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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR VILLAGE	8800 SPOON DR, 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: July 27, 28, and 29, 2021 Facility Number: 011799 Residential: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 4, 2021	R 0000	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be**	

			inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;	

			. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ; and . By the date the systemic changes will be completed.	
R 0033	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(h)(1-2) (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services.	R 0033	**R 033** 1. The addresses and telephone numbers of the IDOH (Indiana Department of Health), FSSA (Family and Social Services), the area agency of aging, local mental health center and adult protective services are posted in an area accessible to residents. 2. The Community reviewed each	08/27/2021

	(C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation, interview, and record review, the facility failed to ensure the addresses and telephone numbers of the IDOH (Indiana Department of Health), FSSA (Family and Social Services), the area agency on aging, local mental health center, and adult protective services were posted in an area accessible to residents for 87 of 87 residents in the facility. Findings include: An interview was conducted and observation of the receptionist area at the facility entrance was made with Receptionist 2 on 7/28/21 at 3:20 p.m. There were no postings of the addresses and telephone numbers to the IDOH, FSSA, the area agency on aging, local mental health center, and adult protective services observed. Receptionist 2 indicated the advocacy		resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Executive Director or designee will confirm weekly then monthly thereafter for four months that the addresses and telephone numbers of the IDOH (Indiana Department of Health), FSSA (Family and Social Services), the area agency of aging, local mental health center and adult protective services are posted in an area accessible to residents. 4. The Executive Director or designee will confirm weekly then monthly thereafter for four months that the addresses and telephone numbers of the IDOH (Indiana Department of Health), FSSA (Family and Social Services), the area agency of aging, local mental health center and adult protective services are posted in an area accessible to residents.	

	information used to be posted on the wall between the ED's (Executive Director's) office and the receptionist window, where a mirror, hand sanitizer dispenser, and small shelf now were, but they painted the area "about a month ago," and it was never put back. An interview was conducted and observation of the above area was made with the ED on 7/28/21 at 3:22 p.m. The ED indicated the posting of the information used to be on the wall, and perhaps it was now in the "junk room." The ED entered a closet down the hall and came out with an empty frame. She indicated it was the old frame that posted the advocacy information, but was unsure as to the whereabouts of the actual advocacy information previously held inside the frame. An environmental tour of the facility was conducted with the Maintenance Director on 7/29/21 at 10:15 a.m. An interview with Receptionist 2 and the Maintenance Director was conducted at this time. The receptionist area at the facility entrance was observed during the tour. The advocacy numbers were not observed posted during the tour. Receptionist 2 was present during this observation and stated, "We haven't put them up anywhere yet. We can't find them." The		5. Systemic changes: August 27, 2021	

	Maintenance Director indicated they'd painted the area recently, maybe 2 weeks ago, but there was a binder with the information upstairs in the activity area. An observation of the upstairs activity area was made with the Maintenance Director during the tour. There was a clear, closed binder on the top shelf of a wire book display stand with the bottom half of the binder covered with the book in front of it. The clear binder did not have a front cover indicating what was contained inside the binder. The Maintenance Director removed the binder from the wire stand. It contained 1 page of advocacy information located directly behind 2 pages of residents rights. The Required Signs and Postings policy was provided by the Maintenance Director on 7/29/21 at 12:15 p.m. It did not reference the posting of the addresses and telephone numbers to the IDOH, FSSA, the area agency on aging, local mental health center, and adult protective services, but indicated, "Contact your REGIONAL MANGER regarding licensing regulations for any additional postings, for example, state surveys, Resident rights, safety committee meetings, etc. that may be required by your state."			

	Based on observation, interview, and record review, the facility failed to ensure the addresses and telephone numbers of the IDOH (Indiana Department of Health), FSSA (Family and Social Services), the area agency on aging, local mental health center, and adult protective services were posted in an area accessible to residents for 87 of 87 residents in the facility. Findings include: An interview was conducted and observation of the receptionist area at the facility entrance was made with Receptionist 2 on 7/28/21 at 3:20 p.m. There were no postings of the addresses and telephone numbers to the IDOH, FSSA, the area agency on aging, local mental health center, and adult protective services observed. Receptionist 2 indicated the advocacy information used to be posted on the wall between the ED's (Executive Director's) office and the receptionist window, where a mirror, hand sanitizer dispenser, and small shelf now were, but they painted the area "about a month ago," and it was never put back. An interview was conducted and observation of the above area was made with the ED on 7/28/21 at 3:22 p.m. The ED indicated the posting of the			

	information used to be on the wall, and perhaps it was now in the "junk room." The ED entered a closet down the hall and came out with an empty frame. She indicated it was the old frame that posted the advocacy information, but was unsure as to the whereabouts of the actual advocacy information previously held inside the frame. An environmental tour of the facility was conducted with the Maintenance Director on 7/29/21 at 10:15 a.m. An interview with Receptionist 2 and the Maintenance Director was conducted at this time. The receptionist area at the facility entrance was observed during the tour. The advocacy numbers were not observed posted during the tour. Receptionist 2 was present during this observation and stated, "We haven't put them up anywhere yet. We can't find them." The Maintenance Director indicated they'd painted the area recently, maybe 2 weeks ago, but there was a binder with the information upstairs in the activity area. An observation of the upstairs activity area was made with the Maintenance Director during the tour. There was a clear, closed binder on the top shelf of a wire book display stand with the bottom half of the binder covered with the book in front of it. The clear binder did not have a front cover			

	indicating what was contained inside the binder. The Maintenance Director removed the binder from the wire stand. It contained 1 page of advocacy information located directly behind 2 pages of residents rights. The Required Signs and Postings policy was provided by the Maintenance Director on 7/29/21 at 12:15 p.m. It did not reference the posting of the addresses and telephone numbers to the IDOH, FSSA, the area agency on aging, local mental health center, and adult protective services, but indicated, "Contact your REGIONAL MANGER regarding licensing regulations for any additional postings, for example, state surveys, Resident rights, safety committee meetings, etc. that may be required by your state."			
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 alarm signal and simulation of emergency fire conditions, except	R 0092	**R 092** 1. The Community will conduct monthly fire alarm drills on each shift . The fire drill will include the transmission of an audible fire alarm unless the fire drill occurs between the hours of 9:00 p.m. and 6:00 a.m.	08/27/2021

	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 include the transmission of an audible fire alarm signal when conducting their fire drills with the potential to affect 87 of 87 residents in the facility. Findings include:		2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Management members in-serviced on the Community's fire alarm drill policy. 4. The Executive Director or designee will confirm monthly fire drills are being conducted on each shift and will confirm the drill will include the transmission of an audible fire alarm unless the fire drill occurs between the hours of 9:00 p.m. and 6:00 a.m. 5. Systemic changes: August 27, 2021	

	Twelve monthly fire drill reports from August, 2020 through July, 2021 were provided by the ED (Executive Director) on 7/27/21 at 11:53 a.m. Four drills were conducted on first shift; 4 on second shift, and 4 on third shift. The 8 drill reports from drills conducted on first and second shifts indicated the alarm was not pulled. An interview was conducted with the ED on 7/28/21 at 11:58 a.m. She indicated there were no audible alarms during the drills, but they do an in depth simulation of a fire. The Fire Inspections policy was provided by the ED on 7/28/21 at 1:52 p.m. It read, "The drill must include the activation of the fire alarm signal, except between 9:00 p.m. and 6:00 a.m....During fire drills the ED should: ...Set off a fire alarm in a pre-determined location (e.g. by holding a smoking item near an alarm). Include transmission of fire alarm signals throughout the Community." Based on interview and record review, the facility failed to include the transmission of an audible fire alarm signal when conducting their fire drills with the potential to affect 87 of 87 residents in the facility. Findings include: Twelve monthly fire drill reports			

	from August, 2020 through July, 2021 were provided by the ED (Executive Director) on 7/27/21 at 11:53 a.m. Four drills were conducted on first shift; 4 on second shift, and 4 on third shift. The 8 drill reports from drills conducted on first and second shifts indicated the alarm was not pulled. An interview was conducted with the ED on 7/28/21 at 11:58 a.m. She indicated there were no audible alarms during the drills, but they do an in depth simulation of a fire. The Fire Inspections policy was provided by the ED on 7/28/21 at 1:52 p.m. It read, "The drill must include the activation of the fire alarm signal, except between 9:00 p.m. and 6:00 a.m....During fire drills the ED should: ...Set off a fire alarm in a pre-determined location (e.g. by holding a smoking item near an alarm). Include transmission of fire alarm signals throughout the Community."			
R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including	R 0155	**R 155** 1. The dumpster doors are now closed, and trash is no longer sticking out of the dumpster doors.	08/27/2021

	dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure dumpster doors were kept closed with the potential to affect 87 of 87 residents in the facility. Findings include: An observation of the outside dumpster area was made on 7/28/21 at 1:20 p.m. The side dumpster door was not closed. There were 2 large opened cardboard boxes with Styrofoam and plastic visible inside, resting on top of the top dumpster doors. An environmental tour of the facility was conducted with the Maintenance Director on 7/29/21 at 0:15 a.m. An observation of the outside dumpster area was made during the tour. The side dumpster doors and one of the top dumpster doors were not closed. There was a bag of trash partially sticking out of the right side dumpster door. The Maintenance Director closed the 3 opened doors and indicated all the doors should be closed. The Trash Reciprocal Area policy was provided by the Maintenance Director on 7/29/21 at 12:15 p.m. It read, "Dumpster container lids were		2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Staff in-service on ensuring the dumpster lids completely closed. 4. The Maintenance Director or designee will inspect the dumpster areas daily to ensure the dumpster lids completely closed. 5. Systemic changes: August 27, 2021	

closed when not in use."

