24 at 12:10 P.M. loperamide 2mg given on 11/17/24 at 12:51 P.M. 2. On 11/26/24 at 10:00 A.M., Resident 7's closed clinical record was reviewed. Diagnosis included, but were not limited to, osteoporosis. Physician orders included, but were not limited to: acetaminophen 1000mg every eight hours as needed. Resident 7's MAR from April 2024 through July 2024 included the following dates/times acetaminophen as needed was administered by a QMA without prior authorization from a licensed nurse: 4/19/24 at 8:00 P.M. 4/22/24 at 8:00 P.M. 4/28/24 at 8:00 P.M. 5/12/24 at 8:00 P.M. 5/26/24 at 8:00 P.M. 6/4/24 at 8:00 P.M.		(DHW) conducted an audit on Medication Administration Records of current residents receiving PRN medications in past 60 days to ensure PRN medication was administered by a QMA after receiving appropriate authorization and properly documenting in the residents' nurses' notes. Results of the audit were reviewed by the ED. 3 By 12/19/2024, current QMA's will be re-educated by DHW on receiving appropriate authorization for each administration of a PRN medication and documenting in the nursing notes indicating the time and date of the contact. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will audit 5 resident records receiving PRN medication to ensure appropriate authorization was obtained and documented in the nurses notes weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during	

	6/7/24 at 8:00 P.M. 6/8/24 at 8:00 P.M. 6/9/24 at 8:00 P.M. 6/18/24 at 8:00 P.M. 6/23/24 at 8:00 P.M. 6/25/24 at 8:00 P.M. 7/2/24 at 8:00 P.M. 7/5/24 at 8:00 P.M. 7/6/24 at 8:00 P.M. 7/7/24 at 8:00 P.M. 7/12/24 at 8:00 P.M. 7/15/24 at 8:00 P.M. 7/18/24 at 8:00 P.M. 7/25/24 at 8:00 P.M. On 11/26/24 at 12:35 P.M., QMA 3 indicated when administering a prn medication, QMAs should obtain prior authorization from a licensed nurse and document that authorization in the MAR. On 11/26/24 at 1:05 P.M., the Administrator provided a current Qualified Medication Aide policy, dated 6/10/24, that indicated "PRN medications can be administered by a QMA only upon authorization by a licensed nurse of physician ... The QMA must receive appropriate		monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	

	authorization for each administration of a PRN medication" Based on interview and record review, the facility failed to ensure as needed (prn) medications were administered by a Qualified Medication Aide (QMA) only upon authorization by a licensed nurse for 2 of 7 resident records reviewed. (Resident 5, Resident 7) Findings include: 1. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease. Current physician orders included, but were not limited to: acetaminophen 325mg (milligrams) every six hours as needed. hydroxyzine 25mg every six hours as needed. ondansetron 4mg three times a day as needed. loperamide 2mg every six hours as needed. Resident 5's MAR (Medication Administration Record) for October and November 2024 included, but were not limited to, the following prn medications administered by a QMA without			

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	5/12/24 at 8:00 P.M. 5/26/24 at 8:00 P.M. 6/4/24 at 8:00 P.M. 6/7/24 at 8:00 P.M. 6/8/24 at 8:00 P.M. 6/9/24 at 8:00 P.M. 6/18/24 at 8:00 P.M. 6/23/24 at 8:00 P.M. 6/25/24 at 8:00 P.M. 7/2/24 at 8:00 P.M. 7/5/24 at 8:00 P.M. 7/6/24 at 8:00 P.M. 7/7/24 at 8:00 P.M. 7/12/24 at 8:00 P.M. 7/15/24 at 8:00 P.M. 7/18/24 at 8:00 P.M. 7/25/24 at 8:00 P.M. On 11/26/24 at 12:35 P.M., QMA 3 indicated when administering a prn medication, QMAs should obtain prior authorization from a licensed nurse and document that authorization in the MAR. On 11/26/24 at 1:05 P.M., the Administrator provided a current Qualified Medication Aide			

	policy, dated 6/10/24, that indicated "PRN medications can be administered by a QMA only upon authorization by a licensed nurse of physician ... The QMA must receive appropriate authorization for each administration of a PRN medication"			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (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. 4. On 11/25/24 from 12:00 P.M. through 12:15 P.M., lunch service was observed in the main dining room. Two ice containers were observed filled with ice on a rolling cart by the kitchen door with an ice scoop sticking out of one of them. Care Manager 7 was observed to use the ice scoop to scoop ice from the container to serve drinks to residents, then place the ice scoop back into the ice container. Care Manager 7 was observed to wash hands in between passing trays to residents with a two second lather, and the rest	R 0273	R 273 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 this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible	12/26/2024

