STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST, CHARLESTOWN, , 47111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey and the Investigation of Complaints IN00363395 and IN00363449. Complaint IN00363395 - Substantiated. State Residential Findings are cited at R241 and R243. Complaint IN00363449 - Substantiated. State Residential Findings are cited at R241, R243, R144 and R149. Survey dates: October 5 and 6, 2021 Facility number: 012007 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 13, 2021.	R 0000	To Whom it May Concern: Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit.	

R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure employees were oriented to their specific job	R 0123	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Employees reviewed during survey completed job specific orientation and signed job descriptions. 2. All employee personnel files are at risk of same alleged deficient practice. BOM/Designee has audited current employee personnel files for signed job descriptions and job specific orientation as of 11/8/21. 3. Staff have been in-serviced on job descriptions and the need to complete job specific orientation as of 10/13/2021. 4. BOM/Designee will audit new	11/08/2021

	duties and overall job description before beginning work in that 5 of 5 employee files reviewed were missing a Job Description and a Job Specific Orientation. (Maintenance, CNA 2, CNA 3, Cook 2, and LPN 2). Findings include: Review of the Employee Files on 10/5/21 at 1:30 p.m., indicated the following employees were missing a Job Description and Job Specific Orientation from their files: 1. The Maintenance Assistant was hired into the Maintenance department on 5/3/21. The employee's file lacked a Job Description and Job Specific Orientation form. 2. CNA (Certified Nurse Aide) 2 was hired into the Nursing Department on 8/28/21. The employee's file lacked a Job Description and Job Specific Orientation form. 3. CNA 3 was hired into the Nursing Department on 8/16/21. The employee's file lacked a Job Description and Job Specific Orientation form.		employee personnel files for completeness per following schedule: all new hires x4 weeks, 50% of new hires x4 weeks, 25% of new hires x4 weeks. 5. BOM/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

	4. Dietary Cook was hired into the Dietary Department on 7/5/21. The employee's file lacked a Job Description and Job Specific Orientation form. 5. LPN 2 was hired into the Nursing Department on 7/15/21. The employee's file lacked a Job Description and Job Specific Orientation form. On 10/6/21 at 9:40 a.m., the Assistant Director of Nursing (ADON) indicated that they are unable to locate a Specific Orientation and Job Description for those staff members. At 10:20 a.m., The ADON indicated the facility did not have a policy which addressed Employee Files. Based on record review and interview, the facility failed to ensure employees were oriented to their specific job duties and overall job description before beginning work in that 5 of 5 employee files reviewed were missing a Job Description and a Job Specific Orientation. (Maintenance, CNA 2, CNA 3, Cook 2, and LPN 2). Findings include: Review of the Employee Files on 10/5/21 at 1:30 p.m.,			

indicated the following employees were missing a Job Description and Job Specific Orientation from their files:

1. The Maintenance Assistant was hired into the Maintenance department on 5/3/21.

The employee's file lacked a Job Description and Job Specific Orientation form.

2. CNA (Certified Nurse Aide) 2 was hired into the Nursing Department on 8/28/21.

The employee's file lacked a Job Description and Job Specific Orientation form.

3. CNA 3 was hired into the Nursing Department on 8/16/21.

The employee's file lacked a Job Description and Job Specific Orientation form.

4. Dietary Cook was hired into the Dietary Department on 7/5/21.

The employee's file lacked a Job Description and Job Specific Orientation form.

5. LPN 2 was hired into the Nursing Department on 7/15/21.

The employee's file lacked a Job Description and Job Specific Orientation form.

On 10/6/21 at 9:40 a.m., the

	Assistant Director of Nursing (ADON) indicated that they are unable to locate a Specific Orientation and Job Description for those staff members. At 10:20 a.m., The ADON indicated the facility did not have a policy which addressed Employee Files.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, record review, and interview, the facility failed to ensure a clean and maintained environment for 3 of 4 residents reviewed for environment. (Resident's 4, 5, and 7) Findings include: 1. During an observation on 10/5/21 at 10:30 a.m., Resident 5's room was observed to have a foul, rancid odor of decaying food. There was a brown substance covering parts of the toilet, bathroom floor, the wall behind the bed, and the blinds in the bedroom. The couch was stained with various types of debris smeared into the	R 0144	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Resident assumed to be resident 5 had apartment deep cleaned and carpet shampooed. Resident assumed to be resident number 4 had carpet shampooed and carpet scheduled for replacement. Resident assumed to be resident 7 had corner protection placed in apartment in the	11/08/2021

