STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEEPSAKE VILLAGE OF COLUMBUS	2564 FOX POINTE DR, COLUMBUS, , 47203

(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 and the Investigation of Complaint IN00368622. Complaint IN00368622 - Unsubstantiated. Allegation did not occur. Survey dates: December 13 and 14, 2021 Facility number: 010680 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5 Quality review completed on December 22, 2021.	R 0000		
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state	R 0117	**1. RN 5 license is current and renewed with Indiana PLA. In addition, licensure checks are being done monthly and are logged in the**	01/14/2022

	laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure nursing staff were licensed for 1 of 13 nursing staff reviewed. (Registered Nurse 5) Findings include: The employee licensure records were provided by the BOM (Business Office Manager) on 12/14/21. RN 5's nursing license expired on 10/31/21. RN 5's nursing license was reviewed on		**monthly licensure log.** **2. The Community reviewed each employee's license to determine which employee, if any, could be affected by the alleged deficient practice.** **3. The BOM has reviewed all employee licenses and confirmed all employees are active and in good standing licenses.** **4. The BOM will audit monthly licensure logs for the next six months to ensure all employees license are active and in good standing and document accordingly.** **5. If compliance is not maintained during the six month monitoring period, the monitoring will extend until the community is found to be compliant for a three month period.**	

	the Indiana Professional Licensing Agency website. The nursing license expired on 10/31/21, with an extension added that expired on 11/30/21. The Employee Time Card Report was provided by the BOM on 12/13/21. The report indicated RN 5 worked in the facility providing care to residents without a valid nursing license on the following dates: - 12/04/21, - 12/07/21, - 12/09/21, - 12/10/21, - 12/12/21, and - 12/13/21. During an interview on 12/14/21 at 2:05 P.M., the BOM indicated RN 5 applied to renew her license but made a computer error during the renewal process. The nurse was working to correct her mistake, but her license was currently expired. Normally, they would not allow nursing staff to work in the building without a license. RN 5 was working in the facility yesterday, but the BOM talked to her and told her they couldn't let her keep working without proof of an active nursing license. When they had nursing staff to cover her, they sent her			

	home. During an interview on 12/14/21 at 2:24 P.M., the Administrator indicated she contacted the licensing agency and RN 5's nursing license had not been renewed as of 12/14/21. The facility did not have a policy related to staff licensure; they followed the state regulations regarding licensure. Based on record review and interview, the facility failed to ensure nursing staff were licensed for 1 of 13 nursing staff reviewed. (Registered Nurse 5) Findings include: The employee licensure records were provided by the BOM (Business Office Manager) on 12/14/21. RN 5's nursing license expired on 10/31/21. RN 5's nursing license was reviewed on the Indiana Professional Licensing Agency website. The nursing license expired on 10/31/21, with an extension added that expired on 11/30/21. The Employee Time Card Report was provided by the BOM on 12/13/21. The report indicated RN 5 worked in the facility providing care to residents without a valid nursing license on the following dates: - 12/04/21,			

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R 0240	Health Services - Deficiency	R 0240	**1. Resident 5 is receiving all**	01/14/2022

	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. Based on observation, interview, and record review, the facility failed to provide showers for a resident according to their service plan for 1 of 7 residents reviewed. (Resident 5) Findings include: During an interview and observation on 12/13/21 at 11:15 A.M., Resident 5 indicated she had not had a shower in a couple of weeks. The girl who gave the showers was always off on the days she was supposed to get one. The resident was sitting in the main dining room and required the assistance one staff member for ADL's.		**showers in accordance with their service plan. In addition, Resident 5 showers are logged in the daily care logs.** **2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice.** **3. The Wellness Director has reviewed and confirmed that all residents are receiving their showers as scheduled and are documented in the daily log. In addition, nursing staff were in-serviced on ensuring residents receive showers in accordance with their Service Plans and documenting the shower or refusal of shower in the daily care log. The nursing staff will follow up with each CNA per shift to ensure showers were given and documented.** **4. The Wellness Director or designee will audit daily care logs for the next six months to ensure residents receive showers in accordance with their Service Plans and that the showers or**	

