STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMS AT MICHIGAN CITY, THE	4300 CLEVELAND RD, MICHIGAN CITY, , 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: September 13 and 14, 2023. Facility number: 012180 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/18/23.	R 0000		
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.	R 0033	1.The information was placed in a picture frame and attached to the wall next to license information. 2. passed out flyer to all residents with contact information 3. Secured to all 4.Will monitor yearly upon license renewal 5. Completed citation on 09/14/2023	09/14/2023

(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.

(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 and interview, the facility failed to to ensure resident rights were maintained related to no posting of Ombudsman or advocacy agency information. This had the potential to affect all 82 residents in the facility.

Finding includes:

On 9/14/23 at 11:00 a.m., while observing the facility for required postings, there was no posting visible related to Ombudsman contact information or other advocacy agencies.

Interview with the Administrator

	on 9/14/23 at 11:40 a.m., indicated she had found the posting in a cabinet. It had been taken down while painting had been done, and she was not sure why it had not been replaced. Based on observation and interview, the facility failed to to ensure resident rights were maintained related to no posting of Ombudsman or advocacy agency information. This had the potential to affect all 82 residents in the facility. Finding includes: On 9/14/23 at 11:00 a.m., while observing the facility for required postings, there was no posting visible related to Ombudsman contact information or other advocacy agencies. Interview with the Administrator on 9/14/23 at 11:40 a.m., indicated she had found the posting in a cabinet. It had been taken down while painting had been done, and she was not sure why it had not been replaced.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a	R 0216	1. Evaluation completed on 09/14/2023 2. Audited all other residents to ensure self medication evaluations were completed.	09/14/2023

	minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure a medication self-administration evaluation was completed for a resident who was self-administering medications for 1 of 8 residents reviewed. (Resident 5) Finding includes: Resident 5's record was reviewed on 9/13/23 at 11:13 a.m. The resident had been admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.		3. Any self med orders will be copied by the nurse and give to DON 4. DON will review self med orders at each assessment 5. Audit was completed on 09/27/2023	

	A Physician Order, dated 5/30/23, indicated to instill Cequa 0.09% solution 1 drop in each eye twice a day for macular degeneration. A Physician Order, dated 8/23/23, indicated to instill Prednisolone AC 1% eye drop. Instill 1 drop in each affected eye twice a day for macular degeneration. The Medication Administration Record (MAR) was reviewed for August and September 2023 and indicted Prednisolone AC 1% (eye drop) and Cequa 0.09% solution (eye drop) were not given by the facility. Interview with the resident on 9/13/23 at 2:18 p.m., indicated she had administered her own eye drops for the last two months. The record lacked any documentation a medication self-administration evaluation had been completed for the resident to ensure she could safely administer her own medications. Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the resident did not have a self administration assessment prior to 9/14/23. Based on record review and interview, the facility failed to			

ensure a medication self-administration evaluation was completed for a resident who was self-administering medications for 1 of 8 residents reviewed. (Resident 5)

Finding includes:

Resident 5's record was reviewed on 9/13/23 at 11:13 a.m. The resident had been admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.

A Physician Order, dated 5/30/23, indicated to instill Cequa 0.09% solution 1 drop in each eye twice a day for macular degeneration.

A Physician Order, dated 8/23/23, indicated to instill Prednisolone AC 1% eye drop. Instill 1 drop in each affected eye twice a day for macular degeneration.

The Medication Administration Record (MAR) was reviewed for August and September 2023 and indicted Prednisolone AC 1% (eye drop) and Cequa 0.09% solution (eye drop) were not given by the facility.

Interview with the resident on 9/13/23 at 2:18 p.m., indicated

	she had administered her own eye drops for the last two months. The record lacked any documentation a medication self-administration evaluation had been completed for the resident to ensure she could safely administer her own medications. Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the resident did not have a self administration assessment prior to 9/14/23.			
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 qualified medication aides (QMAs) received authorization from a licensed	R 0246	1.PRN binder put in place 2.Educated med tech and nurse on proper procedure for PRNs given my med techs 3. PRN binder put in place and educated QMA and nurses on proper use 4. DON/ADON will audit weekly for the one month and then monthly thereafter. 5.09/29/2023	09/29/2023

nurse prior to giving as needed (prn) medications for 4 of 8 records reviewed. (Residents 2, 3, 7, and 5)

Findings include:

1. The record for Resident 2 was reviewed on 9/13/23 at 10:00 a.m. Diagnoses included, but were not limited to Diabetes Mellitus and multiple myeloma.