	cushions. The trash cans were overflowing. There was loose uncovered decaying food in the refrigerator, including crushed unpackaged corn dogs. The strong foul odor could be observed flowing out into the hallway. During an interview on 10/5/21 at 10:31 a.m., the resident indicated staff did not clean his room. Someone came in and emptied the trash can, but they had not cleaned it. He tried to clean it some himself. The clinical record for Resident 5 was reviewed on 10/5/21 at 1:00 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, anemia, heart disease, dementia with behaviors, lack of coordination, and cognitive communication deficit. The most recent BIMS (Brief Interview of Mental Status) assessment, which was undated, indicated the resident was cognitively intact. The most current care plan, dated 7/29/21, indicated the resident required assistance with housekeeping, including dusting, vacuuming, and mopping floors. During an interview, on 10/5/21 at 10:39 a.m., Housekeeper 9 indicated she cleaned Resident 5's room once a week and it		location of wall damage and carpet/bathroom vinyl scheduled for replacement. 2. All residents are at risk of same alleged deficient practice. Audit of all occupied resident rooms for cleanliness and identification of repairs needed has been completed as of 10/27/21. 3. Staff in-serviced on resident room cleaning and identification of repairs on 10/13/21. New form to communicate possible repairs implemented with housekeeping staff. 4. Maintenance Director/Designee will conduct resident room inspections at random to ensure cleanliness and identify repairs needed 5 times weekly x1 month, and then 3 times weekly x2 months. 5. Maintenance Director/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

	was in that condition every week. There had been flies in the room for at least a couple of days. During an interview, on 10/5/21 at 10:40 a.m., the ED (Executive Director) indicated the policy was to clean resident rooms once weekly and if required more than once a week it would be added to their care plan. He did not believe anyone was refusing to clean the residents room. During an interview, on 10/5/21 at 10:45 a.m., Housekeeper 9 indicated nursing staff would not go in to Resident 5's room and get the trash daily. They only had two Housekeepers and they needed the aides to clean the trash. During a confidential interview, between 10/5/21 and 10/6/21, Staff B indicated they had brought the condition of Resident 5's room to the Executive Director in the past, and the DON had been made aware the prior week to look at the room, but they had not addressed it. During an interview, on 10/6/21 at 11:17 a.m., the ED indicated in Resident 5's room there was fecal matter on the walls, blinds, and toilets, and that was Nursing staff's responsibility to clean. That was a care related			

issue.

2. During an observation, on 10/5/21 at 10:49 a.m., of Resident 4's room the carpet was stained with various colors throughout the room. There were black, orange, and pink stains around the refrigerator. There was hardened, black debris caked into the carpet. The refrigerator interior was stained with food debris.

During an interview, on 10/5/21 at 10:50 a.m., Resident 4 indicated the floor was mildewed from moisture, especially around the air conditioner where it had leaked some time back.

The clinical record for Resident 4 was reviewed on 10/5/21 at 1:05 p.m. Diagnoses included, but were not limited to, paranoid schizophrenia, depression, anxiety, dementia, bipolar disorder, and Stage III renal failure.

The most recent BIMS (Brief Interview of Mental Status) assessment, dated 5/27/21, indicated the resident was cognitively intact.

The most current care plan, dated 7/29/21, indicated the resident's housekeeping needs would be met.

During an interview, on 10/5/21 at 10:41 a.m., the DON

	indicated she had been aware of the issue since the day prior. She had called his sister, and said they needed to get a plan. The resident was not cleaning it. He had been throwing stuff and missing the trash. They cleaned refrigerators as needed, but agreed Resident 4 needed to have his checked more frequently. During an interview, on 10/5/21 at 10:45 a.m., Housekeeper 9 indicated Resident 4's trash needed to be removed every day. Stuff got so caked on the resident's floor she had to clean it up with a scraper. During an interview, on 10/6/21 at 11:16 a.m., the ED indicated the carpets in Resident 4's room had been cleaned multiple times, the last time was about a month ago. 3. During an observation, on 10/5/21 at 11:32 a.m., Resident 7's room was observed to have a tear in the carpet, measuring approximately 2 feet long by 2 inches wide, and another rip measuring approximately 2.5 inches by 0.25 inches. The resident's walls were stained with a brown substance behind the head of his bed. There were gouges in the dry wall by cabinet and fridge by baseboard. The tile in the bathroom was cracked. The drywall in the bathroom was			

cracked, with exposed metal. The baseboard in bathroom was peeling. The baseboard behind the dresser was peeling. The door to patio was dirty, and stained black. The baseboard and wall by patio door were stained, and there were multiple areas of drywall damage.