Based on observation, interview, and record review, the facility failed to ensure dumpster doors were kept closed with the potential to affect 87 of 87 residents in the facility.

Findings include:

An observation of the outside dumpster area was made on 7/28/21 at 1:20 p.m. The side dumpster door was not closed. There were 2 large opened cardboard boxes with Styrofoam and plastic visible inside, resting on top of the top dumpster doors.

An environmental tour of the facility was conducted with the Maintenance Director on 7/29/21 at 0:15 a.m. An observation of the outside dumpster area was made during the tour. The side dumpster doors and one of the top dumpster doors were not closed. There was a bag of trash partially sticking out of the right side dumpster door. The Maintenance Director closed the 3 opened doors and indicated all the doors should be closed.

The Trash Reciprocal Area policy was provided by the Maintenance Director on 7/29/21 at 12:15 p.m. It read, "Dumpster container lids were closed when not in use."

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 record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Assistant) were authorized by a licensed nurse and documented in the clinical record indicating the time and date of contact for 1 of 5 residents reviewed for record review. (Resident 67) Findings include: The clinical record for Resident 67 was reviewed on 7/27/21. Resident 67's diagnoses included, but not limited to, chronic kidney disease, aortic valve replacement, congestive heart failure, and Alzheimer's dementia. A physician's order for morphine	R 0246	**R 246** 1. PRN medication administered by QMA (Qualified Medication Assistant) will receive authorization from a licensed nurse and document the authorization in the clinical records indicating the time and date of contact. 2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Medication administration staff in-serviced on the community’s PRN policy. 4. The Wellness Director or designee will conduct weekly monitoring of PRN authorization and documentation for four weeks then monthly thereafter for six months.	08/27/2021

	concentrate 100 mg (milligrams) per 5 ml (milliliters), 0.25 ml sublingual every 4 hours as needed for shortness of breath and/or pain was received on 7/7/21. A physician's order for lorazepam 0.5 mg tablet, one tablet per mouth every 4 hours as needed for anxiety was received on 7/7/21. Resident 67's MAR (Medication Administration Record) for July 2021 was reviewed on 7/27/21 at 3:16 p.m. The July 2021 MAR indicated the following: -On 7/10/21, the PRN lorazepam was administered by QMA 6 at 5:45 p.m. -On 7/12/21, the PRN lorazepam was administered by QMA 3. No time of administration was indicated on the MAR. -On 7/14/21, the PRN morphine concentrate was administered by QMA 6 at 6 p.m. -On 7/14/21, the PRN lorazepam was administered by QMA 6. No time of administration was indicated on the MAR. Resident 67's clinical record did not indicate who gave permission to administer the PRN medications listed above nor was the licensed nurse's		5. Systemic changes: August 27, 2021	

	initials/signature cosigned. An interview with DON (Director of Nursing) was conducted on 7/27/21 at 3:28 p.m. She indicated, the QMA's are required to receive authorization from a licensed nurse prior to administering a PRN medication. The documentation of authorization can be done by the licensed nurse signing the MAR with their initials beside the QMA's initials on the back of the MAR or as a nursing note in the chart. A PRN medication policy was received from DON on 7/28/21 at 9:30 a.m. It indicated, "For all PRN medications (those taken on an as-needed "basis"), follow the instructions given for the medication on the MAR. These should be clear with specific guidelines of amount and time frame they may be made available...There may be additional guidelines such as who needs to be called for approval to give the medication, etc[sic, etcetera]. If no instructions have been given, call the Wellness Director for clarification of procedure to be followed." A Qualified Medication Aide Scope of Practice was provided by DON on 7/28/21 at 9:30 a.m. It indicated, "...11. Administer previously ordered pro re nata (PRN) medication only if			

	authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: A. Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. B. Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. C. Obtain permission to administer the medication each time the symptoms occur in the resident. D. Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty." Based on record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Assistant) were authorized by a licensed nurse and documented in the clinical record indicating the time and date of contact for 1 of 5 residents reviewed for record review. (Resident 67)			

	Findings include: The clinical record for Resident 67 was reviewed on 7/27/21. Resident 67's diagnoses included, but not limited to, chronic kidney disease, aortic valve replacement, congestive heart failure, and Alzheimer's dementia. A physician's order for morphine concentrate 100 mg (milligrams) per 5 ml (milliliters), 0.25 ml sublingual every 4 hours as needed for shortness of breath and/or pain was received on 7/7/21. A physician's order for lorazepam 0.5 mg tablet, one tablet per mouth every 4 hours as needed for anxiety was received on 7/7/21. Resident 67's MAR (Medication Administration Record) for July 2021 was reviewed on 7/27/21 at 3:16 p.m. The July 2021 MAR indicated the following: -On 7/10/21, the PRN lorazepam was administered by QMA 6 at 5:45 p.m. -On 7/12/21, the PRN lorazepam was administered by QMA 3. No time of administration was indicated on the MAR.			

	-On 7/14/21, the PRN morphine concentrate was administered by QMA 6 at 6 p.m. -On 7/14/21, the PRN lorazepam was administered by QMA 6. No time of administration was indicated on the MAR. Resident 67's clinical record did not indicate who gave permission to administer the PRN medications listed above nor was the licensed nurse's initials/signature cosigned. An interview with DON (Director of Nursing) was conducted on 7/27/21 at 3:28 p.m. She indicated, the QMA's are required to receive authorization from a licensed nurse prior to administering a PRN medication. The documentation of authorization can be done by the licensed nurse signing the MAR with their initials beside the QMA's initials on the back of the MAR or as a nursing note in the chart. A PRN medication policy was received from DON on 7/28/21 at 9:30 a.m. It indicated, "For all PRN medications (those taken on an as-needed "basis"), follow the instructions given for the medication on the MAR. These should be clear with specific guidelines of amount and time frame they may be made available...There may be			

additional guidelines such as who needs to be called for approval to give the medication, etc[sic, etcetera]. If no instructions have been given, call the Wellness Director for clarification of procedure to be followed."

A Qualified Medication Aide Scope of Practice was provided by DON on 7/28/21 at 9:30 a.m. It indicated, "...11. Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following:

A. Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred.

B. Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact.

C. Obtain permission to administer the medication each time the symptoms occur in the resident.

D. Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was

	on call, by the end of the nurse's next tour of duty."			
R 0272	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(e) (e) All food shall be served at a safe and appropriate temperature. Based on observation and interview the facility failed to serve food at appropriated temperatures with the potential to affect 11 of 87 residents residing at the facility. Findings include: On 7/28/21 at 11:15 a.m., the lunch service on the 2nd floor of the memory care unit was observed. There were 8 residents in the dining room eating their lunch. QMA 10 dished a plate of chicken alfredo with noodles onto a plate and took it to a resident who was sitting in the dining room. She returned to the steam table and temperatures of the items on the steam table were obtained. The steam table contained a container of chicken alfredo with vegetables, which was 100 degrees Fahrenheit and a container of pasta noodles, which was 110 degrees Fahrenheit. During an interview on 7/28/21	R 0272	**R 272** 1. The Community is serving food at the appropriate temperatures. In addition, QMA 10 was in-serviced on serving food at the appropriate temperatures. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. On (insert date) staff were in-serviced on appropriate food temperatures. 4. The Dietary Manager or designee will monitor the food temperatures daily for four weeks then monthly thereafter for six months.	08/27/2021

	at 11:25 a.m., QMA 10 indicated she was unaware of what temperature the chicken alfredo and noodles should be when served. She was going to continue to serve lunch to the residents. On 7/28/21 at 2:43 p.m., the Executive Director provided the current Meal Preparation Policy which read "Meal Preparation 1. Critical for all Employee Partners working in food preparation and service areas is an understanding of how illness may be transmitted through the unsafe handling of food. They must take proper steps to ensure sanitary surroundings and food that is safe to eat...18. Food must be served at appropriate temperatures. To measure food temperatures, a probe thermometer may be used. Hot food should be served at the following temperatures to ensure that they arrive at the table hot: Vegetables 160 -[sic] 170 degrees Fahrenheit Meat 150-[sic] 160 degrees Fahrenheit...." Based on observation and interview the facility failed to serve food at appropriated temperatures with the potential to affect 11 of 87 residents residing at the facility. Findings include:		5. Systemic changes: August 27, 2021	