	of the hand wash was performed with her hands under the water. QMA (Qualified Medication Aide) 9 was observed to wash hands in between passing trays to residents with a three second lather, and the rest of the hand wash was performed with her hands under the water. On 11/25/24 at 12:15 P.M., QMA 9 indicated there was a separate container for the ice scoop in the kitchen, but not on the rolling cart in the dining room. On 11/25/24 at 12:24 P.M., the Kitchen Manager indicated hands should be washed with soap and water during meal service lathering hands long enough to sing the Happy Birthday song twice slowly. On 11/25/24 at 1:13 P.M., the Administrator provided a current non-dated Ice Scoop policy that indicated "The ice scoop is stored in a clean container that allows water to drain" On 11/26/24 at 8:31 A.M., the Administrator provided a current Hand Hygiene policy, dated 6/10/24, that indicated "Wet hand with water and apply soap ... Rub hands together for at least twenty (20) seconds ... Rinse ..." During an interview on 11/25/24		allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 On 11/29/24, ED and Chef discarded identified opened unlabeled and/or undated food. Storage bins were closed and sealed appropriately. All dented cans were pulled from storage racks to be sent back to food supplier. On 12/6/24 ice scoop holder was ordered for drink cart in the dining room. On 12/5/24 staff were educated to not were open-toed shoes in the kitchen. On 12/10/24 staff were educated on proper hand hygiene. 2 Observational audit was conducted on 12/11/24 by ED of current staff to ensure any items shipped were not damaged, of if they were, that they were pulled to be sent back. Checked for properly sealed storage bins, labeling and	

	at 1:11 P.M., the Administrator indicated he did not have a policy for the dishwasher. On 11/26/24 at 10:10 A.M., the Administrator provided an undated Food Storage Guidelines policy which indicated "All food items must be labeled...Prepared foods must be stored in an appropriated container with an airtight lid." On 11/26/24 10:37 A.M., the Administrator indicated the same was true for bins of sugar and flour. On 11/26/24 at 2:14 P.M., the Administrator provided an undated Food Storage Guidelines policy which indicated " 2. Receiving Food Orders: ...Reject if:...packaging is damaged." At that time, the Administrator indicated this was the same for dented cans. On 11/26/24 at 2:14 P.M., the Administrator provided an undated Personal Appearance policy which indicated "Sandals, flip flops or any type of open toed shoes is not allowed with the uniform." Based on observation, interview, and record review, the facility failed to maintain all food preparation and public serving areas in accordance with state and local sanitation and safe food handling standards for 3 of 3 kitchen observations, and 1 of		dating, and that ice scoop containers were being used. Also, that no open-toed shoes were being worn. DHW completed audit on 12/12/24 for appropriate hand hygiene. 3 By 12/9/24, current staff will be re-educated by ED on labeling/dating, food storage policy, dented can policy, open toed shoes, ice scoop policy and hand hygiene. 4 The Executive Director is responsible for sustained compliance. The Dietary Manager, or designee, will conduct an audit of labeled/dated food, dented cans, food storage, proper ice scoop storage and open toed shoes weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.	

	2 dining observations. Findings include: 1. During an observation of the kitchen on 11/25/24 at 9:00 A.M., the following were observed: An open gallon of milk was not dated in the drink cooler. The lid to the sugar bin was off and lying on top of the flour bin in the dry storage area. A dented can of pizza sauce Three cans of peaches with dents, two of of which had dents along the rim of the can. During an observation on 11/25/24 at 12:34 P.M., the lid to the flour bin was off and lying on the sugar bin. At that time, the Executive Chef indicated all the bins should have been covered at all times. She further indicated she was unaware of what the policy was for dented cans. Since the cans were not leaking she would have used them unless the food looked or smelled bad, at which time she would have disposed of them. During an observation on 11/26/24 at 12:24 P.M., an open gallon of milk was not dated in the drink cooler. At that time, the Executive Chef indicated she was unaware that the milk needed to be dated when		DHW will conduct an audit of hand hygiene weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	

	opened. 2. During an interview on 11/25/24 at 10:47 A.M., the Executive Chef indicated she was not familiar with the process of running the dishwasher since the aides were the ones who ran the dishwasher. At that time, she took a strip from a bottle of chlorine test strips and dipped it into the water in the dishwasher. The strip did not turn colors. She indicated she was unsure why the strip did not turn any colors. At that time, there were no available CNAs (Certified Nurse Aides) to run the dishwasher. During an interview on 11/25/24 at 12:25 P.M., the Executive Chef indicated the chlorine test strips should have tested 50 to 100 ppm (parts per million). On 11/25/24 at 1:01 P.M., the Administrator was observed to test the dishwasher with a Hydrion QT-40 pH test strip. He placed the strip in the water in the dishwasher and it tested 400. At that time, he indicated it should test between 400-500. He indicated they could use either the chlorine or Hydrion test strips for the dishwasher since they were both provided by the company that serviced the dishwasher. At that time, a large plastic container of chlorine was observed under			

	the counter next to the dishwasher. During an interview on 11/25/24 at 1:01 P.M., the Executive Chef indicated she believed the chlorine test strips were outdated and lacked an expiration date on the bottle. On 11/26/24 at 11:48 A.M., Cook 17 provided a copy of the November Low Temperature Dish Washer log with the following bleach readings: Day 17 Breakfast Bleach 55, Lunch Bleach 53, Dinner Bleach 55 Day 18 Breakfast Bleach 51, Lunch Bleach 52, Dinner Bleach 51 Day 19 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 51 Day 20 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach 51 Day 21 Breakfast Bleach 53, Lunch Bleach 53, Dinner Bleach 53 Day 22 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 52 Day 23 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach 51			

