STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST, INDIANAPOLIS, , 46219

(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: September 19 and 20, 2023 Facility number: 005729 Residential Census: 5 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 25, 2023	R 0000		
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status.	R 0216	Re R216 As a corrective action measure all charts for residents who self-medicate were reviewed and it has been determined that all residents had the potential to be affected by such practice. At least one resident was found	11/01/2023

	(2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure the resident needs assessment included an evaluation of the resident's ability to self-administer medications and a physician's order for the residents to self-administer medications for 1 of 5 residents reviewed for self-administration of medications. (Resident 4) Findings include: The clinical record for Resident 4 was reviewed on 9/19/23 at 12:10 p.m. Resident 4's diagnoses included, but not limited to, diabetes type II. An Evaluation of Needs/Service Plan for Resident 4 completed on 8/21/23 was received on 9/20/23 from Nurse Consultant (NC) at 8:47 a.m. The evaluation/service plan indicated, Resident 4 was "alert, oriented-makes sound		to have been affected but not harmed. As a means to ensure compliance all Nurses will be in serviced and re-educated on the process resident assessment for self-administration of medication and the procedures therein. These procedures will include: Initial evaluation of potential resident will include a self-medication administration assessment to be completed by the nurse if resident requests to self-administer medication. If appropriate to self-medicate, then a request for a physician’s order for resident to self-store and administer medication will be requested prior to admission to the facility. The residents’’ ability to continue to self-medicate will be conducted quarterly by the Nurse.	

	independent decisions" however, under the Medication Services/Management of Oral Medication section, it indicated, Resident 4 was "unable to take medications unless administered by someone else" and in the Special Instructions/Needs/Choices of the medication services section, it indicated, "Medications administered by staff." Resident 4's clinical record did not contain a physician's order for her to self administer her diabetic medications, Lantus and Novolog Resident 4's clinical record did not contain a self-administration of medication assessment. A physician's order for Lantus 100 units/ml pen was placed on 8/22/23 for Resident 4. It indicated, to inject 16 units of Lantus subcutaneoulsy once a day. A physician's order for Novolog flex pen was placed 8/22/23 for Resident 4. It indicated, to inject twice daily before breakfast and dinner if blood glucose was 201-250, give 3 units; 251-300, give 4 units; 301-350, give 6 units; and 351-400, give 9 units. Resident 4's September MAR (medication administration record) was received on 9/19/23 at 2:31 p.m. from DON (Director of Nursing). It indicated, on the		Individual service plan must also accurately reflect the assessment. The above In-service will be evidenced by a staff signature for attendance and participation. As a means of quality assurance, a review of the documents of all planned admissions where resident will be self- medicating, prior to admission by the Infection Control Nurse or Executive Director or designee to ensure: All residents who self-administer have a completed assessment in place A physician’s order for self-administration is in place A service plan that accurately reflects the resident’s ability to self-administer medications is in place. As a means of compliancy, charts for self-medicating residents will be audited	

	following days and times that Resident 4 self-administered her own insulins: 9/3/23- Lantus on morning shift 9/4/23- Lantus on morning shift 9/5/23- Lantus on morning shift 9/10/23- Lantus on morning shift 9/11/23- Lantus on morning shift 9/14/23- Lantus on morning shift 9/14/23- Novolog at 4 p.m. 9/15/23- Lantus on morning shift 9/15/23- Novolog at 7 a.m. and 4 p.m. 9/16/23- Novolog at 7 a.m. and 4 p.m. 9/17/23- Lantus on morning shift 9/17/23- Novolog at 7 a.m. 9/18/23- Lantus on morning shift 9/18/23- Novolog at 7 a.m. 9/19/23- Lantus on morning shift		monthly basis for a period of no less than 6 months. Audit dates and outcomes will be documented and initialed in a log book, this book will then be audited weekly by the Executive Director and initialed as completed. These audits will continue until 100 % compliancy is maintained and or deemed unnecessary by the executive director.	