During an interview, on 10/5/21 at 11:33 a.m., the resident indicated the carpets needed replaced and the walls needed painted. The facility had told him they would replace the carpets but they never had.

The clinical record for Resident 7 was reviewed on 10/5/21 at 1:10 p.m. Diagnoses included, but were not limited to

The most recent BIMS (Brief Interview of Mental Status) assessment, dated 3/8/21, indicated the resident was cognitively intact.

During an interview, on 10/6/21 at 11:18 a.m., the ED indicated if carpets were not cleanable, or were ripped as they were in Resident 7's room, they would need to be replaced. He was unaware of the drywall issues or the torn carpets. Staff should be helping with trash daily.

This State Residential Finding relates to Complaint IN00363449.

Based on observation, record

	review, and interview, the facility failed to ensure a clean and maintained environment for 3 of 4 residents reviewed for environment. (Resident's 4, 5, and 7) Findings include: 1. During an observation on 10/5/21 at 10:30 a.m., Resident 5's room was observed to have a foul, rancid odor of decaying food. There was a brown substance covering parts of the toilet, bathroom floor, the wall behind the bed, and the blinds in the bedroom. The couch was stained with various types of debris smeared into the cushions. The trash cans were overflowing. There was loose uncovered decaying food in the refrigerator, including crushed unpackaged corn dogs. The strong foul odor could be observed flowing out into the hallway. During an interview on 10/5/21 at 10:31 a.m., the resident indicated staff did not clean his room. Someone came in and emptied the trash can, but they had not cleaned it. He tried to clean it some himself. The clinical record for Resident 5 was reviewed on 10/5/21 at 1:00 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, anemia, heart disease,			

dementia with behaviors, lack of coordination, and cognitive communication deficit.

The most recent BIMS (Brief Interview of Mental Status) assessment, which was undated, indicated the resident was cognitively intact.

The most current care plan, dated 7/29/21, indicated the resident required assistance with housekeeping, including dusting, vacuuming, and mopping floors.

During an interview, on 10/5/21 at 10:39 a.m., Housekeeper 9 indicated she cleaned Resident 5's room once a week and it was in that condition every week. There had been flies in the room for at least a couple of days.

During an interview, on 10/5/21 at 10:40 a.m., the ED (Executive Director) indicated the policy was to clean resident rooms once weekly and if required more than once a week it would be added to their care plan. He did not believe anyone was refusing to clean the residents room.

During an interview, on 10/5/21 at 10:45 a.m., Housekeeper 9 indicated nursing staff would not go in to Resident 5's room and get the trash daily. They only had two Housekeepers and they needed the aides to clean the

trash.

During a confidential interview, between 10/5/21 and 10/6/21, Staff B indicated they had brought the condition of Resident 5's room to the Executive Director in the past, and the DON had been made aware the prior week to look at the room, but they had not addressed it.

During an interview, on 10/6/21 at 11:17 a.m., the ED indicated in Resident 5's room there was fecal matter on the walls, blinds, and toilets, and that was Nursing staff's responsibility to clean. That was a care related issue.

2. During an observation, on 10/5/21 at 10:49 a.m., of Resident 4's room the carpet was stained with various colors throughout the room. There were black, orange, and pink stains around the refrigerator. There was hardened, black debris caked into the carpet. The refrigerator interior was stained with food debris.

During an interview, on 10/5/21 at 10:50 a.m., Resident 4 indicated the floor was mildewed from moisture, especially around the air conditioner where it had leaked some time back.

The clinical record for Resident 4 was reviewed on 10/5/21 at

1:05 p.m. Diagnoses included, but were not limited to, paranoid schizophrenia, depression, anxiety, dementia, bipolar disorder, and Stage III renal failure.