	During an interview on 12/13/21 at 2:30 P.M., CNA (Certified Nurse Aide) 6 and TNA (Temporary Nurse Aide) 7 indicated when a resident moved into the facility they would get a report as to what kind of assistance a resident required. They documented showers on the shower sheets in the CNA book. They would initial it that it was completed. If a resident refused a shower, they would offer multiple times that day then they would try again the next day. It should be documented on the ADL (Activities of Daily Living) record. The ADL records were provided by the DON (Director of Nursing) on 12/14/21 at 9:00 A.M. The records indicated, "...my initials on the Shower Schedule...indicate I provided assistance as outlined in the...service plan. If the shower was refused...I have documented that in the exception log..." The December 2021 record indicated the resident had only one shower in the past 13 days on 12/04/21. The resident refused on 12/02/21, and 12/07/21. Nothing was documented in the exception log nor were further attempts documented on the days following the resident's refusals.		**refusals are documented on the daily care log.** **5. If compliance is not maintained during the six month monitoring period, the monitoring will extend until the community is found to be compliant for a three month period.**	

The November 2021 record indicated the resident had five showers when she should have had eight. Refusals were initialed on 11/02/21 and 11/09/21. Nothing was documented on the exception log on 11/02/21. On 11/09/21, the exception log indicated the resident was not feeling well and wanted to take her shower the next day. No shower attempts were documented on 11/10/21. The resident did not get a shower for nine days, from 11/13/21 through 11/22/21.

The "Charting Notes" were provided by the DON on 12/13/21 at 2:10 P.M. The notes indicated the resident had been on an antibiotic for UTIs in February, March, May, June, July, August, and November of 2021.

The service plan, with a review date of 09/12/21, was provided by the DON on 12/14/21 at 9:00 A.M. The plan indicated the resident, "...will be bathed safely with the assistance of staff twice weekly..."

Based on observation, interview, and record review, the facility failed to provide showers for a resident according to their service plan for 1 of 7 residents reviewed. (Resident 5)

Findings include:

During an interview and

	observation on 12/13/21 at 11:15 A.M., Resident 5 indicated she had not had a shower in a couple of weeks. The girl who gave the showers was always off on the days she was supposed to get one. The resident was sitting in the main dining room and required the assistance one staff member for ADL's. During an interview on 12/13/21 at 2:30 P.M., CNA (Certified Nurse Aide) 6 and TNA (Temporary Nurse Aide) 7 indicated when a resident moved into the facility they would get a report as to what kind of assistance a resident required. They documented showers on the shower sheets in the CNA book. They would initial it that it was completed. If a resident refused a shower, they would offer multiple times that day then they would try again the next day. It should be documented on the ADL (Activities of Daily Living) record.			

	The ADL records were provided by the DON (Director of Nursing) on 12/14/21 at 9:00 A.M. The records indicated, "...my initials on the Shower Schedule...indicate I provided assistance as outlined in the...service plan. If the shower was refused...I have documented that in the exception log..." The December 2021 record indicated the resident had only one shower in the past 13 days on 12/04/21. The resident refused on 12/02/21, and 12/07/21. Nothing was documented in the exception log nor were further attempts documented on the days following the resident's refusals. The November 2021 record indicated the resident had five showers when she should have had eight. Refusals were initialed on 11/02/21 and 11/09/21. Nothing was documented on the exception log on 11/02/21. On 11/09/21, the exception log indicated the resident was not feeling well and wanted to take her shower the next day. No shower attempts were documented on 11/10/21. The resident did not get a shower for nine days, from 11/13/21 through 11/22/21. The "Charting Notes" were provided by the DON on 12/13/21 at 2:10 P.M. The notes			