	Day 24 Breakfast Bleach 53, Lunch Bleach 55 At that time, the chlorine test trip bottle was observed the the following key for result readings: 10 p.p.m. (parts per million), 50 p.p.m., 100 p.p.m., 200 p.p.m. During an interview on 11/26/24 at 12:01 P.M., the Executive Chef indicated the company that serviced the dishwasher came on 11/25/24. A report from that visit was requested and not received. 3. During an observation on 11/26/24 at 1:13 P.M., CNA 11 was observed coming out of the kitchen carrying a plate wearing soft shoes with several holes in the top and going back into the kitchen. 4. On 11/25/24 from 12:00 P.M. through 12:15 P.M., lunch service was observed in the main dining room. Two ice containers were observed filled with ice on a rolling cart by the kitchen door with an ice scoop sticking out of one of them. Care Manager 7 was observed to use the ice scoop to scoop ice from the container to serve drinks to residents, then place the ice scoop back into the ice container. Care Manager 7 was observed			

to wash hands in between passing trays to residents with a two second lather, and the rest of the hand wash was performed with her hands under the water.

QMA (Qualified Medication Aide) 9 was observed to wash hands in between passing trays to residents with a three second lather, and the rest of the hand wash was performed with her hands under the water.

On 11/25/24 at 12:15 P.M., QMA 9 indicated there was a separate container for the ice scoop in the kitchen, but not on the rolling cart in the dining room.

On 11/25/24 at 12:24 P.M., the Kitchen Manager indicated hands should be washed with soap and water during meal service lathering hands long enough to sing the Happy Birthday song twice slowly.

On 11/25/24 at 1:13 P.M., the Administrator provided a current non-dated Ice Scoop policy that indicated "The ice scoop is stored in a clean container that allows water to drain"

On 11/26/24 at 8:31 A.M., the Administrator provided a current Hand Hygiene policy, dated 6/10/24, that indicated "Wet hand with water and apply soap ... Rub hands together for at least twenty (20) seconds ...

	Rinse ..." During an interview on 11/25/24 at 1:11 P.M., the Administrator indicated he did not have a policy for the dishwasher. On 11/26/24 at 10:10 A.M., the Administrator provided an undated Food Storage Guidelines policy which indicated "All food items must be labeled...Prepared foods must be stored in an appropriated container with an airtight lid." On 11/26/24 10:37 A.M., the Administrator indicated the same was true for bins of sugar and flour. On 11/26/24 at 2:14 P.M., the Administrator provided an undated Food Storage Guidelines policy which indicated " 2. Receiving Food Orders: ...Reject if:...packaging is damaged." At that time, the Administrator indicated this was the same for dented cans. On 11/26/24 at 2:14 P.M., the Administrator provided an undated Personal Appearance policy which indicated "Sandals, flip flops or any type of open toed shoes is not allowed with the uniform." Based on observation, interview, and record review, the facility failed to maintain all food preparation and public serving areas in accordance with state and local sanitation and safe			

	food handling standards for 3 of 3 kitchen observations, and 1 of 2 dining observations. Findings include: 1. During an observation of the kitchen on 11/25/24 at 9:00 A.M., the following were observed: An open gallon of milk was not dated in the drink cooler. The lid to the sugar bin was off and lying on top of the flour bin in the dry storage area. A dented can of pizza sauce Three cans of peaches with dents, two of of which had dents along the rim of the can. During an observation on 11/25/24 at 12:34 P.M., the lid to the flour bin was off and lying on the sugar bin. At that time, the Executive Chef indicated all the bins should have been covered at all times. She further indicated she was unaware of what the policy was for dented cans. Since the cans were not leaking she would have used them unless the food looked or smelled bad, at which time she would have disposed of them. During an observation on 11/26/24 at 12:24 P.M., an open gallon of milk was not dated in the drink cooler. At that time, the Executive Chef indicated she			

	was unaware that the milk needed to be dated when opened. 2. During an interview on 11/25/24 at 10:47 A.M., the Executive Chef indicated she was not familiar with the process of running the dishwasher since the aides were the ones who ran the dishwasher. At that time, she took a strip from a bottle of chlorine test strips and dipped it into the water in the dishwasher. The strip did not turn colors. She indicated she was unsure why the strip did not turn any colors. At that time, there were no available CNAs (Certified Nurse Aides) to run the dishwasher. During an interview on 11/25/24 at 12:25 P.M., the Executive Chef indicated the chlorine test strips should have tested 50 to 100 ppm (parts per million). On 11/25/24 at 1:01 P.M., the Administrator was observed to test the dishwasher with a Hydrion QT-40 pH test strip. He placed the strip in the water in the dishwasher and it tested 400. At that time, he indicated it should test between 400-500. He indicated they could use either the chlorine or Hydrion test strips for the dishwasher since they were both provided by the company that serviced the dishwasher. At that time, a			

large plastic container of chlorine was observed under the counter next to the dishwasher.

During an interview on 11/25/24 at 1:01 P.M., the Executive Chef indicated she believed the chlorine test strips were outdated and lacked an expiration date on the bottle.