The most recent BIMS (Brief Interview of Mental Status) assessment, dated 5/27/21, indicated the resident was cognitively intact.

The most current care plan, dated 7/29/21, indicated the resident's housekeeping needs would be met.

During an interview, on 10/5/21 at 10:41 a.m., the DON indicated she had been aware of the issue since the day prior. She had called his sister, and said they needed to get a plan. The resident was not cleaning it. He had been throwing stuff and missing the trash. They cleaned refrigerators as needed, but agreed Resident 4 needed to have his checked more frequently.

During an interview, on 10/5/21 at 10:45 a.m., Housekeeper 9 indicated Resident 4's trash needed to be removed every day. Stuff got so caked on the resident's floor she had to clean it up with a scraper.

During an interview, on 10/6/21 at 11:16 a.m., the ED indicated the carpets in Resident 4's room had been cleaned multiple

	times, the last time was about a month ago. 3. During an observation, on 10/5/21 at 11:32 a.m., Resident 7's room was observed to have a tear in the carpet, measuring approximately 2 feet long by 2 inches wide, and another rip measuring approximately 2.5 inches by 0.25 inches. The resident's walls were stained with a brown substance behind the head of his bed. There were gouges in the dry wall by cabinet and fridge by baseboard. The tile in the bathroom was cracked. The drywall in the bathroom was cracked, with exposed metal. The baseboard in bathroom was peeling. The baseboard behind the dresser was peeling. The door to patio was dirty, and stained black. The baseboard and wall by patio door were stained, and there were multiple areas of drywall damage. During an interview, on 10/5/21 at 11:33 a.m., the resident indicated the carpets needed replaced and the walls needed painted. The facility had told him they would replace the carpets but they never had. The clinical record for Resident 7 was reviewed on 10/5/21 at 1:10 p.m. Diagnoses included, but were not limited to The most recent BIMS (Brief			

	Interview of Mental Status) assessment, dated 3/8/21, indicated the resident was cognitively intact. During an interview, on 10/6/21 at 11:18 a.m., the ED indicated if carpets were not cleanable, or were ripped as they were in Resident 7's room, they would need to be replaced. He was unaware of the drywall issues or the torn carpets. Staff should be helping with trash daily. This State Residential Finding relates to Complaint IN00363449.			
R 0149	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(f) (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure a a resident's room was free of pests for 1 of 4 residents reviewed for environment. (Resident 5) Findings include: During an observation, on 10/5/21 at 10:30 a.m., Resident 5's room was observed to be filled with flies, too many to count. The trash cans were overflowing, with many flies	R 0149	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Resident assumed to be resident 5 had apartment professionally	10/27/2021

	observed swarming in and around the cans. The clinical record for Resident 5 was reviewed on 10/5/21 at 1:00 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, anemia, heart disease, dementia with behaviors, lack of coordination, and cognitive communication deficit. The most current care plan, dated 7/29/21, indicated the resident required assistance with general housekeeping. During an interview, on 10/5/21 at 10:39 a.m., Housekeeper 9 indicated there had been flies in the room for at least a couple of days. During an interview, on 10/5/21 at 10:41 a.m., the DON indicated she had been aware of the issue since the day prior. She had called his sister, and said they needed to get a plan. The resident was not cleaning it. He had been throwing stuff and missing the trash. They cleaned refrigerators as needed, but agreed Resident 5 needed to have his checked more frequently. During an interview, on 10/5/21 at 10:45 a.m., Housekeeper 9 indicated nursing staff would not go in and get the trash daily. They wouldn't go in the room because of the bugs. She		treated for flies and gnats. 2. All residents are at risk of same alleged deficient practice. Audit has been completed of all occupied resident rooms for signs of pests as of 10/27/21. 3. Staff in-serviced on pest control reporting requirements on 10/13/2021. Pest control log initiated. 4. ED/Designee will conduct resident room inspections at random to identify pest control issues 5 times weekly x1 month, and then 3 times weekly x2 months. 5. ED/Designee will review room inspection results with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review results monthly for duration of the extended timeframe as applicable.	

	sprayed the flies with window cleaner to try and kill them. During a confidential interview between 10/5/21 and 10/6/21, Staff B indicated the flies had been brought to managements attention the week prior, but they had not yet done anything for the bugs. Pest control had not yet been brought in. The ED had been approached about the room's condition in the past, and the DON had been informed the prior week to look in that room, but they had not addressed it. During an interview, on 10/6/21 at 11:16 a.m., the ED indicated he had reached out to the pest control company to see what they had treated on their last visit, but had not heard back from them. He believed they probably just did the hallways, unless otherwise instructed, and he had not asked the pest control company to spray Resident 5's room. They had a pest control log but it actually has not been utilized for over a year. The pest control company had a change in technicians and it fell off at some point. They have been coming in and spraying, but he didn't have documentation of what they actually did. This State Residential Finding relates to Complaint IN00363449.			