	On 7/28/21 at 11:15 a.m., the lunch service on the 2nd floor of the memory care unit was observed. There were 8 residents in the dining room eating their lunch. QMA 10 dished a plate of chicken alfredo with noodles onto a plate and took it to a resident who was sitting in the dining room. She returned to the steam table and temperatures of the items on the steam table were obtained. The steam table contained a container of chicken alfredo with vegetables, which was 100 degrees Fahrenheit and a container of pasta noodles, which was 110 degrees Fahrenheit. During an interview on 7/28/21 at 11:25 a.m., QMA 10 indicated she was unaware of what temperature the chicken alfredo and noodles should be when served. She was going to continue to serve lunch to the residents. On 7/28/21 at 2:43 p.m., the Executive Director provided the current Meal Preparation Policy which read "Meal Preparation 1. Critical for all Employee Partners working in food preparation and service areas is an understanding of how illness may be transmitted through the unsafe handling of food. They must take proper steps to ensure sanitary surroundings and food that is safe to eat...18.			

	Food must be served at appropriate temperatures. To measure food temperatures, a probe thermometer may be used. Hot food should be served at the following temperatures to ensure that they arrive at the table hot: Vegetables 160 -[sic] 170 degrees Fahrenheit Meat 150-[sic] 160 degrees Fahrenheit...."			
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 assure that hair restraints were worn while serving food from a steam table with the potential to affect 24 of 87 residents residing at the facility. Findings include: On 7/28/21 at 11:15 a.m., the 2nd floor memory care unit lunch service was observed. QMA (Qualified Medication Aide) 10 was serving food from the steam table. Her hair was not covered with a hair net.	R 0273	**R** **273** 1. QMA 10 is properly wearing a hair net while serving foot from the steam table. 2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice.	08/27/2021

	On 7/28/21 at 11:35 a.m., the 1st floor memory care unit lunch service was observed. MC (Memory Care Coordinator) and QMA 3 were observed serving food from the steam table. Their hair was not covered with a hair net. During an interview on 7/28/21 at 2:20 p.m., the DM (Dietary Manager) indicated that hair nets should be worn when serving food. On 7/25/21 at 2:43 p.m., the Executive Director provided the current Hair Restraint Policy which read "...Policy: It is the policy of this community that all dietary staff shall wear hair restraints (hairnets), including beard restraints if applicable, while in the kitchen and preparing meals." Based on observation and interview the facility failed to assure that hair restraints were worn while serving food from a steam table with the potential to affect 24 of 87 residents residing at the facility. Findings include: On 7/28/21 at 11:15 a.m., the 2nd floor memory care unit lunch service was observed. QMA (Qualified Medication Aide) 10 was serving food from the steam table. Her hair was not covered with a hair net.		3. Staff in-serviced on proper use of hair nets and the community's policy of hair restraints. In addition, the Dietary Manager or designee will monitor daily that hair nets are worn. 4. The Executive Director or designee will monitor daily for four weeks then six months thereafter to ensure hair nets are worn. 5. Systemic changes: August 27, 2021	

	On 7/28/21 at 11:35 a.m., the 1st floor memory care unit lunch service was observed. MC (Memory Care Coordinator) and QMA 3 were observed serving food from the steam table. Their hair was not covered with a hair net. During an interview on 7/28/21 at 2:20 p.m., the DM (Dietary Manager) indicated that hair nets should be worn when serving food. On 7/25/21 at 2:43 p.m., the Executive Director provided the current Hair Restraint Policy which read "...Policy: It is the policy of this community that all dietary staff shall wear hair restraints (hairnets), including beard restraints if applicable, while in the kitchen and preparing meals."			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use.	R 0301	**R 301** 1. The Diclofenac tube is labeled with the resident's name, physician's name, the prescription number, the date of issue and the name and address of the pharmacy that filled the prescription. 2. The	08/27/2021

	(F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to ensure the proper labeling of medications stored in 1 of 2 medication carts reviewed for medication storage. Findings include: An observation of the medication cart labeled 2&3 was made on 7/29/21 at 12:02 p.m. with Qualified Medicine Aide (QMA) 4. In a bottom drawer of the medication cart, was an opened tube of Diclofenac Na (a topical pain reliever) 1% topical gel. The medication tube was separated from its box and/or baggie and did not have a pharmacy label affixed to the tube. The Diclofenac tube did not indicate the resident's name, physician's name, the prescription number, the date of issue nor the name and address of the pharmacy that filled the prescription. An interview with QMA 4 was conducted at the same time as		Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Staff in-serviced on the community's Storage of Medication policy, including proper labeling of stored medication. 4. The Wellness Director or designee will conduct weekly monitoring and then monthly thereafter of medication labeling. 5.Systemic changes: August 27, 2021	

	the observation. She indicated, she did not know to which resident the Diclofenac gel belonged to nor the date the medication tube had been opened. A Storage of Medication policy was received from DON (Director of Nursing) on 7/29/21 at 12:12 p.m. It indicated, "4. Topical and bottled medications must be stored separately in the medication room in locking cabinets above the counters. Ointments, creams, inhalers, eye or ear drops and nitroglycerin should be stored separately for each Resident in zip lock baggies or plastic baskets which are labeled with Resident's name and unit number..." Based on observation and interview, the facility failed to ensure the proper labeling of medications stored in 1 of 2 medication carts reviewed for medication storage. Findings include: An observation of the medication cart labeled 2&3 was made on 7/29/21 at 12:02 p.m. with Qualified Medicine Aide (QMA) 4. In a bottom drawer of the medication cart, was an opened tube of Diclofenac Na (a topical pain reliever) 1% topical gel. The medication tube was separated from its box and/or			

	baggie and did not have a pharmacy label affixed to the tube. The Diclofenac tube did not indicate the resident's name, physician's name, the prescription number, the date of issue nor the name and address of the pharmacy that filled the prescription. An interview with QMA 4 was conducted at the same time as the observation. She indicated, she did not know to which resident the Diclofenac gel belonged to nor the date the medication tube had been opened. A Storage of Medication policy was received from DON (Director of Nursing) on 7/29/21 at 12:12 p.m. It indicated, "4. Topical and bottled medications must be stored separately in the medication room in locking cabinets above the counters. Ointments, creams, inhalers, eye or ear drops and nitroglycerin should be stored separately for each Resident in zip lock baggies or plastic baskets which are labeled with Resident's name and unit number..."			
R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the	R 0302	**R 302** 1. The Community properly	08/27/2021

	following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to ensure over-the-counter medications were labeled with the resident's name, physician's name, expiration date, name of medication and medication strength in 2 of 2 medication carts observed for medication storage. Findings include: 1. An observation of the Memory Care unit medication cart was made on 7/29/21 at 10:45 a.m. with QMA (Qualified Medication Assistant) 3. The following was observed inside the medication cart: -An opened bottle of B12 1000 mcg(micrograms) capules without a resident nor a pharmacy label affixed. -An opened bottle of Acetaminophen 650 mg(milligrams) tablets without a resident nor pharmacy label affixed.		labeled over-the-counter medication on the med cart to include the resident’s name, physician’s name, expiration date, name of medication, and medication strength. 2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Staff were in-serviced properly labeling over-the-counter medication on the med cart to include the resident’s name, physician’s name, expiration date, name of medication, and medication strength. 4. The Wellness Director or designee will conduct weekly monitoring for four weeks then monthly thereafter for six months to ensure proper labeling of over-the-counter medication on the med cart includes the resident’s name, physician’s name, expiration date, name of	

	-A bottle of stool softener without a resident nor pharmacy label affixed. -A bottle of Calcium 600 mg + D3 tablets without a resident nor pharmacy label affixed. 2. An observation of Medication cart labeled 2&3 was made with QMA 4 on 7/29/21 at 12:02 p.m. Inside the medication cart the following was observed: -A bottle of PreserVision AREDS 2 (eye vitamins) without a resident nor pharmacy label affixed. -A bottle of acetaminophen 500 mg tablets without a resident nor pharmacy label affixed. An interview with DON (Director of Nursing) was conducted on 7/29/21 at 11:01 a.m. She indicated, all OTC medications should be labeled with the resident's name, physician's name, expiration date, name of medication and medication strength. Based on observation and interview, the facility failed to ensure over-the-counter medications were labeled with the resident's name, physician's name, expiration date, name of medication and medication strength in 2 of 2 medication carts observed for medication storage.		medication, and medication strength. 5. Systemic changes: August 27, 2021	

	Findings include: 1. An observation of the Memory Care unit medication cart was made on 7/29/21 at 10:45 a.m. with QMA (Qualified Medication Assistant) 3. The following was observed inside the medication cart: -An opened bottle of B12 1000 mcg(micrograms) capules without a resident nor a pharmacy label affixed. -An opened bottle of Acetaminophen 650 mg(milligrams) tablets without a resident nor pharmacy label affixed. -A bottle of stool softener without a resident nor pharmacy label affixed. -A bottle of Calcium 600 mg + D3 tablets without a resident nor pharmacy label affixed. 2. An observation of Medication cart labeled 2&3 was made with QMA 4 on 7/29/21 at 12:02 p.m. Inside the medication cart the following was observed: -A bottle of PreserVision AREDS 2 (eye vitamins) without a resident nor pharmacy label affixed. -A bottle of acetaminophen 500 mg tablets without a resident nor pharmacy label affixed.			