	indicated the resident had been on an antibiotic for UTIs in February, March, May, June, July, August, and November of 2021. The service plan, with a review date of 09/12/21, was provided by the DON on 12/14/21 at 9:00 A.M. The plan indicated the resident, "...will be bathed safely with the assistance of staff twice weekly..."			
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. Based on observation and interview, the facility failed to follow appropriate guidelines related to dating foods and disposing of expired foods for 2 of 2 kitchen observations. Findings include: 1. The initial kitchen tour was conducted on 12/13/21 at 10:55 A.M. The refrigerators were observed with the Environmental Services Director. A large plastic tub of chicken salad had a received date of 11/29/21, written on the	R 0273	**1. Resident 5 is receiving all showers in accordance with their service plan. In addition, Resident 5 showers are logged in the daily care logs.** **2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice.** **3. The Wellness Director has reviewed and confirmed that all residents are receiving their showers as scheduled and are documented in the daily log. In addition, nursing staff were in-serviced on ensuring residents receive showers in accordance with their Service Plans and**	01/14/2022

	lid in black marker, and a use by date printed on the paper label of 12/11/21. The container was 3/4 full. The Environmental Services Director indicated the tub had just been opened and left it in the refrigerator. 2. The kitchen was observed on 12/14/21 at 10:37 A.M., with the Environmental Services Director and the Dietary Manager. The milk cooler was observed and contained the following: - A large jug of Catalina salad dressing, 1/2 full, with a date on the lid of 06/11/20. The jug had no expiration date or open date. - A large jug of Italian salad dressing, 1/4 full, with a date on the lid of 05/20/21. The jug had no expiration date or open date. - A large jug of tartar sauce, 1/2 full, with no date on the lid. The jug had no expiration date or open date. - A large unlabeled jug, 1/2 full of a white substance, with a date on the lid of 10/14/21. The jug had no expiration date or open date. - A large jug of coleslaw dressing, 1/2 full, with a date on the lid of 08/19/21. The jug had no expiration date or open date. The Environmental Services Director indicated he had disposed of the chicken salad		**documenting the shower or refusal of shower in the daily care log. The nursing staff will follow up with each CNA per shift to ensure showers were given and documented.** **4. The Wellness Director or designee will audit daily care logs for the next six months to ensure residents receive showers in accordance with their Service Plans and that the showers or refusals are documented on the daily care log.** **5.If compliance is not maintained during the six month monitoring period, the monitoring will extend until the community is found to be compliant for a three month period.**	

from the day before. The date written on the lids in black marker was the date the item was received into the facility.

The current "RECEIVING, STORAGE, AND ISSUING" policy, with a revised date of 03-31-16, was provided by the Environmental Services Director on 12/14/21 at 11:09 A.M. The policy indicated, "...All open packages of food shall be...labeled with date package has been opened to ensure proper use of items..."

Based on observation and interview, the facility failed to follow appropriate guidelines related to dating foods and disposing of expired foods for 2 of 2 kitchen observations.

Findings include:

1. The initial kitchen tour was conducted on 12/13/21 at 10:55 A.M. The refrigerators were observed with the Environmental Services Director. A large plastic tub of chicken salad had a received date of 11/29/21, written on the lid in black marker, and a use by date printed on the paper label of 12/11/21. The container was 3/4 full. The Environmental Services Director indicated the tub had just been opened and left it in the refrigerator.

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	on 12/14/21 at 11:09 A.M. The policy indicated, "...All open packages of food shall be...labeled with date package has been opened to ensure proper use of items..."			
R 0299	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(3) (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. 2. The clinical record for Resident 8 was reviewed on 12/14/21 at 9:15 A.M. Diagnoses included, but were not limited to, hypertension, dementia, and congestive heart failure. A "Note to the Attending Physician/Prescriber", dated 9/30/21, indicated quetiapine (Seroquel) an antipsychotic medication 50 mg, once daily and recommended to decreasing to: Seroquel 25 mg once daily. The recommendation was signed by the Nurse Practitioner on 11/22/21 to disagree with the recommendation. During an interview on 12/14/21 at 9:20 A.M., the DON (Director of Nursing) indicated the	R 0299	**1. Resident 5 and Resident 8 clinical records were reviewed. Resident records are all in accordance with pharmacy recommendations.** **2. The Director of Nursing reviewed each resident record to determine if any other residents could be affected by the alleged deficient practice.** **3. The Director of Nursing has reviewed and confirmed that all resident records all medications recommendations and orders have been acted upon within a reasonable time frame. In addition, all nursing staff were in-serviced on how to properly handle and pharmacy recommendations.** **4. The Director of Nursing or designee will audit weekly pharmacy**	01/14/2022