Based on observation, record review, and interview, the facility failed to ensure a a resident's room was free of pests for 1 of 4 residents reviewed for environment. (Resident 5)

Findings include:

During an observation, on 10/5/21 at 10:30 a.m., Resident 5's room was observed to be filled with flies, too many to count. The trash cans were overflowing, with many flies observed swarming in and around the cans.

The clinical record for Resident 5 was reviewed on 10/5/21 at 1:00 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, anemia, heart disease, dementia with behaviors, lack of coordination, and cognitive communication deficit.

The most current care plan, dated 7/29/21, indicated the resident required assistance with general housekeeping.

During an interview, on 10/5/21 at 10:39 a.m., Housekeeper 9 indicated there had been flies in the room for at least a couple of days.

During an interview, on 10/5/21 at 10:41 a.m., the DON indicated she had been aware of the issue since the day prior. She had called his sister, and

	said they needed to get a plan. The resident was not cleaning it. He had been throwing stuff and missing the trash. They cleaned refrigerators as needed, but agreed Resident 5 needed to have his checked more frequently. During an interview, on 10/5/21 at 10:45 a.m., Housekeeper 9 indicated nursing staff would not go in and get the trash daily. They wouldn't go in the room because of the bugs. She sprayed the flies with window cleaner to try and kill them. During a confidential interview between 10/5/21 and 10/6/21, Staff B indicated the flies had been brought to managements attention the week prior, but they had not yet done anything for the bugs. Pest control had not yet been brought in. The ED had been approached about the room's condition in the past, and the DON had been informed the prior week to look in that room, but they had not addressed it. During an interview, on 10/6/21 at 11:16 a.m., the ED indicated he had reached out to the pest control company to see what they had treated on their last visit, but had not heard back from them. He believed they probably just did the hallways, unless otherwise instructed, and he had not asked the pest control company to spray			

	Resident 5's room. They had a pest control log but it actually has not been utilized for over a year. The pest control company had a change in technicians and it fell off at some point. They have been coming in and spraying, but he didn't have documentation of what they actually did. This State Residential Finding relates to Complaint IN00363449.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure medication was administered by a qualified staff member for 1 of 3 residents reviewed for medication administration. (Resident 2) Findings include: During an interview on 10/5/21	R 0241	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Employee 8 has been educated on QMA scope including insulin administration. 2. All residents are at risk of same alleged	10/24/2021

	at 12:15 p.m., Resident 2 indicated QMA (Qualified Medication Aide) 8 administered to her the wrong insulin belonging to another resident. During an interview on 10/5/21 at 12:28 p.m., QMA 8 indicated she had administered insulin to Resident 2 on 9/28/21. She felt there was going to be a class offered at the facility on insulin injections for QMAs. She was not certified, but felt she needed to learn how to do it. During an interview on 10/5/21 at 12:40 p.m., the DON (Director of Nursing) indicated QMAs had to be trained on insulin injections before they could administer it. An LPN (Licensed Practical Nurse) or the DON would be called to administer the insulin otherwise. The QMA should not have administered the insulin to Resident 2. During an interview on 10/6/21 at 10:22 a.m., the ADON (Assistant Director of Nursing) indicated the facility followed the state regulations for QMA education on medication administration, but had no documented procedure for QMA medication administration. The Medication Administration-General Guidelines, revised January 2017, included, but was not limited to, "...B. Administration		deficient practice. Executive Director has Interviewed QMA 8 to identify if there were any other residents affected. Executive Director has determined this to be an isolated event. 3. QMA and LPN personnel have been in-serviced on QMA scope of practice on 10/13/21. 4. DON/Designee to audit current month Medication Administration Records at random 5x/week for 1 month, 3x/week for 1 month, and 1x/week for 1 month to ensure Insulin is administered by LPN. 5. DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