	An interview with DON (Director of Nursing) was conducted on 7/29/21 at 11:01 a.m. She indicated, all OTC medications should be labeled with the resident's name, physician's name, expiration date, name of medication and medication strength.			
R 0306	Pharmaceutical Services - Noncompliance 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.	R 0306	**R 306** 1. The Community disposed of unused medications, expired medications, and documented the disposition of any released, returned or destroyed medications. 2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Staff in-serviced on proper disposal of unused medications, expired medications, and documenting the disposition of any released, returned or destroyed	08/27/2021

	Based on observation, record review and interview, the facility failed to dispose of unused medications, expired medications, and failed to document the disposition of any released, returned or destroyed medications in the resident's clinical record for 3 of 3 residents during the observation for medication storage and 2 of 2 residents chosen for closed record review. (Residents 150, 70, 72, 88, and 89) Findings include: 1. An observation of the Memory Care unit medication cart was made on 7/29/21 at 10:45 a.m. with QMA (Qualified Medication Assistant) 3. In the medication cart was an opened vial of Haldol Decanoate. The medication vial had a pharmacy label affixed indicating it was for Resident 150. An interview with QMA 3 was conducted immediately following the observation. She indicated, Resident 150 was no longer a resident at the facility. The facility failed to remove the remaining unused Haldol vial from the medication cart for a discharged resident. 2. a. An observation of the Memory Care unit medication cart was made on 7/29/21 at		medications. 4. The Wellness Director or designee will conduct weekly monitoring for four weeks then monthly thereafter for six months to ensure proper disposal of unused medications, 5. expired medications, and documenting the disposition of any released, returned or destroyed medications. 6. Systemic changes: August 27, 2021	

	10:45 a.m. with QMA (Qualified Medication Assistant) 3. During the observation, the following medications inside the medication cart were observed to be expired: -A bottle of Warfarin (blood thinner) 2 mg (milligram) for Resident 70 with a pharmacy label affixed. The pharmacy label indicated a discard date of 11/28/20. -A bottle of Rosuvastatin (cholesterol medication) for Resident 72 with a pharmacy label affixed. The pharmacy label indicated a discard date of 9/30/20. b. An observation of Medication cart labeled 2&3 was made with QMA 4 on 7/29/21 at 12:02 p.m. Inside the medication cart was a bottle of Cephalaxin (an antibiotic) 500 mg for Resident 36 with a pharmacy label affixed. The pharmacy label indicated a discard date of 4/19/21. An interview with DON (Director of Nursing) was conducted on 7/29/21 at 11:01 a.m. She indicated, it was the responsibility of the night shift QMAs to perform a weekly audit on the medication carts to ensure medications of discharged residents and expired medications were removed from the medication			

carts.

3. a. The clinical record for Resident 88 was reviewed on 7/28/21. Resident 88's diagnoses included, but not limited to, pancreatitis, alcohol abuse, and diabetes type II. Resident 88 discharged from the facility on 4/30/21.

A Nursing note dated 4/30/21 at 2:30 p.m., indicated, "Family transporting resident to [name of another facility] today. All medications sent w/ [sic, with] daughter to [name of another facility].

The clinical record for Resident 88 failed to contain documentation of disposition of medications to include all the necessary information such as amount of and names of medications released.

b. The clinical record for Resident 89 was reviewed on 7/28/21. Resident 89's diagnoses included, but not limited to, end stage renal disease on dialysis, chronic obstructive pulmonary disease, hypertension, cerebral vascular accident (stroke), and chronic atrial fibrillation.

A Nursing note dated 5/31/21, 7 a.m. to 3 p.m., indicated, Resident 89 had a change in condition and was unable to ambulate with his walker, complained of dizziness and

had a temperature of 100.5. He was sent to the local hospital's ER (Emergency Room).

A Nursing note dated 6/4/21, 7 a.m. to 3 p.m., indicated, Resident 89's daughter informed the facility that Resident 89 was still at the local hospital, was now on hospice, and will not return to the facility.

A Medication Destruction Log dated 6/21/21 indicated, Nitroglycerin (heart medication) 0.4 mg (milligrams) tablets with a quantity of 25 tabs and Albuterol Sulfate HFA (breathing medication) 90 mg with a quantity of 8.5 gm (grams) were destroyed.

The clinical record for Resident 89 did not contain documentation of disposition for the following medications that Resident 89 was taking daily at the facility: pantoprazole (acid reflux medicine), calcitriol (calcium medication), aspirin, vitamin B-12, isosorbide mononitrate (medication for high blood pressure), atorvastatin (medication for high cholesterol), Plavix (anticoagulant), amlodipine (high blood pressure medication), Lantanoprost (glcucoma medication), vitamin C, and sevelamer (phosphate binder).

The clinical record for Resident

	89 did not contain documentation of disposition for the following medications that Resident 89 had for PRN (as needed) use at the facility: Immodium (antidiarrheal), Zofran (nausea medication), Duoneb (breathing medication), Proair (breathing medication), and Tylenol. An interview with DON was conducted on 7/28/21 at 3 p.m. She indicated, when a resident does not return to the facility from a hospitalization, the resident's medications at the facility are sent back to the pharmacy. There is a form which should be filled out with the necessary information for disposition of the medications. A copy of that form should have remained with the facility to place in the clinical record but, she was unable to locate a copy of that form. Based on observation, record review and interview, the facility failed to dispose of unused medications, expired medications, and failed to document the disposition of any released, returned or destroyed medications in the resident's clinical record for 3 of 3 residents during the observation for medication storage and 2 of 2 residents chosen for closed record review. (Residents 150, 70, 72, 88, and 89)			

Findings include:

1. An observation of the Memory Care unit medication cart was made on 7/29/21 at 10:45 a.m. with QMA (Qualified Medication Assistant) 3. In the medication cart was an opened vial of Haldol Decanoate. The medication vial had a pharmacy label affixed indicating it was for Resident 150.

An interview with QMA 3 was conducted immediately following the observation. She indicated, Resident 150 was no longer a resident at the facility.

The facility failed to remove the remaining unused Haldol vial from the medication cart for a discharged resident.

2. a. An observation of the Memory Care unit medication cart was made on 7/29/21 at 10:45 a.m. with QMA (Qualified Medication Assistant) 3. During the observation, the following medications inside the medication cart were observed to be expired:

-A bottle of Warfarin (blood thinner) 2 mg (milligram) for Resident 70 with a pharmacy label affixed. The pharmacy label indicated a discard date of 11/28/20.

-A bottle of Rosuvastatin (cholesterol medication) for Resident 72 with a pharmacy

label affixed. The pharmacy label indicated a discard date of 9/30/20.

b. An observation of Medication cart labeled 2&3 was made with QMA 4 on 7/29/21 at 12:02 p.m. Inside the medication cart was a bottle of Cephalaxin (an antibiotic) 500 mg for Resident 36 with a pharmacy label affixed. The pharmacy label indicated a discard date of 4/19/21.

An interview with DON (Director of Nursing) was conducted on 7/29/21 at 11:01 a.m. She indicated, it was the responsibility of the night shift QMAs to perform a weekly audit on the medication carts to ensure medications of discharged residents and expired medications were removed from the medication carts.

3. a. The clinical record for Resident 88 was reviewed on 7/28/21. Resident 88's diagnoses included, but not limited to, pancreatitis, alcohol abuse, and diabetes type II. Resident 88 discharged from the facility on 4/30/21.

A Nursing note dated 4/30/21 at 2:30 p.m., indicated, "Family transporting resident to [name of another facility] today. All medications sent w/ [sic, with] daughter to [name of another

facility].

The clinical record for Resident 88 failed to contain documentation of disposition of medications to include all the necessary information such as amount of and names of medications released.

b. The clinical record for Resident 89 was reviewed on 7/28/21. Resident 89's diagnoses included, but not limited to, end stage renal disease on dialysis, chronic obstructive pulmonary disease, hypertension, cerebral vascular accident (stroke), and chronic atrial fibrillation.