	Resident 4's September MAR indicated, "IS" as the person who administered the medication and "NR" for the site for the previous administrations. According to the symbol key on the MAR, "'IS" indicated, self-administered and "NR" indicated, not recorded. An interview with DON conducted on 9/19/23 at 2:03 p.m. indicated, Resident 4 does self-administer her own insulin's, but not her pills. DON indicated, Resident 4 should have had a self-administration of medication assessment completed in her chart. A Medication Self-Administration/Administration policy was received on 9/20/23 at 9:16 a.m. from ED (Executive Director). The policy indicated, "It is the policy of this facility to honor the resident's right to self-administer medications upon the request of the resident [sic] the licensed nurse will assess residents and have resident demonstrate the ability to safely execute this task. The self-administration assessment is done before admission, at the same time the prospective resident evaluations done. Also, the attending physician must concur, in form of a physician's order, that the resident may self-administer medication(s). A statement will be added to the MAR that the			

physician signs."

Based on interview and record review, the facility failed to ensure the resident needs assessment included an evaluation of the resident's ability to self-administer medications and a physician's order for the residents to self-administer medications for 1 of 5 residents reviewed for self-administration of medications. (Resident 4)

Findings include:

The clinical record for Resident 4 was reviewed on 9/19/23 at 12:10 p.m. Resident 4's diagnoses included, but not limited to, diabetes type II.

An Evaluation of Needs/Service Plan for Resident 4 completed on 8/21/23 was received on 9/20/23 from Nurse Consultant (NC) at 8:47 a.m. The evaluation/service plan indicated, Resident 4 was "alert, oriented-makes sound independent decisions" however, under the Medication Services/Management of Oral Medication section, it indicated, Resident 4 was "unable to take medications unless administered by someone else" and in the Special Instructions/Needs/Choices of the medication services section, it indicated, "Medications administered by staff."

	Resident 4's clinical record did not contain a physician's order for her to self administer her diabetic medications, Lantus and Novolog Resident 4's clinical record did not contain a self-administration of medication assessment. A physician's order for Lantus 100 units/ml pen was placed on 8/22/23 for Resident 4. It indicated, to inject 16 units of Lantus subcutaneoulsy once a day. A physician's order for Novolog flex pen was placed 8/22/23 for Resident 4. It indicated, to inject twice daily before breakfast and dinner if blood glucose was 201-250, give 3 units; 251-300, give 4 units; 301-350, give 6 units; and 351-400, give 9 units. Resident 4's September MAR (medication administration record) was received on 9/19/23 at 2:31 p.m. from DON (Director of Nursing). It indicated, on the following days and times that Resident 4 self-administered her own insulins: 9/3/23- Lantus on morning shift 9/4/23- Lantus on morning shift 9/5/23- Lantus on morning shift 9/10/23- Lantus on morning shift			

	9/11/23- Lantus on morning shift 9/14/23- Lantus on morning shift 9/14/23- Novolog at 4 p.m. 9/15/23- Lantus on morning shift 9/15/23- Novolog at 7 a.m. and 4 p.m. 9/16/23- Novolog at 7 a.m. and 4 p.m. 9/17/23- Lantus on morning shift 9/17/23- Novolog at 7 a.m. 9/18/23- Lantus on morning shift 9/18/23- Novolog at 7 a.m. 9/19/23- Lantus on morning shift Resident 4's September MAR indicated, "IS" as the person who administered the medication and "NR" for the site for the previous administrations. According to the symbol key on the MAR, "'IS" indicated, self-administered and "NR" indicated, not recorded. An interview with DON conducted on 9/19/23 at 2:03 p.m. indicated, Resident 4 does self-administer her own insulin's, but not her pills. DON indicated, Resident 4 should have had a self-administration of medication assessment completed in her chart.			