On 11/26/24 at 11:48 A.M., Cook 17 provided a copy of the November Low Temperature Dish Washer log with the following bleach readings:

Day 17 Breakfast Bleach 55, Lunch Bleach 53, Dinner Bleach 55

Day 18 Breakfast Bleach 51, Lunch Bleach 52, Dinner Bleach 51

Day 19 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 51

Day 20 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach 51

Day 21 Breakfast Bleach 53, Lunch Bleach 53, Dinner Bleach 53

Day 22 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 52

Day 23 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach

	51 Day 24 Breakfast Bleach 53, Lunch Bleach 55 At that time, the chlorine test trip bottle was observed the the following key for result readings: 10 p.p.m. (parts per million), 50 p.p.m., 100 p.p.m., 200 p.p.m. During an interview on 11/26/24 at 12:01 P.M., the Executive Chef indicated the company that serviced the dishwasher came on 11/25/24. A report from that visit was requested and not received. 3. During an observation on 11/26/24 at 1:13 P.M., CNA 11 was observed coming out of the kitchen carrying a plate wearing soft shoes with several holes in the top and going back into the kitchen. 4. On 11/25/24 from 12:00 P.M. through 12:15 P.M., lunch service was observed in the main dining room.			

	Two ice containers were observed filled with ice on a rolling cart by the kitchen door with an ice scoop sticking out of one of them. Care Manager 7 was observed to use the ice scoop to scoop ice from the container to serve drinks to residents, then place the ice scoop back into the ice container. Care Manager 7 was observed to wash hands in between passing trays to residents with a two second lather, and the rest of the hand wash was performed with her hands under the water. QMA (Qualified Medication Aide) 9 was observed to wash hands in between passing trays to residents with a three second lather, and the rest of the hand wash was performed with her hands under the water. On 11/25/24 at 12:15 P.M., QMA 9 indicated there was a separate container for the ice scoop in the kitchen, but not on the rolling cart in the dining room. On 11/25/24 at 12:24 P.M., the Kitchen Manager indicated hands should be washed with soap and water during meal service lathering hands long enough to sing the Happy Birthday song twice slowly. On 11/25/24 at 1:13 P.M., the			

	Administrator provided a current non-dated Ice Scoop policy that indicated "The ice scoop is stored in a clean container that allows water to drain" On 11/26/24 at 8:31 A.M., the Administrator provided a current Hand Hygiene policy, dated 6/10/24, that indicated "Wet hand with water and apply soap ... Rub hands together for at least twenty (20) seconds ... Rinse ..." During an interview on 11/25/24 at 1:11 P.M., the Administrator indicated he did not have a policy for the dishwasher. On 11/26/24 at 10:10 A.M., the Administrator provided an undated Food Storage Guidelines policy which indicated "All food items must be labeled...Prepared foods must be stored in an appropriated container with an airtight lid." On 11/26/24 10:37 A.M., the Administrator indicated the same was true for bins of sugar and flour. On 11/26/24 at 2:14 P.M., the Administrator provided an undated Food Storage Guidelines policy which indicated " 2. Receiving Food Orders: ...Reject if:...packaging is damaged." At that time, the Administrator indicated this was the same for dented cans. On 11/26/24 at 2:14 P.M., the			

	Administrator provided an undated Personal Appearance policy which indicated "Sandals, flip flops or any type of open toed shoes is not allowed with the uniform." Based on observation, interview, and record review, the facility failed to maintain all food preparation and public serving areas in accordance with state and local sanitation and safe food handling standards for 3 of 3 kitchen observations, and 1 of 2 dining observations. Findings include: 1. During an observation of the kitchen on 11/25/24 at 9:00 A.M., the following were observed: An open gallon of milk was not dated in the drink cooler. The lid to the sugar bin was off and lying on top of the flour bin in the dry storage area. A dented can of pizza sauce Three cans of peaches with dents, two of of which had dents along the rim of the can. During an observation on 11/25/24 at 12:34 P.M., the lid to the flour bin was off and lying on the sugar bin. At that time, the Executive Chef indicated all the bins should have been covered at all times. She further			

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	Administrator was observed to test the dishwasher with a Hydrion QT-40 pH test strip. He placed the strip in the water in the dishwasher and it tested 400. At that time, he indicated it should test between 400-500. He indicated they could use either the chlorine or Hydrion test strips for the dishwasher since they were both provided by the company that serviced the dishwasher. At that time, a large plastic container of chlorine was observed under the counter next to the dishwasher. During an interview on 11/25/24 at 1:01 P.M., the Executive Chef indicated she believed the chlorine test strips were outdated and lacked an expiration date on the bottle. On 11/26/24 at 11:48 A.M., Cook 17 provided a copy of the November Low Temperature Dish Washer log with the following bleach readings: Day 17 Breakfast Bleach 55, Lunch Bleach 53, Dinner Bleach 55 Day 18 Breakfast Bleach 51, Lunch Bleach 52, Dinner Bleach 51 Day 19 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 51 Day 20 Breakfast Bleach 50,			

Lunch Bleach 51, Dinner Bleach 51

Day 21 Breakfast Bleach 53, Lunch Bleach 53, Dinner Bleach 53

Day 22 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 52

Day 23 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach 51

Day 24 Breakfast Bleach 53, Lunch Bleach 55

At that time, the chlorine test trip bottle was observed the the following key for result readings:

10 p.p.m. (parts per million), 50 p.p.m., 100 p.p.m., 200 p.p.m.

During an interview on 11/26/24 at 12:01 P.M., the Executive Chef indicated the company that serviced the dishwasher came on 11/25/24. A report from that visit was requested and not received.