A Nursing note dated 5/31/21, 7 a.m. to 3 p.m., indicated, Resident 89 had a change in condition and was unable to ambulate with his walker, complained of dizziness and had a temperature of 100.5. He was sent to the local hospital's ER (Emergency Room).

A Nursing note dated 6/4/21, 7 a.m. to 3 p.m., indicated, Resident 89's daughter informed the facility that Resident 89 was still at the local hospital, was now on hospice, and will not return to the facility.

A Medication Destruction Log dated 6/21/21 indicated, Nitroglycerin (heart medication) 0.4 mg (milligrams) tablets with a quantity of 25 tabs and

	Albuterol Sulfate HFA (breathing medication) 90 mg with a quantity of 8.5 gm (grams) were destroyed. The clinical record for Resident 89 did not contain documentation of disposition for the following medications that Resident 89 was taking daily at the facility: pantoprazole (acid reflux medicine), calcitriol (calcium medication), aspirin, vitamin B-12, isosorbide mononitrate (medication for high blood pressure), atorvastatin (medication for high cholesterol), Plavix (anticoagulant), amlodipine (high blood pressure medication), Lantanoprost (glcucoma medication), vitamin C, and sevelamer (phosphate binder). The clinical record for Resident 89 did not contain documentation of disposition for the following medications that Resident 89 had for PRN (as needed) use at the facility: Immodium (antidiarrheal), Zofran (nausea medication), Duoneb (breathing medication), Proair (breathing medication), and Tylenol. An interview with DON was conducted on 7/28/21 at 3 p.m. She indicated, when a resident does not return to the facility from a hospitalization, the resident's medications at the			

	facility are sent back to the pharmacy. There is a form which should be filled out with the necessary information for disposition of the medications. A copy of that form should have remained with the facility to place in the clinical record but, she was unable to locate a copy of that form.			
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 interview and record review, the facility failed to accurately document a resident's transfer to an acute care hospital and fall information in the clinical record for 1 of 8 resident records reviewed (Resident 43). Findings include: The clinical record for Resident 43 was reviewed on 7/27/21 at	R 0349	**P 349** 1. Resident 43 clinical records were updated to reflect the residents transfer to an acute care hospital and fall information. 2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Staff in-serviced on clinical record documentation, including ensuring clinical records reflect residents’ transfers and fall information. 4. The	08/27/2021

	11:30 a.m. The Resident's diagnosis included, but were not limited to, heart failure and hypothyroidism. During an interview on 7/27/21 at 11:30 a.m., Resident 43 indicated she had a fall in the dining room on 7/26/21. A Nurse's Note, dated 7/5/21, indicated the night shift QMA (Qualified Medication Aide) had sent her to the hospital for a complaint of chest pain. A Nurse's Note, dated 7/27/21, indicated that the QMA had reported she had a fall in the dining room and had complained of minor pain in her right arm. The clinical record did not contain information that she had fallen on 7/26/21. During an interview on 7/27/21 at 2:20 p.m., LPN (Licensed Practical Nurse) indicated that Resident 43 had fallen on 7/26/21 while the QMA was on duty. An incident report had been filled out. The normal procedure was for the QMA on duty to fill out the incident report and the nurse would review the report and document in the clinical record. It was the facilities preference that the QMA's did not document in the clinical record.		Wellness Director or designee will conduct weekly monitoring for four weeks then monthly thereafter for six months to ensure proper clinical record documentation. 5. Systemic changes: August 27, 2021	

	During an interview on 7/28/21 at 2:55 p.m., QMA 6 indicated she had been had sent Resident 43 to the hospital at around 6:00 a.m. on 7/5/21. She had answered her call light and found her on the couch, holding her chest. She complained that her chest hurt really bad, and she was moaning in pain. When she found her like that, she had contacted the power of attorney and called 911 to transport her to the emergency room. She had attempted to prepare transfer paperwork to send with her, but the EMT's (Emergency Medical Technicians) had left with her before she could give them the paperwork. She had called the hospital to let them know she was on her way there and that she did not have any transfer paperwork with her. She had documented this on the 24-hour report sheet. She was also on duty when she fell in the dining room on 7/26/21 at 4:32 p.m. She had been called to the dining room and had found her on the floor. She had complained of some minor pain in her right arm. She had been able to move her extremities and denied injury. She had completed an incident report about the event but had not documented the fall in the clinical record. During an interview on 7/29/21 at 11:11 a.m., the ED (Executive Director) indicated the incident			

reports were not a part of the clinical record.

During an interview on 7/29/21 at 1:10 p.m., the DON indicated she had been at the facility when Resident 43 fell on 7/26/21. She had not documented that she had informed the physician of the fall.

On 7/28/21 at 9:30 a.m., the DON provided the current Qualified Medication Aide Scope of Practice Policy which read "...The following tasks are within the scope of practice for the QMA unless prohibited by facility policy...24) Document in the clinical record the QMA observations, including what the QMA sees, hears, or smells and document what is reported to the QMA by the resident..."

Based on interview and record review, the facility failed to accurately document a resident's transfer to an acute care hospital and fall information in the clinical record for 1 of 8 resident records reviewed (Resident 43).

Findings include:

The clinical record for Resident 43 was reviewed on 7/27/21 at 11:30 a.m. The Resident's diagnosis included, but were not limited to, heart failure and hypothyroidism.

During an interview on 7/27/21 at 11:30 a.m., Resident 43 indicated she had a fall in the dining room on 7/26/21.

A Nurse's Note, dated 7/5/21, indicated the night shift QMA (Qualified Medication Aide) had sent her to the hospital for a complaint of chest pain.

A Nurse's Note, dated 7/27/21, indicated that the QMA had reported she had a fall in the dining room and had complained of minor pain in her right arm.

The clinical record did not contain information that she had fallen on 7/26/21.

During an interview on 7/27/21 at 2:20 p.m., LPN (Licensed Practical Nurse) indicated that Resident 43 had fallen on 7/26/21 while the QMA was on duty. An incident report had been filled out.

The normal procedure was for the QMA on duty to fill out the incident report and the nurse would review the report and document in the clinical record. It was the facilities preference that the QMA's did not document in the clinical record.

During an interview on 7/28/21 at 2:55 p.m., QMA 6 indicated she had been had sent Resident 43 to the hospital at around 6:00 a.m. on 7/5/21. She

	had answered her call light and found her on the couch, holding her chest. She complained that her chest hurt really bad, and she was moaning in pain. When she found her like that, she had contacted the power of attorney and called 911 to transport her to the emergency room. She had attempted to prepare transfer paperwork to send with her, but the EMT's (Emergency Medical Technicians) had left with her before she could give them the paperwork. She had called the hospital to let them know she was on her way there and that she did not have any transfer paperwork with her. She had documented this on the 24-hour report sheet. She was also on duty when she fell in the dining room on 7/26/21 at 4:32 p.m. She had been called to the dining room and had found her on the floor. She had complained of some minor pain in her right arm. She had been able to move her extremities and denied injury. She had completed an incident report about the event but had not documented the fall in the clinical record. During an interview on 7/29/21 at 11:11 a.m., the ED (Executive Director) indicated the incident reports were not a part of the clinical record. During an interview on 7/29/21 at 1:10 p.m., the DON indicated			

	she had been at the facility when Resident 43 fell on 7/26/21. She had not documented that she had informed the physician of the fall. On 7/28/21 at 9:30 a.m., the DON provided the current Qualified Medication Aide Scope of Practice Policy which read "...The following tasks are within the scope of practice for the QMA unless prohibited by facility policy...24) Document in the clinical record the QMA observations, including what the QMA sees, hears, or smells and document what is reported to the QMA by the resident..."			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills.	R 0383	**R 383** 1. Resident 28 will have a comprehensive care plan developed in cooperation with a mental health service provider. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice.	08/27/2021

	(C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to ensure a resident with a major mental illness had a comprehensive care plan developed in cooperation with a mental health service provider for 1 of 1 resident reviewed with a serious mental illness. (Resident 28) Findings include: The clinical record for Resident 28 was reviewed on 7/27/21 at 2:00 p.m. The diagnoses included, but were not limited to, schizophrenia. She was admitted to the facility on 12/3/18, and received a Medicaid waiver. The physician's orders and MARs (medication administration records) indicated Resident 28 was currently taking 2 mg of Risperidone (antipsychotic medication) every evening related to her schizophrenia, and had been since 2019. The 2/6/20, 3/12/20, and 10/14/20 behavioral health notes, from an outside provider the facility no longer utilized, all		3. Staff in-serviced on ensuring residents with a major mental illness has a comprehensive care plan developed in cooperation with a mental health service provider. 4. The Executive Director or designee will monitor care plans to ensure residents with a major mental illness has a comprehensive care plan developed in cooperation with a mental health service provider. 5. Systemic changes: August 27, 2021	

	indicated a primary diagnosis of schizophrenia and Resident 28 not actively participating in treatment. The 3/31/21 service plan indicated a diagnosis of schizophrenia under the diagnoses section, but was not developed in cooperation with a mental health service provider. An interview was conducted with the DON on 7/27/21 at 3:34 p.m. She indicated the mental health provider the facility utilized in 2020 stopped coming to the facility, and their replacement provider just started coming earlier this month, July, 2021. Resident 28's care plan was not developed with a mental health service provider, and the facility was not a part of their services, unless there was a medication change. The 7/21/21 initial psychiatric progress note from their new mental health service provider did not reference her diagnosis of schizophrenia or her use of Risperidone as a current psyche medication. An interview was conducted with the DON (Director of Nursing) on 7/28/21 at 10:30 a.m. She indicated they hadn't done a comprehensive care plan to address her schizophrenia specifically. They			

used a form upon admission to see if a resident had a psychiatric diagnosis to determine the need for contacting their mental health provider for services, but she had not been care planning it. The facility had no policy referencing residents with a serious mental illness.