	pharmacy reviews residents' medications every 2 months. If the resident was to have a recommendation, she would send them to the Nurse Practitioner. An appropriate timeframe to get a response back from the Nurse Practitioner would be about 2 weeks. During an interview on 12/14/21 at 10:44 A.M., the DON indicated the resident's pharmacy recommendation from 9/30/21 should have been reviewed sooner than 11/22/21. The current undated facility policy titled, "Medication Regimen Review and Reporting" was provided by the DON on 12/14/21 at 1:58 P.M. The policy indicated, "...Findings and recommendations are communicated to those with authority and/or responsibility to implement the recommendations, and the recommendations are responded to in an appropriate and timely fashion...The Consultant Pharmacist and the facility follow up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon within a reasonable time frame..." Based on record review and interview, the facility failed to follow pharmacy recommendations for 2 of 7		**recommendations for the next six months to ensure compliance and document as such.** **5.If compliance is not maintained during the six month monitoring period, the monitoring will extend until the community is found to be compliant for a three month period.**	

	resident records reviewed. (Residents 5 and 8) Findings include: 1. The clinical record for Resident 5 was reviewed on 12/14/21 at 1:00 P.M. The "Doctors To Home" physician visit records were provided by the DON (Director of Nursing) on 12/13/21 at 1:30 P.M. A visit record, dated 11/12/21, indicated the resident had multiple chronic conditions that required frequent monitoring to prevent or diminish hospital visits. Diagnoses included, but were not limited to, dementia, hypertension, anxiety, depression, and urinary tract infections. A pharmacy recommendation, dated 11/24/21, was provided by the DON on 12/13/21 at 2:00 P.M. The record indicated, "...Please evaluate signs and symptoms of [sic] to depression [sic] determine if a dose reduction is appropriate at this time. If not appropriate, please document rationale...sertraline [an antidepressant] 50 mg (milligrams) once daily...Recommend decreasing to: sertraline 25 mg once daily..." The recommendation was not signed by the physician as to whether they agreed or disagreed with the			

	recommendation nor was any rationale documented. The MAR (Medication Administration Record) was provided by the DON on 12/13/21 at 1:30 P.M. The record indicated the resident continued to receive 50 mg of sertraline following the pharmacy recommendation. During an interview on 12/14/21 at 1:58 P.M., the DON indicated after she received the pharmacy recommendations, she would review them with the NP (Nurse Practitioner) and decide how to proceed. The NP came in every week on Thursdays, and they would have reviewed the recommendations on the first Thursday following receipt from the pharmacy. The recommendation form should have been completed. 2. The clinical record for Resident 8 was reviewed on 12/14/21 at 9:15 A.M. Diagnoses included, but were not limited to, hypertension, dementia, and congestive heart failure. A "Note to the Attending Physician/Prescriber", dated 9/30/21, indicated quetiapine (Seroquel) an antipsychotic medication 50 mg, once daily and recommended to decreasing to: Seroquel 25 mg once daily. The			

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Based on record review and interview, the facility failed to follow pharmacy recommendations for 2 of 7 resident records reviewed. (Residents 5 and 8)

Findings include:

1. The clinical record for Resident 5 was reviewed on 12/14/21 at 1:00 P.M.

The "Doctors To Home" physician visit records were provided by the DON (Director of Nursing) on 12/13/21 at 1:30 P.M. A visit record, dated 11/12/21, indicated the resident had multiple chronic conditions that required frequent monitoring to prevent or diminish hospital visits. Diagnoses included, but were not limited to, dementia, hypertension, anxiety, depression, and urinary tract infections.