	A Medication Self-Administration/Administration policy was received on 9/20/23 at 9:16 a.m. from ED (Executive Director). The policy indicated, "It is the policy of this facility to honor the resident's right to self-administer medications upon the request of the resident [sic] the licensed nurse will assess residents and have resident demonstrate the ability to safely execute this task. The self-administration assessment is done before admission, at the same time the prospective resident evaluations done. Also, the attending physician must concur, in form of a physician's order, that the resident may self-administer medication(s). A statement will be added to the MAR that the physician signs."			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. 2. The clinical record for Resident 3 was reviewed on 9/19/23 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, seizure disorder. He was admitted to the facility on 9/5/23.	R 0240	Re: R 240 As a corrective action measure all resident chart have been reviewed and it has been determined that all residents had the potential to be affected by such practice. one resident was found to have been affected. That resident's situation has been corrected and medication was in house by end of day on 9/22/23	11/01/2023

	A service plan, dated 9/5/23, indicated Resident 3 was able to take medications that were prepared in advance by another person. A physician's order, dated 9/5/23, indicated he was to take a Vitamin B-12 500 mcg (Microgram) quick dissolve tablets each morning. On 9/20/23 at 7:30 a.m., QMA (Qualified Medication Aide) 3 was observed administering medications to Resident 3. QMA 3 indicated the Vitamin B-12 was not available to be administered because it had not been delivered by the pharmacy. The September MAR (Medication Administration Record) indicated that Resident 3 had not received his Vitamin B-12 on the following days: 9/6, 9/8, 9/12, 9/13, 9/18, 9/19, and 9/20/2023. During an interview on 9/20/23 at 10:20 a.m., the Nurse Consultant indicated that Resident 3's Vitamin B-12 had not been delivered by the pharmacy due to a formulary error. Resident 3 should have received his medication as ordered by the physician. Based on observation, interview and record review, the facility failed to notify a resident's		As a means to ensure compliance all Nursing Staff will be in serviced and re-educated on the process of medication administration and the procedures therein. These procedures will include but are not limited to: What to do if a medication is unavailable. What to do if a medication is refused. The above In-service will be evidenced by a staff signature for attendance and participation. As a means of quality assurance, observation will be preformed by the DON or Infection Control Nurse or designee to ensure that medications are being administered as ordered, if unavailable or refused, assuring that appropriate steps are taken and proper documentation is completed. As a means of compliancy, systematic audits will be preformed of the MARS,	

	physician timely of a resident's refusal of a medication and to timely obtain medication from the pharmacy to administer, as ordered by the physician, to a resident for 1 of 5 resident records reviewed (Resident 3 and Resident 4). Findings include: 1. The clinical record for Resident 4 was reviewed on 9/19/23 at 12:10 p.m. Resident 4's diagnoses included, but not limited to, diabetes type II. An Evaluation of Needs/Service Plan for Resident 4 completed on 8/21/23 was received on 9/20/23 from Nurse Consultant (NC) at 8:47 a.m. The evaluation/service plan indicated, Resident 4 was "alert, oriented-makes sound independent decisions" however, under the Medication Services/Management of Oral Medication section, it indicated, Resident 4 was "unable to take medications unless administered by someone else" and in the Special Instructions/Needs/Choices of the medication services section, it indicated, "Medications administered by staff." Resident 4's clinical record did not contain a physician's order for her to self administer her diabetic medications, Lantus and Novolog		checking for any medications not administered as ordered and for proper documentation. The observations and audits will be preformed by the DON or Infection Control Nurse or designee randomly: 3 times per week for 4 weeks 2 times per week for 4 weeks 1 time per week for 4 weeks Monthly for 3 months or until deemed unnecessary as evidenced by 100% compliancy for a period of no less than 4 weeks or as deemed necessary by the Executive Director. Observations and audit dates and outcomes will be documented and initialed in a log book, this book will then be audited weekly by the Executive Director and initialed as completed.	