A Physician's Order, dated 9/3/21, indicated acetaminophen 650 milligrams (mg) every 4 hours, as needed for pain.

The August 2023 Medication Administration Record (MAR) indicated the resident had been given acetaminophen by QMAs as follows:

- on 8/2/23 by QMA 2

- on 8/7/23 by QMA 3

- twice on 8/10/23 by QMA 1 and QMA 5

- on 8/13/23 by QMA 4

There was no documentation on the MAR or in Nursing Notes that the nurse had given authorization prior to the QMAs giving the medication.

Interview with LPN 1, on 9/13/23 at 1:57 p.m., indicated she monitored all prn medications given during the day on the

	MAR dashboard, but there was no resident assessment documented prior to the medication administration or co-signature for the medications documented. 4. The record for Resident 5 was reviewed on 9/13/23 at 11:13 a.m. . The resident was admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke. The Physician's Order Summary, dated 8/2023, indicated an order for Acetaminophen (pain medication) 325 mg tablet by mouth every 4 hours PRN. The Medication Administration Record (MAR), dated 8/2023, indicated the PRN Acetaminophen was given by QMA 3 on 8/5/23, 8/6/23, 8/7/23, 8/9/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23, 8/17/23, 8/19/23, 8/20/23, 8/21/23, 8/24/23, 8/25/23, 8/26, 23, 8/29/23, 8/30/23 and 8/31/23. The PRN Acetaminophen was given by QMA 6 on 8/22/23. QMA 3 and QMA 6 also documented effectiveness for each administration.			

	The Medication Administration Record (MAR), dated 9/2023, indicated the PRN Acetaminophen was given by QMA 3 on 9/3/23, 9/4/23, 9/7/23, and 9/8/23. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse prior to administering the medication. There was lack of documentation to indicate the Nurse had assessed PRN effectiveness prior to QMAs documenting effectiveness. Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated they do not document anywhere when the QMAs ask for authorization before administering PRN medication. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses but do not document it anywhere. Interview with the Healthcare Coordinator on 9/14/23 at 10:15 a.m., indicated the QMAs had signed off on effectiveness of medication in the MAR not the nurse. Nursing is required to use the PRN medication binder to document PRN medication given. 2. Record review for Resident 3			

	was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, and osteoarthritis. The September 2023 Physician's Order Summary (POS) included the following orders: - morphine (pain medication) 10 mg (milligrams)/0.5 ml (milliliters) every 2 hours as needed - Robafen CF Liquid (cough syrup) 10 ml every 4 hours as needed - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed for pain/fever The August 2023 Medication Administration Record (MAR) indicated the following PRN (when necessary) medications were administered by QMAs: - 8/2/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 5. - 8/3/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 8. - 8/17/23 at 1:32 a.m., morphine 0.5 ml was administered by QMA 3.			

	- 8/17/23 at 5:34 p.m., morphine 0.5 ml was administered by QMA 5. - 8/26/23 at 7:30 a.m., acetaminophen 650 mg was administered by QMA 4. - 8/27/23 at 12:13 p.m., acetaminophen 650 mg was administered by QMA 4. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medications. The September 2023 MAR indicated the following PRN medications were administered by QMAs: - 9/11/23 at 8:49 a.m., Robafen CF Liquid 10 ml was administered by QMA 1. - 9/11/23 at 4:08 p.m., morphine 0.5 ml was administered by QMA 5. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication. 3. A closed record review for Resident 7 was completed on 9/13/23 at 2:55 p.m. Diagnoses included, but were not limited to, stage 4 lung cancer. The			

resident was on Hospice and passed away in the facility on 7/29/23.