3. During an observation on 11/26/24 at 1:13 P.M., CNA 11 was observed coming out of the kitchen carrying a plate wearing soft shoes with several holes in the top and going back into the kitchen.

4. On 11/25/24 from 12:00 P.M. through 12:15 P.M., lunch service was observed in the

	main dining room. Two ice containers were observed filled with ice on a rolling cart by the kitchen door with an ice scoop sticking out of one of them. Care Manager 7 was observed to use the ice scoop to scoop ice from the container to serve drinks to residents, then place the ice scoop back into the ice container. Care Manager 7 was observed to wash hands in between passing trays to residents with a two second lather, and the rest of the hand wash was performed with her hands under the water. QMA (Qualified Medication Aide) 9 was observed to wash hands in between passing trays to residents with a three second lather, and the rest of the hand wash was performed with her hands under the water. On 11/25/24 at 12:15 P.M., QMA 9 indicated there was a separate container for the ice scoop in the kitchen, but not on the rolling cart in the dining room.			

	On 11/25/24 at 12:24 P.M., the Kitchen Manager indicated hands should be washed with soap and water during meal service lathering hands long enough to sing the Happy Birthday song twice slowly. On 11/25/24 at 1:13 P.M., the Administrator provided a current non-dated Ice Scoop policy that indicated "The ice scoop is stored in a clean container that allows water to drain" On 11/26/24 at 8:31 A.M., the Administrator provided a current Hand Hygiene policy, dated 6/10/24, that indicated "Wet hand with water and apply soap ... Rub hands together for at least twenty (20) seconds ... Rinse ..." During an interview on 11/25/24 at 1:11 P.M., the Administrator indicated he did not have a policy for the dishwasher. On 11/26/24 at 10:10 A.M., the Administrator provided an undated Food Storage Guidelines policy which indicated "All food items must be labeled...Prepared foods must be stored in an appropriated container with an airtight lid." On 11/26/24 10:37 A.M., the Administrator indicated the same was true for bins of sugar and flour. On 11/26/24 at 2:14 P.M., the Administrator provided an			

undated Food Storage Guidelines policy which indicated " 2. Receiving Food Orders: ...Reject if:...packaging is damaged." At that time, the Administrator indicated this was the same for dented cans.

On 11/26/24 at 2:14 P.M., the Administrator provided an undated Personal Appearance policy which indicated "Sandals, flip flops or any type of open toed shoes is not allowed with the uniform."

Based on observation, interview, and record review, the facility failed to maintain all food preparation and public serving areas in accordance with state and local sanitation and safe food handling standards for 3 of 3 kitchen observations, and 1 of 2 dining observations.

Findings include:

1. During an observation of the kitchen on 11/25/24 at 9:00 A.M., the following were observed:

An open gallon of milk was not dated in the drink cooler.

The lid to the sugar bin was off and lying on top of the flour bin in the dry storage area.

A dented can of pizza sauce

Three cans of peaches with dents, two of of which had dents

along the rim of the can.

During an observation on 11/25/24 at 12:34 P.M., the lid to the flour bin was off and lying on the sugar bin. At that time, the Executive Chef indicated all the bins should have been covered at all times. She further indicated she was unaware of what the policy was for dented cans. Since the cans were not leaking she would have used them unless the food looked or smelled bad, at which time she would have disposed of them.

During an observation on 11/26/24 at 12:24 P.M., an open gallon of milk was not dated in the drink cooler. At that time, the Executive Chef indicated she was unaware that the milk needed to be dated when opened.

2. During an interview on 11/25/24 at 10:47 A.M., the Executive Chef indicated she was not familiar with the process of running the dishwasher since the aides were the ones who ran the dishwasher. At that time, she took a strip from a bottle of chlorine test strips and dipped it into the water in the dishwasher. The strip did not turn colors. She indicated she was unsure why the strip did not turn any colors. At that time, there were no available CNAs (Certified Nurse Aides) to run the

dishwasher.

During an interview on 11/25/24 at 12:25 P.M., the Executive Chef indicated the chlorine test strips should have tested 50 to 100 ppm (parts per million).

On 11/25/24 at 1:01 P.M., the Administrator was observed to test the dishwasher with a Hydrion QT-40 pH test strip. He placed the strip in the water in the dishwasher and it tested 400. At that time, he indicated it should test between 400-500. He indicated they could use either the chlorine or Hydrion test strips for the dishwasher since they were both provided by the company that serviced the dishwasher. At that time, a large plastic container of chlorine was observed under the counter next to the dishwasher.

During an interview on 11/25/24 at 1:01 P.M., the Executive Chef indicated she believed the chlorine test strips were outdated and lacked an expiration date on the bottle.