	Resident 4's clinical record did not contain a self-administration of medication assessment. A physician's order for Lantus 100 units/ml pen was placed on 8/22/23 for Resident 4. It indicated, to inject 16 units of Lantus subcutaneoulsy once a day. Resident 4's September 2023 MAR (medication administration record) was received on 9/19/23 at 2:31 p.m. from DON (Director of Nursing). It indicated, on the following days that Resident 4 did not administer her Lantus 9/8/23- reason listed on MAR was "blood sugar to[sic, too] low"; blood sugar recorded on MAR was 126 in a.m. 9/12/23- reason listed on MAR was "blood sugar too low"; blood sugar recorded on MAR was 117 in a.m. 9/13/23- reason listed on MAR was "blood sugar to[sic, too] low; blood sugar recorded on MAR was 115 in a.m. Resident 4's clinical record did not indicate that her physician had been notified of her refusal to take Lantus when she believed her blood sugar to be too low. An interview with DON conducted on 9/19/23 at 2:03 p.m. indicated, Resident 4 does			

	self-administer her own insulins, but not her pills. DON indicated, Resident 4 should have had a self-administration of medication assessment completed in her chart. An interview with NC (Nurse Consultant) conducted on 9/20/23 at 9:07 a.m. indicated, Resident 4's physician should have been informed of her refusals to administer her Lantus because her blood sugar reading was "too low". 2. The clinical record for Resident 3 was reviewed on 9/19/23 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, seizure disorder. He was admitted to the facility on 9/5/23. A service plan, dated 9/5/23, indicated Resident 3 was able to take medications that were prepared in advance by another person. A physician's order, dated 9/5/23, indicated he was to take a Vitamin B-12 500 mcg (Microgram) quick dissolve tablets each morning. On 9/20/23 at 7:30 a.m., QMA (Qualified Medication Aide) 3 was observed administering medications to Resident 3. QMA 3 indicated the Vitamin B-12 was not available to be administered because it had not			

	been delivered by the pharmacy. The September MAR (Medication Administration Record) indicated that Resident 3 had not received his Vitamin B-12 on the following days: 9/6, 9/8, 9/12, 9/13, 9/18, 9/19, and 9/20/2023. During an interview on 9/20/23 at 10:20 a.m., the Nurse Consultant indicated that Resident 3's Vitamin B-12 had not been delivered by the pharmacy due to a formulary error. Resident 3 should have received his medication as ordered by the physician. Based on observation, interview and record review, the facility failed to notify a resident's physician timely of a resident's refusal of a medication and to timely obtain medication from the pharmacy to administer, as ordered by the physician, to a resident for 1 of 5 resident records reviewed (Resident 3 and Resident 4). Findings include: 1. The clinical record for Resident 4 was reviewed on 9/19/23 at 12:10 p.m. Resident 4's diagnoses included, but not limited to, diabetes type II. An Evaluation of Needs/Service Plan for Resident 4 completed on 8/21/23 was received on			

	9/20/23 from Nurse Consultant (NC) at 8:47 a.m. The evaluation/service plan indicated, Resident 4 was "alert, oriented-makes sound independent decisions" however, under the Medication Services/Management of Oral Medication section, it indicated, Resident 4 was "unable to take medications unless administered by someone else" and in the Special Instructions/Needs/Choices of the medication services section, it indicated, "Medications administered by staff." Resident 4's clinical record did not contain a physician's order for her to self administer her diabetic medications, Lantus and Novolog Resident 4's clinical record did not contain a self-administration of medication assessment. A physician's order for Lantus 100 units/ml pen was placed on 8/22/23 for Resident 4. It indicated, to inject 16 units of Lantus subcutaneoulsy once a day. Resident 4's September 2023 MAR (medication administration record) was received on 9/19/23 at 2:31 p.m. from DON (Director of Nursing). It indicated, on the following days that Resident 4 did not administer her Lantus 9/8/23- reason listed on MAR			