The July 2023 POS included the following orders:

- Dilaudid (pain medication) 0.5 mg/0.5 ml every 2 hours as needed for pain/dyspnea (difficulty breathing)

- acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed

- hydromorphone hydrochloride (pain medication) 2 mg/ml, give 1 syringe orally every 2 hours PRN

- Lorazepam Intensol (anxiety medication) 2 mg/ml, take 0.25 ml every 2 hours as needed for anxiety/dyspnea

The July 2023 MAR indicated the following PRN medications were administered by QMAs:

- 7/27/23 at 9:08 a.m., acetaminophen 650 mg was administered by QMA 2.

- 7/27/23 at 11:12 a.m., Dilaudid 0.5 mg/0.5 ml was administered by QMA 6.

- 7/27/23 at 3:38 p.m., Lorazepam Intensol 2 mg/ml was administered by QMA 8.

- 7/28/23 at 7:26 p.m.,

	hydromorphone hydrochloride 2 mg/ml was administered by QMA 7. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication. Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated the nurses and QMAs do not document anywhere when the QMAs get authorization prior to administering PRN medications. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses before administering PRN medications. They do not document anywhere they received the authorization. Based on record review and interview, the facility failed to ensure qualified medication aides (QMAs) received authorization from a licensed nurse prior to giving as needed (prn) medications for 4 of 8 records reviewed. (Residents 2, 3, 7, and 5) Findings include:			

	1. The record for Resident 2 was reviewed on 9/13/23 at 10:00 a.m. Diagnoses included, but were not limited to Diabetes Mellitus and multiple myeloma. A Physician's Order, dated 9/3/21, indicated acetaminophen 650 milligrams (mg) every 4 hours, as needed for pain. The August 2023 Medication Administration Record (MAR) indicated the resident had been given acetaminophen by QMAs as follows: - on 8/2/23 by QMA 2 - on 8/7/23 by QMA 3 - twice on 8/10/23 by QMA 1 and QMA 5 - on 8/13/23 by QMA 4 There was no documentation on the MAR or in Nursing Notes that the nurse had given authorization prior to the QMAs giving the medication. Interview with LPN 1, on 9/13/23 at 1:57 p.m., indicated she monitored all prn medications given during the day on the MAR dashboard, but there was no resident assessment documented prior to the medication administration or co-signature for the medications documented.			

	4. The record for Resident 5 was reviewed on 9/13/23 at 11:13 a.m. . The resident was admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke. The Physician's Order Summary, dated 8/2023, indicated an order for Acetaminophen (pain medication) 325 mg tablet by mouth every 4 hours PRN. The Medication Administration Record (MAR), dated 8/2023, indicated the PRN Acetaminophen was given by QMA 3 on 8/5/23, 8/6/23, 8/7/23, 8/9/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23, 8/17/23, 8/19/23, 8/20/23, 8/21/23, 8/24/23, 8/25/23, 8/26, 23, 8/29/23, 8/30/23 and 8/31/23. The PRN Acetaminophen was given by QMA 6 on 8/22/23. QMA 3 and QMA 6 also documented effectiveness for each administration. The Medication Administration Record (MAR), dated 9/2023, indicated the PRN Acetaminophen was given by QMA 3 on 9/3/23, 9/4/23, 9/7/23, and 9/8/23.			

There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse prior to administering the medication.

There was lack of documentation to indicate the Nurse had assessed PRN effectiveness prior to QMAs documenting effectiveness.

Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated they do not document anywhere when the QMAs ask for authorization before administering PRN medication.

Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses but do not document it anywhere.

Interview with the Healthcare Coordinator on 9/14/23 at 10:15 a.m., indicated the QMAs had signed off on effectiveness of medication in the MAR not the nurse. Nursing is required to use the PRN medication binder to document PRN medication given.

2. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, and osteoarthritis.

	The September 2023 Physician's Order Summary (POS) included the following orders: - morphine (pain medication) 10 mg (milligrams)/0.5 ml (milliliters) every 2 hours as needed - Robafen CF Liquid (cough syrup) 10 ml every 4 hours as needed - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed for pain/fever The August 2023 Medication Administration Record (MAR) indicated the following PRN (when necessary) medications were administered by QMAs: - 8/2/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 5. - 8/3/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 8. - 8/17/23 at 1:32 a.m., morphine 0.5 ml was administered by QMA 3. - 8/17/23 at 5:34 p.m., morphine 0.5 ml was administered by QMA 5.			