	1) Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medication..." The current QUALIFIED MEDICATION AIDE Scope of Practice from the https://www.in.gov/health/files/QMAScopeofPractice.pdf, included, but was not limited to, "...The following tasks shall NOT be included in the QMA scope of practice:(1) Administer medication by the injection route, including the following...(C) Subcutaneous route..." This State Residential Finding relates to IN00363395 and IN00363449 Based on record review and interview, the facility failed to ensure medication was administered by a qualified staff member for 1 of 3 residents reviewed for medication administration. (Resident 2) Findings include: During an interview on 10/5/21 at 12:15 p.m., Resident 2 indicated QMA (Qualified Medication Aide) 8 administered to her the wrong insulin belonging to another resident. During an interview on 10/5/21 at 12:28 p.m., QMA 8 indicated			

	she had administered insulin to Resident 2 on 9/28/21. She felt there was going to be a class offered at the facility on insulin injections for QMAs. She was not certified, but felt she needed to learn how to do it. During an interview on 10/5/21 at 12:40 p.m., the DON (Director of Nursing) indicated QMAs had to be trained on insulin injections before they could administer it. An LPN (Licensed Practical Nurse) or the DON would be called to administer the insulin otherwise. The QMA should not have administered the insulin to Resident 2. During an interview on 10/6/21 at 10:22 a.m., the ADON (Assistant Director of Nursing) indicated the facility followed the state regulations for QMA education on medication administration, but had no documented procedure for QMA medication administration. The Medication Administration-General Guidelines, revised January 2017, included, but was not limited to, "...B. Administration 1) Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medication..." The current QUALIFIED			

	MEDICATION AIDE Scope of Practice from the https://www.in.gov/health/files/QMAScopeofPractice.pdf, included, but was not limited to, "...The following tasks shall NOT be included in the QMA scope of practice:(1) Administer medication by the injection route, including the following...(C) Subcutaneous route..." This State Residential Finding relates to IN00363395 and IN00363449			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure insulin was administered to the correct resident during 1 of 3 residents reviewed for insulin administration. (Resident	R 0243	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Employee 8 has been educated on the 5 rights of resident medication administration. 2.	11/01/2021

	2) Findings include: During an interview on 10/5/21 at 12:15 p.m., Resident 2 indicated QMA (Qualified Medication Aide) 8 administered to her the wrong insulin belonging to another resident. The resident informed the QMA the insulin wasn't correct before the injection. She told her the pen wasn't hers. After the insulin was injected the QMA looked at the label and found that it wasn't the resident's. The resident administered most of her own medications. She indicated the QMA shouldn't have administered the Levemir flexpen. She was supposed to receive the Treciba flexpen. She recognized the Treciba by the color of the flexpen. The clinical record for Resident 2 was reviewed on 10/5/21 at 12:50 p.m. The diagnosis included, but was not limited to type 2 diabetes mellitus. The care plan, dated 8/29/21, indicated the medication interventions included, but were not limited to, ensure a clear understanding of medications, purpose, dose and takes as prescribed. Independent with obtaining medication prescriptions and/or refills. Independent with self administration of medications.		All residents are at risk of same alleged deficient practice. Executive Director has interviewed Employee 8 to identify if there were any other residents affected. Executive Director has determined this to be an isolated event. 3. Nurses and QMAs have been in-serviced on medication administration, including the 5 rights of medication administration on 10/13/21. DON/Designee has completed Medication Administration Competency Reviews on all nurses and QMAs to verify accuracy in following the 5 rights of medication administration as of 11/1/2021. 1. DON/Designee will audit newly completed medication administration competencies for nurses and QMAs 2 times a week x 1 month and then once weekly x2 months to verify accuracy in following the 5 rights of medication administration. 2. DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if	