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	but were not limited to, seizure disorder. He was admitted to the facility on 9/5/23. A service plan, dated 9/5/23, indicated Resident 3 was able to take medications that were prepared in advance by another person. A physician's order, dated 9/5/23, indicated he was to take a Vitamin B-12 500 mcg (Microgram) quick dissolve tablets each morning. On 9/20/23 at 7:30 a.m., QMA (Qualified Medication Aide) 3 was observed administering medications to Resident 3. QMA 3 indicated the Vitamin B-12 was not available to be administered because it had not been delivered by the pharmacy. The September MAR (Medication Administration Record) indicated that Resident 3 had not received his Vitamin B-12 on the following days: 9/6, 9/8, 9/12, 9/13, 9/18, 9/19, and 9/20/2023.			

	During an interview on 9/20/23 at 10:20 a.m., the Nurse Consultant indicated that Resident 3's Vitamin B-12 had not been delivered by the pharmacy due to a formulary error. Resident 3 should have received his medication as ordered by the physician. Based on observation, interview and record review, the facility failed to notify a resident's physician timely of a resident's refusal of a medication and to timely obtain medication from the pharmacy to administer, as ordered by the physician, to a resident for 1 of 5 resident records reviewed (Resident 3 and Resident 4). Findings include: 1. The clinical record for Resident 4 was reviewed on 9/19/23 at 12:10 p.m. Resident 4's diagnoses included, but not limited to, diabetes type II. An Evaluation of Needs/Service Plan for Resident 4 completed on 8/21/23 was received on 9/20/23 from Nurse Consultant (NC) at 8:47 a.m. The evaluation/service plan indicated, Resident 4 was "alert, oriented-makes sound independent decisions" however, under the Medication Services/Management of Oral Medication section, it indicated, Resident 4 was "unable to take			

	medications unless administered by someone else" and in the Special Instructions/Needs/Choices of the medication services section, it indicated, "Medications administered by staff." Resident 4's clinical record did not contain a physician's order for her to self administer her diabetic medications, Lantus and Novolog Resident 4's clinical record did not contain a self-administration of medication assessment. A physician's order for Lantus 100 units/ml pen was placed on 8/22/23 for Resident 4. It indicated, to inject 16 units of Lantus subcutaneoulsy once a day. Resident 4's September 2023 MAR (medication administration record) was received on 9/19/23 at 2:31 p.m. from DON (Director of Nursing). It indicated, on the following days that Resident 4 did not administer her Lantus 9/8/23- reason listed on MAR was "blood sugar to[sic, too] low"; blood sugar recorded on MAR was 126 in a.m. 9/12/23- reason listed on MAR was "blood sugar too low"; blood sugar recorded on MAR was 117 in a.m. 9/13/23- reason listed on MAR			

was "blood sugar to[sic, too] low; blood sugar recorded on MAR was 115 in a.m.

Resident 4's clinical record did not indicate that her physician had been notified of her refusal to take Lantus when she believed her blood sugar to be too low.

An interview with DON conducted on 9/19/23 at 2:03 p.m. indicated, Resident 4 does self-administer her own insulins, but not her pills. DON indicated, Resident 4 should have had a self-administration of medication assessment completed in her chart.

An interview with NC (Nurse Consultant) conducted on 9/20/23 at 9:07 a.m. indicated, Resident 4's physician should have been informed of her refusals to administer her Lantus because her blood sugar reading was "too low".

2. The clinical record for Resident 3 was reviewed on 9/19/23 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, seizure disorder. He was admitted to the facility on 9/5/23.

A service plan, dated 9/5/23, indicated Resident 3 was able to take medications that were prepared in advance by another person.

A physician's order, dated 9/5/23, indicated he was to take a Vitamin B-12 500 mcg (Microgram) quick dissolve tablets each morning.

On 9/20/23 at 7:30 a.m., QMA (Qualified Medication Aide) 3 was observed administering medications to Resident

3. QMA 3 indicated the Vitamin B-12 was not available to be administered because it had not been delivered by the pharmacy.