A pharmacy recommendation, dated 11/24/21, was provided by the DON on 12/13/21 at 2:00 P.M. The record indicated, "...Please evaluate signs and symptoms of [sic] to depression [sic] determine if a dose reduction is appropriate at this time. If not appropriate, please document rationale...sertraline [an antidepressant] 50 mg

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	Physician/Prescriber", dated 9/30/21, indicated quetiapine (Seroquel) an antipsychotic medication 50 mg, once daily and recommended to decreasing to: Seroquel 25 mg once daily. The recommendation was signed by the Nurse Practitioner on 11/22/21 to disagree with the recommendation. During an interview on 12/14/21 at 9:20 A.M., the DON (Director of Nursing) indicated the pharmacy reviews residents' medications every 2 months. If the resident was to have a recommendation, she would send them to the Nurse Practitioner. An appropriate timeframe to get a response back from the Nurse Practitioner would be about 2 weeks. During an interview on 12/14/21 at 10:44 A.M., the DON indicated the resident's pharmacy recommendation from 9/30/21 should have been reviewed sooner than 11/22/21. The current undated facility policy titled, "Medication Regimen Review and Reporting" was provided by the DON on 12/14/21 at 1:58 P.M. The policy indicated, "...Findings and recommendations are communicated to those with authority and/or responsibility to implement the recommendations, and the			

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Based on record review and interview, the facility failed to follow pharmacy recommendations for 2 of 7 resident records reviewed. (Residents 5 and 8)

Findings include:

1. The clinical record for Resident 5 was reviewed on 12/14/21 at 1:00 P.M.

The "Doctors To Home" physician visit records were provided by the DON (Director of Nursing) on 12/13/21 at 1:30 P.M. A visit record, dated 11/12/21, indicated the resident had multiple chronic conditions that required frequent monitoring to prevent or diminish hospital visits. Diagnoses included, but were not limited to, dementia, hypertension, anxiety, depression, and urinary tract infections.

A pharmacy recommendation, dated 11/24/21, was provided by the DON on 12/13/21 at 2:00 P.M. The record indicated,

	"...Please evaluate signs and symptoms of [sic] to depression [sic] determine if a dose reduction is appropriate at this time. If not appropriate, please document rationale...sertraline [an antidepressant] 50 mg (milligrams) once daily...Recommend decreasing to: sertraline 25 mg once daily..." The recommendation was not signed by the physician as to whether they agreed or disagreed with the recommendation nor was any rationale documented. The MAR (Medication Administration Record) was provided by the DON on 12/13/21 at 1:30 P.M. The record indicated the resident continued to receive 50 mg of sertraline following the pharmacy recommendation. During an interview on 12/14/21 at 1:58 P.M., the DON indicated after she received the pharmacy recommendations, she would review them with the NP (Nurse Practitioner) and decide how to proceed. The NP came in every week on Thursdays, and they would have reviewed the recommendations on the first Thursday following receipt from the pharmacy. The recommendation form should have been completed. 2. The clinical record for Resident 8 was reviewed on			

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	recommendations on the first Thursday following receipt from the pharmacy. The recommendation form should have been completed.			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility failed to store medication appropriately related to unlabeled insulin pens for 1 of 2 medication carts observed (Medication Cart 1), and appropriately store medications related to unlabeled TB (tuberculin) serum for 1 of 1 medication storage room observed (Medication Storage Room 1). Findings include: 1. During an observation with LPN (Licensed Practical Nurse) 2 on 12/14/21 at 9:47 A.M., Medication Cart 1 contained the following:	R 0300	**1. All open solution vials have been reviewed. All open vials have appropriate dating upon vial being put into use.** **2. The Director of Nursing reviewed each open solution vial to determine if any other residents could be affected by the alleged deficient practice.** **3. The Director of Nursing has reviewed and confirmed each open solution vial is properly stored, has appropriate dating upon being put into use, and appropriate disposal per manufacturer established length of safe storage. In addition, nursing staff who are licensed to administer medications were in-serviced on how to properly handle open solution vials.** **4. The Director of Nursing or designee will audit daily for the next six months**	06/14/2022