	The resident's September 2021 Diabetic Flowsheet indicated, but was not limited to, the following: -Treciba Flextouch 100 units. Inject 26 units subcutaneously every bedtime. The start date was 11/25/20. The insulin was initialed as given at 6:00 p.m. on 9/28/21. -Accu checks per self before meals and bedtime. -May self administer insulin after nurse draws up ordered dose. The physician's order, dated 11/25/21 at 10:55 a.m., indicated the resident was to receive Treciba. The Treciba was increased to 26 units at bedtime. The nurse's note, dated 9/28/21 at 5:00 p.m., indicated the resident was administered the incorrect insulin. The pharmacy was notified and confirmed the insulins were the same long acting formula with different brand names. The MD was notified of the medication error. The Self Administration Medication Assessment, dated 9/1/21, indicated the resident was capable of recognizing each medication she was taking. She could correctly state what each medication was used for. The resident was capable of performing finger sticks, reading		audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

	and monitoring blood sugars. She was capable of administering insulin, but needed assistance with attaching a new needed to the insulin pen. During an interview on 10/5/21 at 12:28 p.m., QMA 8 indicated she had given Resident 1 the wrong insulin. There was going to be a class offered on insulin injections. She was not certified, but felt she needed to learn how to do it. She was just nervous they were not in bags and the labels were hard to read. The resident made her nervous. She thought she read it correctly, but she administered it and she indicated it was the wrong insulin. During an interview on 10/5/21 at 12:40 p.m., the DON indicated the Resident 2 had been given the right type of insulin, but just with a different brand name and another resident's name on the pen. It did not make her ill. The physician was notified. The Medication Administration-General Guidelines, revised January 2017, included, but was not limited to, "...FIVE RIGHTS-Right resident, right drug... are applied for each medication being administered... Medications supplied for one resident are never administered			

to another resident..."

This State Residential Finding relates to IN00363395 and IN00363449

Based on record review and interview, the facility failed to ensure insulin was administered to the correct resident during 1 of 3 residents reviewed for insulin administration. (Resident 2)

Findings include:

During an interview on 10/5/21 at 12:15 p.m., Resident 2 indicated QMA (Qualified Medication Aide) 8 administered to her the wrong insulin belonging to another resident. The resident informed the QMA the insulin wasn't correct before the injection. She told her the pen wasn't hers. After the insulin was injected the QMA looked at the label and found that it wasn't the resident's. The resident administered most of her own medications. She indicated the QMA shouldn't have administered the Levemir flexpen. She was supposed to receive the Treciba flexpen. She recognized the Treciba by the color of the flexpen.

The clinical record for Resident 2 was reviewed on 10/5/21 at 12:50 p.m. The diagnosis included, but was not limited to type 2 diabetes mellitus.

The care plan, dated 8/29/21, indicated the medication interventions included, but were not limited to, ensure a clear understanding of medications, purpose, dose and takes as prescribed. Independent with obtaining medication prescriptions and/or refills. Independent with self administration of medications.

The resident's September 2021 Diabetic Flowsheet indicated, but was not limited to, the following:

-Treciba Flextouch 100 units. Inject 26 units subcutaneously every bedtime. The start date was 11/25/20. The insulin was initialed as given at 6:00 p.m. on 9/28/21.

-Accu checks per self before meals and bedtime.

-May self administer insulin after nurse draws up ordered dose.

The physician's order, dated 11/25/21 at 10:55 a.m., indicated the resident was to receive Treciba. The Treciba was increased to 26 units at bedtime.

The nurse's note, dated 9/28/21 at 5:00 p.m., indicated the resident was administered the incorrect insulin. The pharmacy was notified and confirmed the insulins were the same long acting formula with different

	brand names. The MD was notified of the medication error. The Self Administration Medication Assessment, dated 9/1/21, indicated the resident was capable of recognizing each medication she was taking. She could correctly state what each medication was used for. The resident was capable of performing finger sticks, reading and monitoring blood sugars. She was capable of administering insulin, but needed assistance with attaching a new needed to the insulin pen. During an interview on 10/5/21 at 12:28 p.m., QMA 8 indicated she had given Resident 1 the wrong insulin. There was going to be a class offered on insulin injections. She was not certified, but felt she needed to learn how to do it. She was just nervous they were not in bags and the labels were hard to read. The resident made her nervous. She thought she read it correctly, but she administered it and she indicated it was the wrong insulin. During an interview on 10/5/21 at 12:40 p.m., the DON indicated the Resident 2 had been given the right type of insulin, but just with a different brand name and another resident's name on the pen. It did not make her ill. The			

	physician was notified. The Medication Administration-General Guidelines, revised January 2017, included, but was not limited to, "...FIVE RIGHTS-Right resident, right drug... are applied for each medication being administered... Medications supplied for one resident are never administered to another resident..." This State Residential Finding relates to IN00363395 and IN00363449			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation and interview, the facility failed to ensure infection control procedures were followed for hand hygiene before entering the kitchen for 2 of 4 staff observed (Cook 1 and ED) and the proper placement of the ice scoop. This deficient practice had the potential to affect 84 residents residing in the facility. Findings include: During a tour of the kitchen, on	R 0414	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Ice scoop removed from ice machine during survey.	10/24/2021