The September MAR (Medication Administration Record) indicated that Resident 3 had not received his Vitamin B-12 on the following days: 9/6, 9/8, 9/12, 9/13, 9/18, 9/19, and 9/20/2023.

During an interview on 9/20/23 at 10:20 a.m., the Nurse Consultant indicated that Resident 3's Vitamin B-12 had not been delivered by the pharmacy due to a formulary error. Resident 3 should have received his medication as ordered by the physician.

Based on observation, interview and record review, the facility failed to notify a resident's physician timely of a resident's refusal of a medication and to timely obtain medication from the pharmacy to administer, as ordered by the physician, to a resident for 1 of 5 resident

records reviewed (Resident 3 and Resident 4).

Findings include:

1. The clinical record for Resident 4 was reviewed on 9/19/23 at 12:10 p.m. Resident 4's diagnoses included, but not limited to, diabetes type II.

An Evaluation of Needs/Service Plan for Resident 4 completed on 8/21/23 was received on 9/20/23 from Nurse Consultant (NC) at 8:47 a.m. The evaluation/service plan indicated, Resident 4 was "alert, oriented-makes sound independent decisions" however, under the Medication Services/Management of Oral Medication section, it indicated, Resident 4 was "unable to take medications unless administered by someone else" and in the Special Instructions/Needs/Choices of the medication services section, it indicated, "Medications administered by staff."

Resident 4's clinical record did not contain a physician's order for her to self administer her diabetic medications, Lantus and Novolog

Resident 4's clinical record did not contain a self-administration of medication assessment.

A physician's order for Lantus 100 units/ml pen was placed on

	8/22/23 for Resident 4. It indicated, to inject 16 units of Lantus subcutaneoulsy once a day. Resident 4's September 2023 MAR (medication administration record) was received on 9/19/23 at 2:31 p.m. from DON (Director of Nursing). It indicated, on the following days that Resident 4 did not administer her Lantus 9/8/23- reason listed on MAR was "blood sugar to[sic, too] low"; blood sugar recorded on MAR was 126 in a.m. 9/12/23- reason listed on MAR was "blood sugar too low"; blood sugar recorded on MAR was 117 in a.m. 9/13/23- reason listed on MAR was "blood sugar to[sic, too] low; blood sugar recorded on MAR was 115 in a.m. Resident 4's clinical record did not indicate that her physician had been notified of her refusal to take Lantus when she believed her blood sugar to be too low.			

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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. (4) Reporting communicable disease to public health authorities.	R 0407	Re: R 407 As a corrective action measure all resident interactions/tasks being conducted were reviewed and it has been determined that all residents had the potential to be affected by such practice. At least one resident was found to have been affected but not harmed. As a means to ensure compliance all Facility Staff will be in serviced and re-educated on the process of regarding hand hygiene and the	11/01/2023

	Based on observation, interview, and record review, the facility failed to assure hand hygiene was done appropriately during medication administration for 3 of 4 residents randomly observed during medication administration (Resident 2, 3, and 5) Findings include: On 9/20/23 at 7:30 a.m., QMA (Qualified Medication Aide) 3 was observed administering medications. Resident 2 entered the nursing station and QMA 3 went to the medication cart to prepare his medications. QMA 3 opened the medication cart and removed the medication packets for Resident 3. She opened the medication packets and poured the medications into a medication cup. She then gave the medications to Resident 2 and gave him a glass of water to use to take his medications. QMA 3 then went to the medication cart and obtained Resident 2's nasal spray. QMA 3 donned a pair of non-sterile gloves. She did not perform hand hygiene prior to putting on the gloves. QMA 3 then administered the nasal spray to Resident 2 and returned to the medication cart. QMA 3 removed her gloves and placed the nasal spray back into the drawer. QMA 3 did not perform hand hygiene after removing the gloves. QMA 3 then started to		procedures therein. These procedures will include but are not limited to: How to hand wash When to perform hand hygiene How to properly don on and off gloves including performing hand hygiene When to use gloves The above In-service will be evidenced by a staff signature for attendance and participation. As a means of quality assurance, observation will be performed by the DON or Infection Control Nurse or designee to ensure that proper hand hygiene is being conducted as recommended during a variety of tasks such as but not limited to glucose testing and medication administration, between residents and resident	