	- 8/26/23 at 7:30 a.m., acetaminophen 650 mg was administered by QMA 4. - 8/27/23 at 12:13 p.m., acetaminophen 650 mg was administered by QMA 4. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medications. The September 2023 MAR indicated the following PRN medications were administered by QMAs: - 9/11/23 at 8:49 a.m., Robafen CF Liquid 10 ml was administered by QMA 1. - 9/11/23 at 4:08 p.m., morphine 0.5 ml was administered by QMA 5. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication. 3. A closed record review for Resident 7 was completed on 9/13/23 at 2:55 p.m. Diagnoses included, but were not limited to, stage 4 lung cancer. The resident was on Hospice and passed away in the facility on 7/29/23.			

	The July 2023 POS included the following orders: - Dilaudid (pain medication) 0.5 mg/0.5 ml every 2 hours as needed for pain/dyspnea (difficulty breathing) - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed - hydromorphone hydrochloride (pain medication) 2 mg/ml, give 1 syringe orally every 2 hours PRN - Lorazepam Intensol (anxiety medication) 2 mg/ml, take 0.25 ml every 2 hours as needed for anxiety/dyspnea The July 2023 MAR indicated the following PRN medications were administered by QMAs: - 7/27/23 at 9:08 a.m., acetaminophen 650 mg was administered by QMA 2. - 7/27/23 at 11:12 a.m., Dilaudid 0.5 mg/0.5 ml was administered by QMA 6. - 7/27/23 at 3:38 p.m., Lorazepam Intensol 2 mg/ml was administered by QMA 8. - 7/28/23 at 7:26 p.m., hydromorphone hydrochloride 2 mg/ml was administered by QMA 7.			

There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication.

Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated the nurses and QMAs do not document anywhere when the QMAs get authorization prior to administering PRN medications.

Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses before administering PRN medications. They do not document anywhere they received the authorization.

Based on record review and interview, the facility failed to ensure qualified medication aides (QMAs) received authorization from a licensed nurse prior to giving as needed (prn) medications for 4 of 8 records reviewed. (Residents 2, 3, 7, and 5)

Findings include:

1. The record for Resident 2 was reviewed on 9/13/23 at 10:00 a.m. Diagnoses included, but were not limited to Diabetes Mellitus and multiple myeloma.

A Physician's Order, dated 9/3/21, indicated acetaminophen 650 milligrams

	(mg) every 4 hours, as needed for pain. The August 2023 Medication Administration Record (MAR) indicated the resident had been given acetaminophen by QMAs as follows: - on 8/2/23 by QMA 2 - on 8/7/23 by QMA 3 - twice on 8/10/23 by QMA 1 and QMA 5 - on 8/13/23 by QMA 4 There was no documentation on the MAR or in Nursing Notes that the nurse had given authorization prior to the QMAs giving the medication. Interview with LPN 1, on 9/13/23 at 1:57 p.m., indicated she monitored all prn medications given during the day on the MAR dashboard, but there was no resident assessment documented prior to the medication administration or co-signature for the medications documented. 4. The record for Resident 5 was reviewed on 9/13/23 at 11:13 a.m. . The resident was admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease),			

	macular degeneration (eye condition), and stroke. The Physician's Order Summary, dated 8/2023, indicated an order for Acetaminophen (pain medication) 325 mg tablet by mouth every 4 hours PRN. The Medication Administration Record (MAR), dated 8/2023, indicated the PRN Acetaminophen was given by QMA 3 on 8/5/23, 8/6/23, 8/7/23, 8/9/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23, 8/17/23, 8/19/23, 8/20/23, 8/21/23, 8/24/23, 8/25/23, 8/26, 23, 8/29/23, 8/30/23 and 8/31/23. The PRN Acetaminophen was given by QMA 6 on 8/22/23. QMA 3 and QMA 6 also documented effectiveness for each administration. The Medication Administration Record (MAR), dated 9/2023, indicated the PRN Acetaminophen was given by QMA 3 on 9/3/23, 9/4/23, 9/7/23, and 9/8/23. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse prior to administering the medication. There was lack of documentation to indicate the Nurse had assessed PRN			

effectiveness prior to QMAs documenting effectiveness.

Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated they do not document anywhere when the QMAs ask for authorization before administering PRN medication.

Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses but do not document it anywhere.

Interview with the Healthcare Coordinator on 9/14/23 at 10:15 a.m., indicated the QMAs had signed off on effectiveness of medication in the MAR not the nurse. Nursing is required to use the PRN medication binder to document PRN medication given.

2. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, and osteoarthritis.

The September 2023 Physician's Order Summary (POS) included the following orders:

- morphine (pain medication) 10 mg (milligrams)/0.5 ml (milliliters) every 2 hours as needed

	- Robafen CF Liquid (cough syrup) 10 ml every 4 hours as needed - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed for pain/fever The August 2023 Medication Administration Record (MAR) indicated the following PRN (when necessary) medications were administered by QMAs: - 8/2/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 5. - 8/3/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 8. - 8/17/23 at 1:32 a.m., morphine 0.5 ml was administered by QMA 3. - 8/17/23 at 5:34 p.m., morphine 0.5 ml was administered by QMA 5. - 8/26/23 at 7:30 a.m., acetaminophen 650 mg was administered by QMA 4. - 8/27/23 at 12:13 p.m., acetaminophen 650 mg was administered by QMA 4. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to			

	administering the medications. The September 2023 MAR indicated the following PRN medications were administered by QMAs: - 9/11/23 at 8:49 a.m., Robafen CF Liquid 10 ml was administered by QMA 1. - 9/11/23 at 4:08 p.m., morphine 0.5 ml was administered by QMA 5. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication. 3. A closed record review for Resident 7 was completed on 9/13/23 at 2:55 p.m. Diagnoses included, but were not limited to, stage 4 lung cancer. The resident was on Hospice and passed away in the facility on 7/29/23. The July 2023 POS included the following orders: - Dilaudid (pain medication) 0.5 mg/0.5 ml every 2 hours as needed for pain/dyspnea (difficulty breathing) - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed			

	- hydromorphone hydrochloride (pain medication) 2 mg/ml, give 1 syringe orally every 2 hours PRN - Lorazepam Intensol (anxiety medication) 2 mg/ml, take 0.25 ml every 2 hours as needed for anxiety/dyspnea The July 2023 MAR indicated the following PRN medications were administered by QMAs: - 7/27/23 at 9:08 a.m., acetaminophen 650 mg was administered by QMA 2. - 7/27/23 at 11:12 a.m., Dilaudid 0.5 mg/0.5 ml was administered by QMA 6. - 7/27/23 at 3:38 p.m., Lorazepam Intensol 2 mg/ml was administered by QMA 8. - 7/28/23 at 7:26 p.m., hydromorphone hydrochloride 2 mg/ml was administered by QMA 7. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication.			

	Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated the nurses and QMAs do not document anywhere when the QMAs get authorization prior to administering PRN medications. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses before administering PRN medications. They do not document anywhere they received the authorization. Based on record review and interview, the facility failed to ensure qualified medication aides (QMAs) received authorization from a licensed nurse prior to giving as needed (prn) medications for 4 of 8 records reviewed. (Residents 2, 3, 7, and 5) Findings include: 1. The record for Resident 2 was reviewed on 9/13/23 at 10:00 a.m. Diagnoses included, but were not limited to Diabetes Mellitus and multiple myeloma. A Physician's Order, dated 9/3/21, indicated acetaminophen 650 milligrams (mg) every 4 hours, as needed for pain. The August 2023 Medication Administration Record (MAR) indicated the resident had been given acetaminophen by QMAs			

as follows:

- on 8/2/23 by QMA 2

- on 8/7/23 by QMA 3

- twice on 8/10/23 by QMA 1 and QMA 5

- on 8/13/23 by QMA 4

There was no documentation on the MAR or in Nursing Notes that the nurse had given authorization prior to the QMAs giving the medication.

Interview with LPN 1, on 9/13/23 at 1:57 p.m., indicated she monitored all prn medications given during the day on the MAR dashboard, but there was no resident assessment documented prior to the medication administration or co-signature for the medications documented.

4. The record for Resident 5 was reviewed on 9/13/23 at 11:13 a.m. . The resident was admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.