On 11/26/24 at 11:48 A.M., Cook 17 provided a copy of the November Low Temperature Dish Washer log with the following bleach readings:

Day 17 Breakfast Bleach 55, Lunch Bleach 53, Dinner Bleach 55

	Day 18 Breakfast Bleach 51, Lunch Bleach 52, Dinner Bleach 51 Day 19 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 51 Day 20 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach 51 Day 21 Breakfast Bleach 53, Lunch Bleach 53, Dinner Bleach 53 Day 22 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 52 Day 23 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach 51 Day 24 Breakfast Bleach 53, Lunch Bleach 55 At that time, the chlorine test trip bottle was observed the the following key for result readings: 10 p.p.m. (parts per million), 50 p.p.m., 100 p.p.m., 200 p.p.m. During an interview on 11/26/24 at 12:01 P.M., the Executive Chef indicated the company that serviced the dishwasher came on 11/25/24. A report from that visit was requested and not received. 3. During an observation on 11/26/24 at 1:13 P.M., CNA 11			

	was observed coming out of the kitchen carrying a plate wearing soft shoes with several holes in the top and going back into the kitchen.			
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview the facility failed to store a schedule II (narcotic) medication under a double lock for 1 of 5 medication observations. A resident's narcotic medication was in a clear medicine cup in the top drawer of the medication cart. (Resident 14) Finding includes: During an observation of medication administration 11/25/24 at 12:15 P.M., LPN (Licensed Practical Nurse) 28 opened the top drawer of a medication cart and obtained a clear, unlabeled medication cup with 3 tablets in it. At that time,	R 0304	R 304 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 this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after	12/26/2024

	LPN 28 indicated Resident 14 refused her medication prior to eating lunch so the 2 sodium chloride 1 gram tablets and 1 oxycodone--acetaminophen 7.5mg (milligrams/ 325mg tablet was placed in the top of the medication cart until Resident 14 finished lunch. During an interview on 11/26/24 at 10:08 A.M., the DON (Director of Nursing) indicated if a resident refused to take a narcotic medication, the medication should be destroyed, and the narcotic should be obtained from the double locked box at the time of administration. On 11/26/24 at 8:31 A.M., a current Medication Storage--Centrally Stored Medications policy, dated 6/10/24 indicated, "...All Schedule II drugs administered by the facility shall be kept in individual containers under double lock..." Based on observation and interview the facility failed to store a schedule II (narcotic) medication under a double lock for 1 of 5 medication observations. A resident's narcotic medication was in a clear medicine cup in the top drawer of the medication cart. (Resident 14) Finding includes:		12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 Resident 14 suffered no negative effects related to findings. LPN 28 educated on proper labeling and storage of narcotic medication. 12/5/24 2 Director of Health and Wellness (DHW) conducted on audit of medication carts on 12/3/24 to ensure all narcotic medications are in double locked drawers. No findings at time of audit. 3 By 12/19/24, current Nurses and QMA’s will be re-educated proper labeling and storing of narcotic medication in individual containers and double locked. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will conduct an audit of medication	

	During an observation of medication administration 11/25/24 at 12:15 P.M., LPN (Licensed Practical Nurse) 28 opened the top drawer of a medication cart and obtained a clear, unlabeled medication cup with 3 tablets in it. At that time, LPN 28 indicated Resident 14 refused her medication prior to eating lunch so the 2 sodium chloride 1 gram tablets and 1 oxycodone--acetaminophen 7.5mg (milligrams/ 325mg tablet was placed in the top of the medication cart until Resident 14 finished lunch. During an interview on 11/26/24 at 10:08 A.M., the DON (Director of Nursing) indicated if a resident refused to take a narcotic medication, the medication should be destroyed, and the narcotic should be obtained from the double locked box at the time of administration. On 11/26/24 at 8:31 A.M., a current Medication Storage--Centrally Stored Medications policy, dated 6/10/24 indicated, "...All Schedule II drugs administered by the facility shall be kept in individual containers under double lock..."		carts to make sure all narcotic medications are labeled properly and stored in double locked drawers weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	
R 0306	Pharmaceutical Services - Noncompliance	R 0306	R 306 Submission of this response	12/26/2024

	410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.		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 this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 All medications identified were destroyed on 11/28/24. 2	

	Based on observation and interview, the facility failed to ensure the proper disposal of medications in 1 of 1 medication rooms, and the facility failed to document the temperature of the medication refrigerator for 1 of 1 medication refrigerator's. Numerous medications in clear packets and multiple pill bottles were observed in the medication room. Findings include: On 11/25/24 at 9:00 A.M., the medication room was observed. A blue gallon size medication bin overflowed with clear packets that was too numerous to count and were filled with medications, and the following medications were observed in pill bottles on the counter in the medication room: Resident 9: terazosin 10mg (milligrams)-- 1 bottle mirtazapine 15mg-- 1 bottle simvastatin 40mg-- 1 bottle quetiapine 50mg-- 1 bottle carbidopa / levodopa 25mg/100mg-- 2 bottles Resident 10: metformin 850mg-- 1 bottle		On 11/29/24 an audit of the medication room was completed for all medications to be destroyed. Any identified medications were destroyed. An audit of the fridge log was also completed, and staff were educated on 12/2/24 of the policy of Daily Refrigerator Temp Control Log. 3 By 12/19/24, current Nurses and QMA's will be re-educated proper destruction of medication policy and refrigerator temp control log. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will conduct an audit of medication fridge log for temps and medication destruction log and any medications to be destroyed weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.	

	trazodone 100mg-- 1 bottle montelukast 10mg-- 1 bottle isosorbide mononitrate 30mg-- 1 bottle pentoxifylline 400mg-- 1 bottle warfarin 5mg-- 1 bottle nortriptyline 25mg-- 1 bottle atorvastatin 10mg-- 1 bottle metoprolol 25mg-- 1 bottle Resident 11: levothyroxine 100mcg (micrograms)-- 1 bottle Myrbetriq ER (extended release) 50mg-- 1 bottle esomeprazole 40mg--1 bottle metoprolol 25mg-- 1 bottle lamotrigine 100mg-- 2 bottles trazodone 150mg-- 1 bottle atorvastatin 20mcg-- 1 bottle Resident 12: stimulant laxative 8.6/50mg--1 bottle Aspirin 81mg-- 1 bottle sulfamethoxazole trimethoprim 800/160mg-- 1 bottle		5 December 26th, 2024.	