Based on interview and record review, the facility failed to ensure a resident with a major mental illness had a comprehensive care plan developed in cooperation with a mental health service provider for 1 of 1 resident reviewed with a serious mental illness. (Resident 28)

Findings include:

The clinical record for Resident 28 was reviewed on 7/27/21 at 2:00 p.m. The diagnoses included, but were not limited to, schizophrenia. She was admitted to the facility on 12/3/18, and received a Medicaid waiver.

The physician's orders and MARs (medication administration records) indicated Resident 28 was currently taking 2 mg of Risperidone (antipsychotic medication) every evening related to her schizophrenia, and had been since 2019.

The 2/6/20, 3/12/20, and

	10/14/20 behavioral health notes, from an outside provider the facility no longer utilized, all indicated a primary diagnosis of schizophrenia and Resident 28 not actively participating in treatment. The 3/31/21 service plan indicated a diagnosis of schizophrenia under the diagnoses section, but was not developed in cooperation with a mental health service provider. An interview was conducted with the DON on 7/27/21 at 3:34 p.m. She indicated the mental health provider the facility utilized in 2020 stopped coming to the facility, and their replacement provider just started coming earlier this month, July, 2021. Resident 28's care plan was not developed with a mental health service provider, and the facility was not a part of their services, unless there was a medication change. The 7/21/21 initial psychiatric progress note from their new mental health service provider did not reference her diagnosis of schizophrenia or her use of Risperidone as a current psyche medication. An interview was conducted with the DON (Director of Nursing) on 7/28/21 at 10:30 a.m. She indicated they hadn't			

	done a comprehensive care plan to address her schizophrenia specifically. They used a form upon admission to see if a resident had a psychiatric diagnosis to determine the need for contacting their mental health provider for services, but she had not been care planning it. The facility had no policy referencing residents with a serious mental illness.			
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, interview, and record review, the facility failed to maintain an infection control program by a licensed nurse not wiping the	R 0407	**R 407** 1. QMA 10 was in-serviced on hand hygiene and changing gloves. The Community will ensure COVID-19 screenings forms contained a signature of the screener. The Community will screen non-vaccinated residents for signs or symptoms of COVID-19 as directed by the Indiana Department of Health guidelines dated July 23, 2021, *"…should take everyday preventive measures to help contain the spread of COVID-19*". LPN 5 was in-serviced on wiping the rubber stopper on the insulin pen prior to attaching the sterile 2.	08/27/2021

	rubber stopper of an insulin pen with an alcohol swab prior to attaching the disposable, sterile needle for 1 of 2 residents reviewed for insulin administration; not performing hand hygiene prior to administration of a medication; handling a medication cup improperly for 1 of 5 residents reviewed for medication administration; not assuring staff performed hand hygiene prior to donning disposable gloves to serve a meal; not assuring a staff member was screened for Covid 19 prior to working, affecting 1 of 3 staff members reviewed for Covid 19 screening (CNA 11), and not monitoring non-vaccinated residents for signs and symptoms of Covid 19 daily affecting 3 of 3 residents reviewed for monitoring of Covid 19 (Residents 20, 56, 68, 72, and 78) Findings include: 1. On 7/28/21 at 11:15 a.m., the lunch service on the 2nd floor of the memory care unit was observed. There were 8 residents in the dining room eating their lunch. QMA 10 dished a plate of chicken alfredo with noodles onto a plate and took it to a resident who was sitting in the dining room. She was wearing a pair of disposable gloves. She then assisted a resident to push her		1. needle to the pen. QMA 4 was in-serviced on hand hygiene prior to preparing to dispense medications. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Staff in-serviced on maintaining infection control program, including sanitizing needles, hand hygiene, proper hygiene while preparing to dispense medications. 4. The Wellness Director or designee will conduct weekly monitoring for four weeks then monthly thereafter for six months to ensure proper infection control. 5. Systemic changes: August 27, 2021	

chair closer to the table, using her right hand, and adjusted the resident's silverware on her plate. She patted the resident's arm with her right hand and returned to the kitchen area. She removed her right glove and replaced it with a new disposable glove. She did not change her left glove and did not perform hand hygiene prior to donning the new right glove. She then went to the steam table and continued to serve lunch.

During an interview on 7/28/21 at 11:25 a.m., QMA 10 indicated she normally got the residents into the dining room and then washed her hands and put on gloves prior to serving the meals.

2. On 7/29/21 at 10:20 a.m., CNA (Certified Nursing Assistance) 11's Covid-19 screenings forms for 7/14/21 through 7/29/21 were reviewed. The screening forms did not contain a signature of the screener for 7/19/21, 7/20/21, 7/22/21, 7/23/21, and 7/23/21.

During an interview on 7/29/21 at 10:40 a.m., Receptionist 2 indicated that the staff member who opens the door for the employee is the one who is responsible for filling out and signing the screening form.

During an interview on 7/29/21

at 11:10 a.m., the DON (Director of Nursing) indicated that it is the expectation that staff are screened prior to work by another employee. They should not screen themselves.

3. The clinical record for Resident 68 was reviewed on 7/28/21 at 10:20 a.m. The Resident's diagnosis included, but were not limited to, dementia and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 68 was on the list.

4. The clinical record for Resident 72 was reviewed on 7/29/21 at 12:10 p.m. The Resident's diagnosis included, but were not limited to, memory loss and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 72 was on the list.

5. The clinical record for Resident 80 was reviewed on 7/29/21 at 12:15 p.m. The Resident's diagnosis included, but were not limited to, dementia and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 80 was on the list.

During an interview on 7/28/21 at 11:40 a.m., the DON indicated she believed that residents no longer needed to be monitored daily for signs or symptoms of Covid 19.

On 7/28/21 at 3:00 p.m., the Executive Director provided the current Handwashing/ Hand Hygiene Policy which read " ...Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...Before and after direct resident contact...Before and after eating or handling

food (hand washing with soap and water) ..."

On 7/29/21 at 11:40 a.m., the COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 7/23/21, was retrieved from the Indiana Department of Health website. It reads as follows "...Long-term care centers should take everyday preventive measures to help contain the spread of COVID-19. Actively screen all healthcare personnel (HCP), visitors, vendors entering the facility for symptoms of COVID 19 and any history of being a close contact or exposed to COVID 19 positive or symptomatic person...Unvaccinated residents require once-daily assessment for COVID-19..."

6. An observation was made of LPN (Licensed Practical Nurse) 5 on 7/29/21 at 11:45 a.m. LPN 5, in preparation to administer Humalog (insulin) to Resident 20, performed hand hygiene, donned a clean pair of gloves, removed the cap of the insulin pen, and then attached the sterile needle to the insulin pen. She then wasted a couple units of insulin, dialed up Resident 20's ordered doses of insulin, and administered the insulin.

LPN failed to wipe the rubber stopper on the insulin pen prior to attaching the sterile needle to

the pen.

An interview with LPN 5 was conducted immediately following the observation. LPN 5 indicated, she had indeed forgot to wipe the stopper prior to attaching the needle.

An insulin pen instruction sheet was provided by DON (Director of Nursing) on 7/29/21 at 1:09 p.m. It indicated, "A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab."

7. An observation was made of QMA (Qualified Medication Assistant) 4 on 7/28/21 at 11:33 a.m. QMA 4 walked up to the medication cart with Resident 56. She unlocked and opened her medication cart, pulled out Resident 56's medications and closed the drawer on the medication cart. QMA 4 proceeded to open the plastic package containing Resident 56's medications and dumped them into a plastic medication cup. QMA 4 gripped the medication cup by placing her index finger inside the medication cup and pinching it with her thumb. QMA 4 had not performed hand hygiene prior to preparing to dispense the medications.