The Physician's Order Summary, dated 8/2023, indicated an order for Acetaminophen (pain

	medication) 325 mg tablet by mouth every 4 hours PRN. The Medication Administration Record (MAR), dated 8/2023, indicated the PRN Acetaminophen was given by QMA 3 on 8/5/23, 8/6/23, 8/7/23, 8/9/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23, 8/17/23, 8/19/23, 8/20/23, 8/21/23, 8/24/23, 8/25/23, 8/26, 23, 8/29/23, 8/30/23 and 8/31/23. The PRN Acetaminophen was given by QMA 6 on 8/22/23. QMA 3 and QMA 6 also documented effectiveness for each administration. The Medication Administration Record (MAR), dated 9/2023, indicated the PRN Acetaminophen was given by QMA 3 on 9/3/23, 9/4/23, 9/7/23, and 9/8/23. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse prior to administering the medication. There was lack of documentation to indicate the Nurse had assessed PRN effectiveness prior to QMAs documenting effectiveness. Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated they do not document anywhere when the QMAs ask for authorization			

	before administering PRN medication. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses but do not document it anywhere. Interview with the Healthcare Coordinator on 9/14/23 at 10:15 a.m., indicated the QMAs had signed off on effectiveness of medication in the MAR not the nurse. Nursing is required to use the PRN medication binder to document PRN medication given. 2. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, and osteoarthritis. The September 2023 Physician's Order Summary (POS) included the following orders: - morphine (pain medication) 10 mg (milligrams)/0.5 ml (milliliters) every 2 hours as needed - Robafen CF Liquid (cough syrup) 10 ml every 4 hours as needed - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6			

	hours as needed for pain/fever The August 2023 Medication Administration Record (MAR) indicated the following PRN (when necessary) medications were administered by QMAs: - 8/2/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 5. - 8/3/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 8. - 8/17/23 at 1:32 a.m., morphine 0.5 ml was administered by QMA 3. - 8/17/23 at 5:34 p.m., morphine 0.5 ml was administered by QMA 5. - 8/26/23 at 7:30 a.m., acetaminophen 650 mg was administered by QMA 4. - 8/27/23 at 12:13 p.m., acetaminophen 650 mg was administered by QMA 4. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medications. The September 2023 MAR indicated the following PRN medications were administered by QMAs:			

	- 9/11/23 at 8:49 a.m., Robafen CF Liquid 10 ml was administered by QMA 1. - 9/11/23 at 4:08 p.m., morphine 0.5 ml was administered by QMA 5. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication. 3. A closed record review for Resident 7 was completed on 9/13/23 at 2:55 p.m. Diagnoses included, but were not limited to, stage 4 lung cancer. The resident was on Hospice and passed away in the facility on 7/29/23. The July 2023 POS included the following orders: - Dilaudid (pain medication) 0.5 mg/0.5 ml every 2 hours as needed for pain/dyspnea (difficulty breathing) - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed - hydromorphone hydrochloride (pain medication) 2 mg/ml, give 1 syringe orally every 2 hours PRN - Lorazepam Intensol (anxiety medication) 2 mg/ml, take 0.25			

	ml every 2 hours as needed for anxiety/dyspnea The July 2023 MAR indicated the following PRN medications were administered by QMAs: - 7/27/23 at 9:08 a.m., acetaminophen 650 mg was administered by QMA 2. - 7/27/23 at 11:12 a.m., Dilaudid 0.5 mg/0.5 ml was administered by QMA 6. - 7/27/23 at 3:38 p.m., Lorazepam Intensol 2 mg/ml was administered by QMA 8. - 7/28/23 at 7:26 p.m., hydromorphone hydrochloride 2 mg/ml was administered by QMA 7. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication. Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated the nurses and QMAs do not document anywhere when the QMAs get authorization prior to administering PRN medications. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses before administering PRN medications. They do not document			

anywhere they received the authorization.

Based on record review and interview, the facility failed to ensure qualified medication aides (QMAs) received authorization from a licensed nurse prior to giving as needed (prn) medications for 4 of 8 records reviewed. (Residents 2, 3, 7, and 5)

Findings include:

1. The record for Resident 2 was reviewed on 9/13/23 at 10:00 a.m. Diagnoses included, but were not limited to Diabetes Mellitus and multiple myeloma.