	- A nearly empty Novolog insulin pen for Resident 11. The pharmacy label on the pen indicated it was delivered to the facility on 09/16/21. There was no opened on date or use by date on the pen. - A 1/2 full Lantus insulin pen for Resident 11. The pharmacy label on the pen indicated it was delivered to the facility on 11/22/21. There was no opened on date or use by date on the pen. During an interview on 12/14/21 at 9:55 A.M., LPN 2 indicated insulin pens should be labeled with an opened on date and a use by date. Resident 11 received insulin on a regular basis. During an interview on 12/14/21 at 1:35 P.M., the DON (Director of Nursing) indicated Resident 11 suffered no ill effects from the use of the undated insulin. 2. During an observation of Medication Storage Room 1 with LPN 2 on 12/14/21 at 10:05 A.M., the medication refrigerator contained the following:		**to ensure compliance and document as such.** **5. If compliance is not maintained during the six month monitoring period, the monitoring will extend until the community is found to be compliant for a three month period.**	

	- A half filled vial of Aplisol (Tuberculin PPD) serum. The vial was not labeled with an opened on or use by date. LPN 2 was unsure of when the serum was opened. There was no indication as to when it was received from the pharmacy. During an interview on 12/14/21 at 10:05 A.M., LPN 2 indicated TB serum should be labeled with an opened on date. During an interview on 12/14/21 at 1:35 P.M., the DON indicated there were no residents that received an injection of the TB serum in the last few months. The Aplisol package insert was provided by the DON on 12/14/21 at 1:57 P.M. The insert indicated, "...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." The current facility policy, titled "MEDICATION STORAGE", and dated 07/12, was provided by the DON on 12/14/21 at 1:57 P.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations...Date insulin vials when first opened..." Based on observation, interview, and record review, the facility failed to store medication			

appropriately related to unlabeled insulin pens for 1 of 2 medication carts observed (Medication Cart 1), and appropriately store medications related to unlabeled TB (tuberculin) serum for 1 of 1 medication storage room observed (Medication Storage Room 1).

Findings include:

1. During an observation with LPN (Licensed Practical Nurse) 2 on 12/14/21 at 9:47 A.M., Medication Cart 1 contained the following:

- A nearly empty Novolog insulin pen for Resident 11. The pharmacy label on the pen indicated it was delivered to the facility on 09/16/21. There was no opened on date or use by date on the pen.

- A 1/2 full Lantus insulin pen for Resident 11. The pharmacy label on the pen indicated it was delivered to the facility on 11/22/21. There was no opened on date or use by date on the pen.

During an interview on 12/14/21 at 9:55 A.M., LPN 2 indicated insulin pens should be labeled with an opened on date and a use by date. Resident 11 received insulin on a regular basis.

During an interview on 12/14/21

at 1:35 P.M., the DON (Director of Nursing) indicated Resident 11 suffered no ill effects from the use of the undated insulin.

2. During an observation of Medication Storage Room 1 with LPN 2 on 12/14/21 at 10:05 A.M., the medication refrigerator contained the following:

- A half filled vial of Aplisol (Tuberculin PPD) serum. The vial was not labeled with an opened on or use by date. LPN 2 was unsure of when the serum was opened. There was no indication as to when it was received from the pharmacy.

During an interview on 12/14/21 at 10:05 A.M., LPN 2 indicated TB serum should be labeled with an opened on date.

During an interview on 12/14/21 at 1:35 P.M., the DON indicated there were no residents that received an injection of the TB serum in the last few months.

The Aplisol package insert was provided by the DON on 12/14/21 at 1:57 P.M. The insert indicated, "...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..."

The current facility policy, titled "MEDICATION STORAGE", and dated 07/12, was provided by the DON on 12/14/21 at 1:57

	P.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations...Date insulin vials when first opened..."			
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. Based on observation and interview, the facility failed to follow appropriate infection control guidelines related to PPE (Personal Protection Equipment) usage for 1 of 4 staff observed. (Cook 2) Findings include: The initial kitchen tour was	R 0407	**1. Cook 2 has been coached on infection control in the dietary department.** **2. The Environmental Service Director reviewed each shift and dietary employee to determine if any other residents could be affected by the alleged deficient practice.** **3. The Environmental Service Director has reviewed and confirmed each dietary department employee is aware of the infection control policy of mask wearing. In addition, all staff have been in-serviced on proper personal protective equipment for infection control.** **4. The Environmental Service Director or designee will audit the dietary department daily for the next six months to ensure**	01/14/2022