A Handwashing/Hand Hygiene policy was received on 7/28/21 from ED (Executive Director) at 3:09 p.m. The policy indicated,

"...In, most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visible soiled, use and alcohol-based hand rub containing 60-95% ethanol or isopropanol [types of alcohol] for all the following situations:

Before donning sterile gloves;

Before performing any nonsurgical invasive procedures;

Before preparing or handling medications;...

After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident..."

An interview with DON was conducted on 7/28/21 at 11:48 p.m. She indicated, medication cups should be handled in such a way as to not touch the inside of the cup or in any place a resident's lips may touch.

Based on observation, interview, and record review, the facility failed to maintain an infection control program by a licensed nurse not wiping the rubber stopper of an insulin pen with an alcohol swab prior to attaching the disposable, sterile needle for 1 of 2 residents reviewed for insulin administration; not performing hand hygiene prior to

administration of a medication; handling a medication cup improperly for 1 of 5 residents reviewed for medication administration; not assuring staff performed hand hygiene prior to donning disposable gloves to serve a meal; not assuring a staff member was screened for Covid 19 prior to working, affecting 1 of 3 staff members reviewed for Covid 19 screening (CNA 11), and not monitoring non-vaccinated residents for signs and symptoms of Covid 19 daily affecting 3 of 3 residents reviewed for monitoring of Covid 19 (Residents 20, 56, 68, 72, and 78)

Findings include:

1. On 7/28/21 at 11:15 a.m., the lunch service on the 2nd floor of the memory care unit was observed. There were 8 residents in the dining room eating their lunch. QMA 10 dished a plate of chicken alfredo with noodles onto a plate and took it to a resident who was sitting in the dining room. She was wearing a pair of disposable gloves. She then assisted a resident to push her chair closer to the table, using her right hand, and adjusted the resident's silverware on her plate. She patted the resident's arm with her right hand and returned to the kitchen area. She removed her right glove

and replaced it with a new disposable glove. She did not change her left glove and did not perform hand hygiene prior to donning the new right glove. She then went to the steam table and continued to serve lunch.

During an interview on 7/28/21 at 11:25 a.m., QMA 10 indicated she normally got the residents into the dining room and then washed her hands and put on gloves prior to serving the meals.

2. On 7/29/21 at 10:20 a.m., CNA (Certified Nursing Assistance) 11's Covid-19 screenings forms for 7/14/21 through 7/29/21 were reviewed. The screening forms did not contain a signature of the screener for 7/19/21, 7/20/21, 7/22/21, 7/23/21, and 7/23/21.

During an interview on 7/29/21 at 10:40 a.m., Receptionist 2 indicated that the staff member who opens the door for the employee is the one who is responsible for filling out and signing the screening form.

During an interview on 7/29/21 at 11:10 a.m., the DON (Director of Nursing) indicated that it is the expectation that staff are screened prior to work by another employee. They should not screen themselves.

3. The clinical record for

Resident 68 was reviewed on 7/28/21 at 10:20 a.m. The Resident's diagnosis included, but were not limited to, dementia and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 68 was on the list.

4. The clinical record for Resident 72 was reviewed on 7/29/21 at 12:10 p.m. The Resident's diagnosis included, but were not limited to, memory loss and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 72 was on the list.

5. The clinical record for Resident 80 was reviewed on 7/29/21 at 12:15 p.m. The Resident's diagnosis included, but were not limited to, dementia and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 80 was on the list.

During an interview on 7/28/21 at 11:40 a.m., the DON indicated she believed that residents no longer needed to be monitored daily for signs or symptoms of Covid 19.

On 7/28/21 at 3:00 p.m., the Executive Director provided the current Handwashing/ Hand Hygiene Policy which read " ...Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...Before and after direct resident contact...Before and after eating or handling food (hand washing with soap and water) ..."

On 7/29/21 at 11:40 a.m., the COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 7/23/21, was retrieved from the Indiana Department of Health website. It reads as follows "...Long-term care centers should take everyday preventive

measures to help contain the spread of COVID-19. Actively screen all healthcare personnel (HCP), visitors, vendors entering the facility for symptoms of COVID 19 and any history of being a close contact or exposed to COVID 19 positive or symptomatic person...Unvaccinated residents require once-daily assessment for COVID-19..."

6. An observation was made of LPN (Licensed Practical Nurse) 5 on 7/29/21 at 11:45 a.m. LPN 5, in preparation to administer Humalog (insulin) to Resident 20, performed hand hygiene, donned a clean pair of gloves, removed the cap of the insulin pen, and then attached the sterile needle to the insulin pen. She then wasted a couple units of insulin, dialed up Resident 20's ordered doses of insulin, and administered the insulin.

LPN failed to wipe the rubber stopper on the insulin pen prior to attaching the sterile needle to the pen.

An interview with LPN 5 was conducted immediately following the observation. LPN 5 indicated, she had indeed forgot to wipe the stopper prior to attaching the needle.

An insulin pen instruction sheet was provided by DON (Director of Nursing) on 7/29/21 at 1:09

p.m. It indicated, "A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab."

7. An observation was made of QMA (Qualified Medication Assistant) 4 on 7/28/21 at 11:33 a.m. QMA 4 walked up to the medication cart with Resident 56. She unlocked and opened her medication cart, pulled out Resident 56's medications and closed the drawer on the medication cart. QMA 4 proceeded to open the plastic package containing Resident 56's medications and dumped them into a plastic medication cup. QMA 4 gripped the medication cup by placing her index finger inside the medication cup and pinching it with her thumb. QMA 4 had not performed hand hygiene prior to preparing to dispense the medications.

A Handwashing/Hand Hygiene policy was received on 7/28/21 from ED (Executive Director) at 3:09 p.m. The policy indicated, "...In, most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visible soiled, use and alcohol-based hand rub containing 60-95% ethanol or isopropanol [types of alcohol] for all the following situations:

Before donning sterile gloves;

Before performing any nonsurgical invasive procedures;

Before preparing or handling medications;...

After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident..."

An interview with DON was conducted on 7/28/21 at 11:48 p.m. She indicated, medication cups should be handled in such a way as to not touch the inside of the cup or in any place a resident's lips may touch.

Based on observation, interview, and record review, the facility failed to maintain an infection control program by a licensed nurse not wiping the rubber stopper of an insulin pen with an alcohol swab prior to attaching the disposable, sterile needle for 1 of 2 residents reviewed for insulin administration; not performing hand hygiene prior to administration of a medication; handling a medication cup improperly for 1 of 5 residents reviewed for medication administration; not assuring staff performed hand hygiene prior to donning disposable gloves to serve a meal; not assuring a staff member was screened for Covid 19 prior to working, affecting 1 of 3 staff members

reviewed for Covid 19 screening (CNA 11), and not monitoring non-vaccinated residents for signs and symptoms of Covid 19 daily affecting 3 of 3 residents reviewed for monitoring of Covid 19 (Residents 20, 56, 68, 72, and 78)

Findings include:

1. On 7/28/21 at 11:15 a.m., the lunch service on the 2nd floor of the memory care unit was observed. There were 8 residents in the dining room eating their lunch. QMA 10 dished a plate of chicken alfredo with noodles onto a plate and took it to a resident who was sitting in the dining room. She was wearing a pair of disposable gloves. She then assisted a resident to push her chair closer to the table, using her right hand, and adjusted the resident's silverware on her plate. She patted the resident's arm with her right hand and returned to the kitchen area. She removed her right glove and replaced it with a new disposable glove. She did not change her left glove and did not perform hand hygiene prior to donning the new right glove. She then went to the steam table and continued to serve lunch.

During an interview on 7/28/21 at 11:25 a.m., QMA 10 indicated

she normally got the residents into the dining room and then washed her hands and put on gloves prior to serving the meals.

2. On 7/29/21 at 10:20 a.m., CNA (Certified Nursing Assistance) 11's Covid-19 screenings forms for 7/14/21 through 7/29/21 were reviewed. The screening forms did not contain a signature of the screener for 7/19/21, 7/20/21, 7/22/21, 7/23/21, and 7/23/21.

During an interview on 7/29/21 at 10:40 a.m., Receptionist 2 indicated that the staff member who opens the door for the employee is the one who is responsible for filling out and signing the screening form.

During an interview on 7/29/21 at 11:10 a.m., the DON (Director of Nursing) indicated that it is the expectation that staff are screened prior to work by another employee. They should not screen themselves.

3. The clinical record for Resident 68 was reviewed on 7/28/21 at 10:20 a.m. The Resident's diagnosis included, but were not limited to, dementia and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 68 was on the list.

4. The clinical record for Resident 72 was reviewed on 7/29/21 at 12:10 p.m. The Resident's diagnosis included, but were not limited to, memory loss and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 72 was on the list.