	A review of the November temperature log lacked a temperature recorded for the AM and PM on the medication refrigerator: November 1 November 4--5 November 7 November 9--10 November 13--15 November 18--19 November 23--24 During an interview on 11/25/24 at 9:10 A.M., the DON (Director of Nursing) indicated all medications in the blue bin and on the counter should have been destroyed as the medications were brought into the medication room. At that time, she further indicated the temperature of the refrigerator should be documented daily. On 11/26/24 at 8:31 A.M., a current Medication Storage--Centrally Stored Medications policy, dated 6/10/24 indicated, "...Medications will be stored in a manner that ensures the maintenance of the medication's integrity and safety of all residents residing in the Community...The refrigerator temperature is checked daily and documented on the Daily			

	Refrigerator Temperature Control Log..." Based on observation and interview, the facility failed to ensure the proper disposal of medications in 1 of 1 medication rooms, and the facility failed to document the temperature of the medication refrigerator for 1 of 1 medication refrigerator's. Numerous medications in clear packets and multiple pill bottles were observed in the medication room. Findings include: On 11/25/24 at 9:00 A.M., the medication room was observed. A blue gallon size medication bin overflowed with clear packets that was too numerous to count and were filled with medications, and the following medications were observed in pill bottles on the counter in the medication room: Resident 9: terazosin 10mg (milligrams)-- 1 bottle mirtazapine 15mg-- 1 bottle simvastatin 40mg-- 1 bottle quetiapine 50mg-- 1 bottle carbidopa / levodopa 25mg/100mg-- 2 bottles			

	Resident 10: metformin 850mg-- 1 bottle trazodone 100mg-- 1 bottle montelukast 10mg-- 1 bottle isosorbide mononitrate 30mg-- 1 bottle pentoxifylline 400mg-- 1 bottle warfarin 5mg-- 1 bottle nortriptyline 25mg-- 1 bottle atorvastatin 10mg-- 1 bottle metoprolol 25mg-- 1 bottle Resident 11: levothyroxine 100mcg (micrograms)-- 1 bottle Myrbetriq ER (extended release) 50mg-- 1 bottle esomeprazole 40mg--1 bottle metoprolol 25mg-- 1 bottle lamotrigine 100mg-- 2 bottles trazodone 150mg-- 1 bottle atorvastatin 20mcg-- 1 bottle Resident 12: stimulant laxative 8.6/50mg--1 bottle			

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	integrity and safety of all residents residing in the Community...The refrigerator temperature is checked daily and documented on the Daily Refrigerator Temperature Control Log..."			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to accurately document in the resident's clinical record for 5 of 7 residents reviewed. Resident's had an order for an annual health statement, but the facility failed to provide a Tuberculin (TB) skin test or Risk Assessment. (Resident 2, Resident 3, Resident 4, Resident 5, Resident 8) Findings include: 1. On 11/25/24 at 9:50 A.M.,	R 0349	R 349 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 this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for	12/26/2024

	Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, high blood and diabetes mellitus. Resident 4 was admitted to the facility on 12/20/23. A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated, 2/29/24 . Resident 4's clinical record lacked an annual TB skin test or any other test to support the health statement. 2. On 11/26/24 at 8:50 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but was not limited to, woundcare and mobility. Resident 8 was admitted to the facility on 2/28/2020. A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated, 8/3/23 . Resident 8's clinical record lacked documentation of a yearly TB test or Risk Assessment support the health statement. 3. On 11/25/24 at 8:45 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limited to,		paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 Resident 4 was corrected on 11/26/24. Resident 2 and 3 corrected on 12/9/24. No residents were harmed during this finding. 2 On 12/11/24 Director of Health and Wellness (DHW) completed an observational audit of the resident TB's for accuracy of completion. Any identified issues were corrected. 3 By 12/19/24, current Nurses will be re-educated proper Resident Record policy and documenting clinical records on each resident. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will conduct an audit of resident	

	hypertension, status post CVA (cerebrovascular accident), and prediabetic. Admission date was 2/3/24. A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated 2/3/24. Resident 3's clinical record lacked an admission TB skin test or any other test to support the health statement. 4. On 11/25/24 at 9:30 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and atrial fibrillation. Admission date was 1/27/23. A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated 4/2/24. Resident 2's clinical record lacked an annual TB skin test or any other test to support the health statement. 5. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. Admission date was 11/4/23.		records to make sure all documentation is completed at admission and annually for each resident weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	