A Physician's Order, dated 9/3/21, indicated acetaminophen 650 milligrams (mg) every 4 hours, as needed for pain.

The August 2023 Medication Administration Record (MAR) indicated the resident had been given acetaminophen by QMAs as follows:

- on 8/2/23 by QMA 2

- on 8/7/23 by QMA 3

- twice on 8/10/23 by QMA 1 and QMA 5

- on 8/13/23 by QMA 4

There was no documentation on the MAR or in Nursing Notes

	that the nurse had given authorization prior to the QMAs giving the medication. Interview with LPN 1, on 9/13/23 at 1:57 p.m., indicated she monitored all prn medications given during the day on the MAR dashboard, but there was no resident assessment documented prior to the medication administration or co-signature for the medications documented. 4. The record for Resident 5 was reviewed on 9/13/23 at 11:13 a.m. . The resident was admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke. The Physician's Order Summary, dated 8/2023, indicated an order for Acetaminophen (pain medication) 325 mg tablet by mouth every 4 hours PRN. The Medication Administration Record (MAR), dated 8/2023, indicated the PRN Acetaminophen was given by QMA 3 on 8/5/23, 8/6/23, 8/7/23, 8/9/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23, 8/17/23, 8/19/23, 8/20/23, 8/21/23, 8/24/23, 8/25/23, 8/26,			

	23, 8/29/23, 8/30/23 and 8/31/23. The PRN Acetaminophen was given by QMA 6 on 8/22/23. QMA 3 and QMA 6 also documented effectiveness for each administration. The Medication Administration Record (MAR), dated 9/2023, indicated the PRN Acetaminophen was given by QMA 3 on 9/3/23, 9/4/23, 9/7/23, and 9/8/23. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse prior to administering the medication. There was lack of documentation to indicate the Nurse had assessed PRN effectiveness prior to QMAs documenting effectiveness. Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated they do not document anywhere when the QMAs ask for authorization before administering PRN medication. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses but do not document it anywhere. Interview with the Healthcare Coordinator on 9/14/23 at 10:15 a.m., indicated the QMAs had			

	signed off on effectiveness of medication in the MAR not the nurse. Nursing is required to use the PRN medication binder to document PRN medication given. 2. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, and osteoarthritis. The September 2023 Physician's Order Summary (POS) included the following orders: - morphine (pain medication) 10 mg (milligrams)/0.5 ml (milliliters) every 2 hours as needed - Robafen CF Liquid (cough syrup) 10 ml every 4 hours as needed - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed for pain/fever The August 2023 Medication Administration Record (MAR) indicated the following PRN (when necessary) medications were administered by QMAs: - 8/2/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 5.			

	- 8/3/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 8. - 8/17/23 at 1:32 a.m., morphine 0.5 ml was administered by QMA 3. - 8/17/23 at 5:34 p.m., morphine 0.5 ml was administered by QMA 5. - 8/26/23 at 7:30 a.m., acetaminophen 650 mg was administered by QMA 4. - 8/27/23 at 12:13 p.m., acetaminophen 650 mg was administered by QMA 4. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medications. The September 2023 MAR indicated the following PRN medications were administered by QMAs: - 9/11/23 at 8:49 a.m., Robafen CF Liquid 10 ml was administered by QMA 1. - 9/11/23 at 4:08 p.m., morphine 0.5 ml was administered by QMA 5. There was a lack of documentation to indicate the QMAs had received authorization from a licensed			

nurse or physician prior to administering the medication.

3. A closed record review for Resident 7 was completed on 9/13/23 at 2:55 p.m. Diagnoses included, but were not limited to, stage 4 lung cancer. The resident was on Hospice and passed away in the facility on 7/29/23.

The July 2023 POS included the following orders:

- Dilaudid (pain medication) 0.5 mg/0.5 ml every 2 hours as needed for pain/dyspnea (difficulty breathing)

- acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed

- hydromorphone hydrochloride (pain medication) 2 mg/ml, give 1 syringe orally every 2 hours PRN

- Lorazepam Intensol (anxiety medication) 2 mg/ml, take 0.25 ml every 2 hours as needed for anxiety/dyspnea

The July 2023 MAR indicated the following PRN medications were administered by QMAs:

- 7/27/23 at 9:08 a.m., acetaminophen 650 mg was administered by QMA 2.