	10/5/21 at 10:00 a.m., Cook 1 entered the kitchen from the dining area and was observed not performing hand hygiene before proceeding with food preparation. There was an ice scoop observed sticking down into the ice in the ice machine. The ice scoop was currently not being used. During an observation on 10/5/21 at 12:20 p.m., the ED (Executive Director) was observed entering the kitchen without performing hand hygiene and was not wearing a hair net. He retrieved a hair net and walked to the back of the kitchen. During an interview, on 10/5/21 at 10:00 a.m., Cook 1 indicated the ice scoop should not be in the ice. There was a container beside the ice machine to put the ice scoop after each use. During an interview, on 10/5/21 at 12:25 p.m., Server 2 indicated the ice scoop should not be left in the ice. There was a blue container beside the ice machine to put the scoop in. During an interview, on 10/5/21 at 12:30 p.m., Server 3 indicated staff should wash there hands anytime they enter the kitchen and put on gloves. . During an interview, on 10/5/21		2. All residents are at risk of same alleged deficient practice. 3. Executive Director has In-serviced staff on hand hygiene and proper placement of ice scoop on 10/13/21. 4. DON/Designee will observe employee hand hygiene practices 5x/week for 1 month, 3x/week for 1 month, and then 2x/week for 1 month. Proper placement of ice scoop to be audited daily by Dietary Manager/designee ongoing. 5. DON/Designee will review observations with QA Committee monthly x3 months for identified issues. QA Committee will determine if observations necessitate extension past 3 months and will continue to review observations monthly for duration of the extended timeframe as applicable. Dietary Manager/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to	

	1:05 p.m., Cook 1 indicated before staff entered into the kitchen they should have washed their hands and wear a hairnet. On 10/6/21 at 9:00 a.m., the ED provided a current copy of the document titled, Infection Prevention and Control, dated 2019 included, but was not limited to, "...To cleanse hands to prevent the spread of potentially deadly infections to provide a clean and healthy environment for residents, staff and visitors To reduce the risk to the healthcare provider of colonization or infection acquired from a resident..." Based on observation and interview, the facility failed to ensure infection control procedures were followed for hand hygiene before entering the kitchen for 2 of 4 staff observed (Cook 1 and ED) and the proper placement of the ice scoop. This deficient practice had the potential to affect 84 residents residing in the facility. Findings include: During a tour of the kitchen, on 10/5/21 at 10:00 a.m., Cook 1 entered the kitchen from the dining area and was observed not performing hand hygiene before proceeding with food preparation. There was an ice		review audit results monthly for duration of the extended timeframe as applicable.	

scoop observed sticking down into the ice in the ice machine. The ice scoop was currently not being used.

During an observation on 10/5/21 at 12:20 p.m., the ED (Executive Director) was observed entering the kitchen without performing hand hygiene and was not wearing a hair net. He retrieved a hair net and walked to the back of the kitchen.

During an interview, on 10/5/21 at 10:00 a.m., Cook 1 indicated the ice scoop should not be in the ice. There was a container beside the ice machine to put the ice scoop after each use.

During an interview, on 10/5/21 at 12:25 p.m., Server 2 indicated the ice scoop should not be left in the ice. There was a blue container beside the ice machine to put the scoop in.

During an interview, on 10/5/21 at 12:30 p.m., Server 3 indicated staff should wash there hands anytime they enter the kitchen and put on gloves.

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During an interview, on 10/5/21 1:05 p.m., Cook 1 indicated before staff entered into the kitchen they should have washed their hands and wear a hairnet.

	On 10/6/21 at 9:00 a.m., the ED provided a current copy of the document titled, Infection Prevention and Control, dated 2019 included, but was not limited to, "...To cleanse hands to prevent the spread of potentially deadly infections to provide a clean and healthy environment for residents, staff and visitors To reduce the risk to the healthcare provider of colonization or infection acquired from a resident..."			

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