	A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated 3/2/24. Resident 2's clinical record lacked an annual TB skin test or any other test to support the health statement. During an interview on 11/26/24 at 10:30 A.M., the DON indicated the facility was unable to find TB results for Resident 2, Resident 3, Resident 4, Resident 5, and Resident 8 and TB tests should be completed on admission and then a Risk Assessment or a TB test should be done annually. At that time, she indicated the annual health statement should be updated for the resident when the TB tests or Risk Assessments are completed. On 11/26/24 at 1:05 P.M., the Administrator provided a current Resident Record policy, dated 6/10/24, that indicated the facility must maintain accurately documented clinical records on each resident. Based on observation, record review, and interview, the facility failed to accurately document in the resident's clinical record for 5 of 7 residents reviewed. Resident's had an order for an annual health statement, but the			

facility failed to provide a Tuberculin (TB) skin test or Risk Assessment. (Resident 2, Resident 3, Resident 4, Resident 5, Resident 8)

Findings include:

1. On 11/25/24 at 9:50 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, high blood and diabetes mellitus. Resident 4 was admitted to the facility on 12/20/23.

A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated, 2/29/24 .

Resident 4's clinical record lacked an annual TB skin test or any other test to support the health statement.

2. On 11/26/24 at 8:50 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but was not limited to, woundcare and mobility. Resident 8 was admitted to the facility on 2/28/2020.

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R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. 3. On 11/25/24 at 8:45 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limitied to, hypertension, status post CVA (cerebrovascular accident), and prediabetic. Admission date was 2/3/24. Resident 3's clinical record	R 0410	R 410 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 this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024.	12/26/2024

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Resident 3's clinical record lacked an admission TB skin test or any other test to indicate active TB.

4. On 11/25/24 at 9:30 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and atrial fibrillation. Admission date was 1/27/23.

Resident 2's clinical record lacked an annual TB skin test, risk assessment, or any other test to indicate active TB.

5. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. Admission date was 11/4/23.

Resident 2's clinical record lacked an annual TB skin test, risk assessment, or any other test to indicate active TB.

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Findings include:

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Resident 8's clinical record lacked documentation of a yearly TB test or risk assessment.

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1. On 11/25/24 at 9:50 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, high blood and diabetes mellitus. Resident 4 was admitted to the facility on 12/20/23.

Resident 4's clinical record lacked an annual TB skin test or any other test to indicate active TB.

2. On 11/26/24 at 8:50 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but was not limited to, woundcare and mobility. Resident 8 was admitted to the facility on 2/28/2020.

Resident 8's clinical record lacked documentation of a yearly TB test or risk assessment.

3. On 11/25/24 at 8:45 A.M.,

Resident 3's clinical record was reviewed. Diagnosis included, but were not limitied to, hypertension, status post CVA (cerebrovascular accident), and prediabetic. Admission date was 2/3/24.

Resident 3's clinical record lacked an admission TB skin test or any other test to indicate active TB.

4. On 11/25/24 at 9:30 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and atrial fibrillation. Admission date was 1/27/23.

Resident 2's clinical record lacked an annual TB skin test, risk assessment, or any other test to indicate active TB.

5. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. Admission date was 11/4/23.

Resident 2's clinical record lacked an annual TB skin test, risk assessment, or any other test to indicate active TB.

During an interview on 11/26/24 at 10:30 A.M., the DON indicated the facility was unable to find TB results for Resident 2, Resident 4, Resident 5, and Resident 8 and TB tests should

be completed on admission and then a Risk Assessment or a TB test should be done annually.

On 11/26/24 at 10:10 A.M., the Administrator provided a current Resident Tuberculosis policy, dated 6/10/24, that indicated "The Community will screen all residents for TB infection and disease upon admission or readmission. Additionally, residents will be screened annually per Indiana regulations"

Based on interview, observation, and record review, the facility failed to ensure a tuberculin (TB) skin test or risk assessment was completed for 5 of 7 residents reviewed. Residents lacked admission and yearly TB test and/or risk assessment. (Resident 2, Resident 3, Resident 4, Resident 5, Resident 8)

Findings include:

1. On 11/25/24 at 9:50 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, high blood and diabetes mellitus. Resident 4 was admitted to the facility on 12/20/23.

Resident 4's clinical record lacked an annual TB skin test or any other test to indicate active TB.

2. On 11/26/24 at 8:50 A.M.,

Resident 8's clinical record was reviewed. Diagnosis included, but was not limited to, woundcare and mobility. Resident 8 was admitted to the facility on 2/28/2020.

Resident 8's clinical record lacked documentation of a yearly TB test or risk assessment.

3. On 11/25/24 at 8:45 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limitied to, hypertension, status post CVA (cerebrovascular accident), and prediabetic. Admission date was 2/3/24.

Resident 3's clinical record lacked an admission TB skin test or any other test to indicate active TB.

4. On 11/25/24 at 9:30 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and atrial fibrillation. Admission date was 1/27/23.

Resident 2's clinical record lacked an annual TB skin test, risk assessment, or any other test to indicate active TB.

5. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. Admission date was

11/4/23.

Resident 2's clinical record lacked an annual TB skin test, risk assessment, or any other test to indicate active TB.

During an interview on 11/26/24 at 10:30 A.M., the DON indicated the facility was unable to find TB results for Resident 2, Resident 4, Resident 5, and Resident 8 and TB tests should be completed on admission and then a Risk Assessment or a TB test should be done annually.

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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 SIGNATURE	TITLE	(X6) DATE