	prepare medications for Resident 5. She obtained Resident 5's medication packets from the medication cart and opened the pill packets, pouring the pills into a medication cup. QMA 3 administered Resident 5 his medications and returned to the medication cart. QMA 3 did not perform hand hygiene after administering the medications to Resident 5. QMA 3 then began preparing the medications to administer to Resident 3. She obtained the medication packets for Resident 3 from the medication cart and opened them, pouring them into a medication cup, and administered the medications to Resident 3. QMA 3 did not perform hand hygiene prior to preparing the medications for Resident 3 or after administering them. During an interview on 9/20/23 at 9:03 a.m., QMA 3 indicated that she should have done hand hygiene between each resident when she was passing medications.		tasks. As a means of compliancy, systematic audits will be performed during resident care tasks, checking to ensure that proper hand hygiene is being utilized during a variety of resident care tasks including but not limited to medication administration tasks, glucose testing, dining room service and other resident care tasks. The observations and audits will be performed by the DON or Infection Control Nurse or designee randomly: 3 times per week for 4 weeks 2 times per week for 4 weeks 1 time per week for 4 weeks	

	On 9/20/23 at 9:16 a.m., the Executive Director provided the Handwashing Hand Hygiene policy, last reviewed 3/2023, which read "...Hand rubs should be used before and after each Resident contact, just as gloves should be changed before and after each Resident contact, when glove use is applicable..." Based on observation, interview, and record review, the facility failed to assure hand hygiene was done appropriately during medication administration for 3 of 4 residents randomly observed during medication administration (Resident 2, 3, and 5) Findings include: On 9/20/23 at 7:30 a.m., QMA (Qualified Medication Aide) 3 was observed administering medications. Resident 2 entered the nursing station and QMA 3 went to the medication cart to prepare his medications. QMA 3 opened the medication cart and removed the medication packets for Resident 3. She opened the medication packets and poured the medications into a medication cup. She then gave the medications to Resident 2 and gave him a glass of water to use to take his medications. QMA 3 then went to the medication cart and obtained Resident 2's nasal spray. QMA 3 donned a pair of non-sterile		Monthly for 3 months or until deemed unnecessary as evidenced by 100% compliancy for a period of no less than 4 weeks or as deemed necessary by the Executive Director. Observations and audit dates and outcomes will be documented and initialed in a log book, this book will then be audited weekly by the Executive Director and initialed as completed.	

	gloves. She did not perform hand hygiene prior to putting on the gloves. QMA 3 then administered the nasal spray to Resident 2 and returned to the medication cart. QMA 3 removed her gloves and placed the nasal spray back into the drawer. QMA 3 did not perform hand hygiene after removing the gloves. QMA 3 then started to prepare medications for Resident 5. She obtained Resident 5's medication packets from the medication cart and opened the pill packets, pouring the pills into a medication cup. QMA 3 administered Resident 5 his medications and returned to the medication cart. QMA 3 did not perform hand hygiene after administering the medications to Resident 5. QMA 3 then began preparing the medications to administer to Resident 3. She obtained the medication packets for Resident 3 from the medication cart and opened them, pouring them into a medication cup, and administered the medications to Resident 3. QMA 3 did not perform hand hygiene prior to preparing the medications for Resident 3 or after administering them.			

	During an interview on 9/20/23 at 9:03 a.m., QMA 3 indicated that she should have done hand hygiene between each resident when she was passing medications. On 9/20/23 at 9:16 a.m., the Executive Director provided the Handwashing Hand Hygiene policy, last reviewed 3/2023, which read "...Hand rubs should be used before and after each Resident contact, just as gloves should be changed before and after each Resident contact, when glove use is applicable..."			

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