	conducted on 12/13/21 at 10:55 A.M. Cook 2 was working in the kitchen with her surgical mask under her chin. She washed her hands, dried them with a paper towel, wiped her nose with the paper towel, then threw the towel in the trash can. She proceeded to handle some paperwork that was laying on a food preparation table. She touched the trash can lid, stacked some dirty pans containing food remnants, then covered a foil pan containing sliced purple onions with plastic wrap. She adjusted her surgical mask over her face, put her hands in her scrub top pockets, pulled out a black marker, and dated the plastic covering on the onions. The kitchen was observed on 12/14/21 at 10:37 A.M. Cook 2 was wearing her surgical mask under her nose while working in the food preparation area. At 10:40 A.M., Cook 2 was wearing her surgical mask under her chin while working in the food preparation area. During an interview on 12/14/21 at 10:50 A.M., the DM (Dietary Manager) and Environmental Services Director indicated staff should wear masks in the kitchen covering their nose and mouth. During an interview on 12/13/21 at 2:35 P.M., CNA (Certified		**compliance and document as such.** **5.If compliance is not maintained during the six month monitoring period, the monitoring will extend until the community is found to be compliant for a three month period.**	

Nurse Aide) 6 and TNA (Temporary Nurse Aide) 7 indicated face masks should be worn covering their nose and mouth.

During an observation on 12/13/21 at 11:56 A.M., Cook 2 was in the kitchen with her mask under her chin while talking with CNA 3 who was standing at the counter outside of the kitchen and within 6 feet of Cook 2. Cook 2 was placing bowls of potato salad on the counter, CNA 3 then started serving residents the potato salad.

During an observation on 12/13/21 at 12:15 P.M., Cook 2 was in the kitchen with her mask under her nose preparing a plate of food, the plate of food was then served to Resident 9. Cook 2 then prepared a peanut butter and jelly sandwich that was served to Resident 10.

The current facility policy, updated on 11/6/2020, "Face Mask and Face Shields (Goggles) Guidelines" was provided by the DON (Director of Nursing) on 12/14/21 at 2:39 P.M. The policy indicated, " ...Surgical Masks are to be worn any time the staff is in the community ..."

Based on observation and interview, the facility failed to follow appropriate infection control guidelines related to

PPE (Personal Protection Equipment) usage for 1 of 4 staff observed. (Cook 2)

Findings include:

The initial kitchen tour was conducted on 12/13/21 at 10:55 A.M. Cook 2 was working in the kitchen with her surgical mask under her chin. She washed her hands, dried them with a paper towel, wiped her nose with the paper towel, then threw the towel in the trash can. She proceeded to handle some paperwork that was laying on a food preparation table. She touched the trash can lid, stacked some dirty pans containing food remnants, then covered a foil pan containing sliced purple onions with plastic wrap. She adjusted her surgical mask over her face, put her hands in her scrub top pockets, pulled out a black marker, and dated the plastic covering on the onions.

The kitchen was observed on 12/14/21 at 10:37 A.M. Cook 2 was wearing her surgical mask under her nose while working in the food preparation area. At 10:40 A.M., Cook 2 was wearing her surgical mask under her chin while working in the food preparation area.

During an interview on 12/14/21 at 10:50 A.M., the DM (Dietary Manager) and Environmental

Services Director indicated staff should wear masks in the kitchen covering their nose and mouth.

During an interview on 12/13/21 at 2:35 P.M., CNA (Certified Nurse Aide) 6 and TNA (Temporary Nurse Aide) 7 indicated face masks should be worn covering their nose and mouth.

During an observation on 12/13/21 at 11:56 A.M., Cook 2 was in the kitchen with her mask under her chin while talking with CNA 3 who was standing at the counter outside of the kitchen and within 6 feet of Cook 2. Cook 2 was placing bowls of potato salad on the counter, CNA 3 then started serving residents the potato salad.

During an observation on 12/13/21 at 12:15 P.M., Cook 2 was in the kitchen with her mask under her nose preparing a plate of food, the plate of food was then served to Resident 9. Cook 2 then prepared a peanut butter and jelly sandwich that was served to Resident 10.