5. The clinical record for Resident 80 was reviewed on 7/29/21 at 12:15 p.m. The Resident's diagnosis included, but were not limited to, dementia and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 80 was on the list.

During an interview on 7/28/21 at 11:40 a.m., the DON indicated she believed that residents no longer needed to be monitored daily for signs or symptoms of Covid 19.

On 7/28/21 at 3:00 p.m., the Executive Director provided the current Handwashing/ Hand Hygiene Policy which read " ...Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...Before and after direct resident contact...Before and after eating or handling food (hand washing with soap and water) ..."

On 7/29/21 at 11:40 a.m., the COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 7/23/21, was retrieved from the Indiana Department of Health website. It reads as follows "...Long-term care centers should take everyday preventive measures to help contain the spread of COVID-19. Actively screen all healthcare personnel (HCP), visitors, vendors entering the facility for symptoms of COVID 19 and any

history of being a close contact or exposed to COVID 19 positive or symptomatic person...Unvaccinated residents require once-daily assessment for COVID-19..."

6. An observation was made of LPN (Licensed Practical Nurse) 5 on 7/29/21 at 11:45 a.m. LPN 5, in preparation to administer Humalog (insulin) to Resident 20, performed hand hygiene, donned a clean pair of gloves, removed the cap of the insulin pen, and then attached the sterile needle to the insulin pen. She then wasted a couple units of insulin, dialed up Resident 20's ordered doses of insulin, and administered the insulin.

LPN failed to wipe the rubber stopper on the insulin pen prior to attaching the sterile needle to the pen.

An interview with LPN 5 was conducted immediately following the observation. LPN 5 indicated, she had indeed forgot to wipe the stopper prior to attaching the needle.

An insulin pen instruction sheet was provided by DON (Director of Nursing) on 7/29/21 at 1:09 p.m. It indicated, "A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab."

7. An observation was made of QMA (Qualified Medication Assistant) 4 on 7/28/21 at 11:33

a.m. QMA 4 walked up to the medication cart with Resident 56. She unlocked and opened her medication cart, pulled out Resident 56's medications and closed the drawer on the medication cart. QMA 4 proceeded to open the plastic package containing Resident 56's medications and dumped them into a plastic medication cup. QMA 4 gripped the medication cup by placing her index finger inside the medication cup and pinching it with her thumb. QMA 4 had not performed hand hygiene prior to preparing to dispense the medications.

A Handwashing/Hand Hygiene policy was received on 7/28/21 from ED (Executive Director) at 3:09 p.m. The policy indicated, "...In, most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visible soiled, use and alcohol-based hand rub containing 60-95% ethanol or isopropanol [types of alcohol] for all the following situations:

Before donning sterile gloves;

Before performing any nonsurgical invasive procedures;

Before preparing or handling medications;...

After contact with objects (e.g.,

medical equipment) in the immediate vicinity of the resident..."

An interview with DON was conducted on 7/28/21 at 11:48 p.m. She indicated, medication cups should be handled in such a way as to not touch the inside of the cup or in any place a resident's lips may touch.

Based on observation, interview, and record review, the facility failed to maintain an infection control program by a licensed nurse not wiping the rubber stopper of an insulin pen with an alcohol swab prior to attaching the disposable, sterile needle for 1 of 2 residents reviewed for insulin administration; not performing hand hygiene prior to administration of a medication; handling a medication cup improperly for 1 of 5 residents reviewed for medication administration; not assuring staff performed hand hygiene prior to donning disposable gloves to serve a meal; not assuring a staff member was screened for Covid 19 prior to working, affecting 1 of 3 staff members reviewed for Covid 19 screening (CNA 11), and not monitoring non-vaccinated residents for signs and symptoms of Covid 19 daily affecting 3 of 3 residents reviewed for monitoring of Covid 19 (Residents 20, 56, 68, 72, and

78)

Findings include:

1. On 7/28/21 at 11:15 a.m., the lunch service on the 2nd floor of the memory care unit was observed. There were 8 residents in the dining room eating their lunch. QMA 10 dished a plate of chicken alfredo with noodles onto a plate and took it to a resident who was sitting in the dining room. She was wearing a pair of disposable gloves. She then assisted a resident to push her chair closer to the table, using her right hand, and adjusted the resident's silverware on her plate. She patted the resident's arm with her right hand and returned to the kitchen area. She removed her right glove and replaced it with a new disposable glove. She did not change her left glove and did not perform hand hygiene prior to donning the new right glove. She then went to the steam table and continued to serve lunch.

During an interview on 7/28/21 at 11:25 a.m., QMA 10 indicated she normally got the residents into the dining room and then washed her hands and put on gloves prior to serving the meals.

2. On 7/29/21 at 10:20 a.m., CNA (Certified Nursing

Assistance) 11's Covid-19 screenings forms for 7/14/21 through 7/29/21 were reviewed. The screening forms did not contain a signature of the screener for 7/19/21, 7/20/21, 7/22/21, 7/23/21, and 7/23/21.

During an interview on 7/29/21 at 10:40 a.m., Receptionist 2 indicated that the staff member who opens the door for the employee is the one who is responsible for filling out and signing the screening form.

During an interview on 7/29/21 at 11:10 a.m., the DON (Director of Nursing) indicated that it is the expectation that staff are screened prior to work by another employee. They should not screen themselves.

3. The clinical record for Resident 68 was reviewed on 7/28/21 at 10:20 a.m. The Resident's diagnosis included, but were not limited to, dementia and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 68 was on the list.

4. The clinical record for

Resident 72 was reviewed on 7/29/21 at 12:10 p.m. The Resident's diagnosis included, but were not limited to, memory loss and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 72 was on the list.

5. The clinical record for Resident 80 was reviewed on 7/29/21 at 12:15 p.m. The Resident's diagnosis included, but were not limited to, dementia and diabetes.

The clinical record, including the July 2021 MARs (medication administration records), did not include daily monitoring for signs or symptoms of Covid 19.

The DON (Director of Nursing) provided a list of residents who had not been vaccinated for Covid 19. Resident 80 was on the list.

During an interview on 7/28/21 at 11:40 a.m., the DON indicated she believed that residents no longer needed to be monitored daily for signs or symptoms of Covid 19.

On 7/28/21 at 3:00 p.m., the Executive Director provided the current Handwashing/ Hand Hygiene Policy which read " ...Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...Before and after direct resident contact...Before and after eating or handling food (hand washing with soap and water) ..."

On 7/29/21 at 11:40 a.m., the COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 7/23/21, was retrieved from the Indiana Department of Health website. It reads as follows "...Long-term care centers should take everyday preventive measures to help contain the spread of COVID-19. Actively screen all healthcare personnel (HCP), visitors, vendors entering the facility for symptoms of COVID 19 and any history of being a close contact or exposed to COVID 19 positive or symptomatic person...Unvaccinated residents require once-daily assessment for COVID-19..."

6. An observation was made of LPN (Licensed Practical Nurse) 5 on 7/29/21 at 11:45 a.m. LPN 5, in preparation to administer Humalog (insulin) to Resident 20, performed hand hygiene,

donned a clean pair of gloves, removed the cap of the insulin pen, and then attached the sterile needle to the insulin pen. She then wasted a couple units of insulin, dialed up Resident 20's ordered doses of insulin, and administered the insulin.

LPN failed to wipe the rubber stopper on the insulin pen prior to attaching the sterile needle to the pen.

An interview with LPN 5 was conducted immediately following the observation. LPN 5 indicated, she had indeed forgot to wipe the stopper prior to attaching the needle.

An insulin pen instruction sheet was provided by DON (Director of Nursing) on 7/29/21 at 1:09 p.m. It indicated, "A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab."

7. An observation was made of QMA (Qualified Medication Assistant) 4 on 7/28/21 at 11:33 a.m. QMA 4 walked up to the medication cart with Resident 56. She unlocked and opened her medication cart, pulled out Resident 56's medications and closed the drawer on the medication cart. QMA 4 proceeded to open the plastic package containing Resident 56's medications and dumped them into a plastic medication cup. QMA 4 gripped the

medication cup by placing her index finger inside the medication cup and pinching it with her thumb. QMA 4 had not performed hand hygiene prior to preparing to dispense the medications.

A Handwashing/Hand Hygiene policy was received on 7/28/21 from ED (Executive Director) at 3:09 p.m. The policy indicated, "...In, most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visible soiled, use and alcohol-based hand rub containing 60-95% ethanol or isopropanol [types of alcohol] for all the following situations:

Before donning sterile gloves;

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Before preparing or handling medications;...

After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident..."

An interview with DON was conducted on 7/28/21 at 11:48 p.m. She indicated, medication cups should be handled in such a way as to not touch the inside of the cup or in any place a resident's lips may touch.

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