The current facility policy, updated on 11/6/2020, "Face Mask and Face Shields (Goggles) Guidelines" was provided by the DON (Director of Nursing) on 12/14/21 at 2:39 P.M. The policy indicated, " ...Surgical Masks are to be worn

any time the staff is in the community ..."

Based on observation and interview, the facility failed to follow appropriate infection control guidelines related to PPE (Personal Protection Equipment) usage for 1 of 4 staff observed. (Cook 2)

Findings include:

The initial kitchen tour was conducted on 12/13/21 at 10:55 A.M. Cook 2 was working in the kitchen with her surgical mask under her chin. She washed her hands, dried them with a paper towel, wiped her nose with the paper towel, then threw the towel in the trash can. She proceeded to handle some paperwork that was laying on a food preparation table. She touched the trash can lid, stacked some dirty pans containing food remnants, then covered a foil pan containing sliced purple onions with plastic wrap. She adjusted her surgical mask over her face, put her hands in her scrub top pockets, pulled out a black marker, and dated the plastic covering on the onions.

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her surgical mask under her chin while working in the food preparation area.

During an interview on 12/14/21 at 10:50 A.M., the DM (Dietary Manager) and Environmental Services Director indicated staff should wear masks in the kitchen covering their nose and mouth.

During an interview on 12/13/21 at 2:35 P.M., CNA (Certified Nurse Aide) 6 and TNA (Temporary Nurse Aide) 7 indicated face masks should be worn covering their nose and mouth.

During an observation on 12/13/21 at 11:56 A.M., Cook 2 was in the kitchen with her mask under her chin while talking with CNA 3 who was standing at the counter outside of the kitchen and within 6 feet of Cook 2. Cook 2 was placing bowls of potato salad on the counter, CNA 3 then started serving residents the potato salad.

During an observation on 12/13/21 at 12:15 P.M., Cook 2 was in the kitchen with her mask under her nose preparing a plate of food, the plate of food was then served to Resident 9. Cook 2 then prepared a peanut butter and jelly sandwich that was served to Resident 10.

The current facility policy, updated on 11/6/2020, "Face

Mask and Face Shields (Goggles) Guidelines" was provided by the DON (Director of Nursing) on 12/14/21 at 2:39 P.M. The policy indicated, " ...Surgical Masks are to be worn any time the staff is in the community ..."

Based on observation and interview, the facility failed to follow appropriate infection control guidelines related to PPE (Personal Protection Equipment) usage for 1 of 4 staff observed. (Cook 2)

Findings include:

The initial kitchen tour was conducted on 12/13/21 at 10:55 A.M. Cook 2 was working in the kitchen with her surgical mask under her chin. She washed her hands, dried them with a paper towel, wiped her nose with the paper towel, then threw the towel in the trash can. She proceeded to handle some paperwork that was laying on a food preparation table. She touched the trash can lid, stacked some dirty pans containing food remnants, then covered a foil pan containing sliced purple onions with plastic wrap. She adjusted her surgical mask over her face, put her hands in her scrub top pockets, pulled out a black marker, and dated the plastic covering on the onions.

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During an interview on 12/14/21 at 10:50 A.M., the DM (Dietary Manager) and Environmental Services Director indicated staff should wear masks in the kitchen covering their nose and mouth.

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During an observation on 12/13/21 at 11:56 A.M., Cook 2 was in the kitchen with her mask under her chin while talking with CNA 3 who was standing at the counter outside of the kitchen and within 6 feet of Cook 2. Cook 2 was placing bowls of potato salad on the counter, CNA 3 then started serving residents the potato salad.

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	was then served to Resident 9. Cook 2 then prepared a peanut butter and jelly sandwich that was served to Resident 10. The current facility policy, updated on 11/6/2020, "Face Mask and Face Shields (Goggles) Guidelines" was provided by the DON (Director of Nursing) on 12/14/21 at 2:39 P.M. The policy indicated, " ...Surgical Masks are to be worn any time the staff is in the community ..."			

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