- 7/27/23 at 11:12 a.m., Dilaudid

	0.5 mg/0.5 ml was administered by QMA 6. - 7/27/23 at 3:38 p.m., Lorazepam Intensol 2 mg/ml was administered by QMA 8. - 7/28/23 at 7:26 p.m., hydromorphone hydrochloride 2 mg/ml was administered by QMA 7. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication. Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated the nurses and QMAs do not document anywhere when the QMAs get authorization prior to administering PRN medications. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses before administering PRN medications. They do not document anywhere they received the authorization.			

	Based on record review and interview, the facility failed to ensure qualified medication aides (QMAs) received authorization from a licensed nurse prior to giving as needed (prn) medications for 4 of 8 records reviewed. (Residents 2, 3, 7, and 5) Findings include: 1. The record for Resident 2 was reviewed on 9/13/23 at 10:00 a.m. Diagnoses included, but were not limited to Diabetes Mellitus and multiple myeloma. A Physician's Order, dated 9/3/21, indicated acetaminophen 650 milligrams (mg) every 4 hours, as needed for pain. The August 2023 Medication Administration Record (MAR) indicated the resident had been given acetaminophen by QMAs as follows: - on 8/2/23 by QMA 2 - on 8/7/23 by QMA 3 - twice on 8/10/23 by QMA 1 and QMA 5 - on 8/13/23 by QMA 4			

	There was no documentation on the MAR or in Nursing Notes that the nurse had given authorization prior to the QMAs giving the medication. Interview with LPN 1, on 9/13/23 at 1:57 p.m., indicated she monitored all prn medications given during the day on the MAR dashboard, but there was no resident assessment documented prior to the medication administration or co-signature for the medications documented. 4. The record for Resident 5 was reviewed on 9/13/23 at 11:13 a.m. . The resident was admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke. The Physician's Order Summary, dated 8/2023, indicated an order for Acetaminophen (pain medication) 325 mg tablet by mouth every 4 hours PRN. The Medication Administration Record (MAR), dated 8/2023, indicated the PRN Acetaminophen was given by QMA 3 on 8/5/23, 8/6/23, 8/7/23, 8/9/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23,			

	8/17/23, 8/19/23, 8/20/23, 8/21/23, 8/24/23, 8/25/23, 8/26, 23, 8/29/23, 8/30/23 and 8/31/23. The PRN Acetaminophen was given by QMA 6 on 8/22/23. QMA 3 and QMA 6 also documented effectiveness for each administration. The Medication Administration Record (MAR), dated 9/2023, indicated the PRN Acetaminophen was given by QMA 3 on 9/3/23, 9/4/23, 9/7/23, and 9/8/23. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse prior to administering the medication. There was lack of documentation to indicate the Nurse had assessed PRN effectiveness prior to QMAs documenting effectiveness. Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated they do not document anywhere when the QMAs ask for authorization before administering PRN medication. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses but do not document it anywhere. Interview with the Healthcare			

Coordinator on 9/14/23 at 10:15 a.m., indicated the QMAs had signed off on effectiveness of medication in the MAR not the nurse. Nursing is required to use the PRN medication binder to document PRN medication given.

2. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, and osteoarthritis.

The September 2023 Physician's Order Summary (POS) included the following orders:

- morphine (pain medication) 10 mg (milligrams)/0.5 ml (milliliters) every 2 hours as needed

- Robafen CF Liquid (cough syrup) 10 ml every 4 hours as needed

- acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed for pain/fever

The August 2023 Medication Administration Record (MAR) indicated the following PRN (when necessary) medications were administered by QMAs:

- 8/2/23 at 3:08 p.m., morphine 0.5 ml was administered by

QMA 5.

- 8/3/23 at 3:08 p.m., morphine 0.5 ml was administered by QMA 8.

- 8/17/23 at 1:32 a.m., morphine 0.5 ml was administered by QMA 3.

- 8/17/23 at 5:34 p.m., morphine 0.5 ml was administered by QMA 5.

- 8/26/23 at 7:30 a.m., acetaminophen 650 mg was administered by QMA 4.

- 8/27/23 at 12:13 p.m., acetaminophen 650 mg was administered by QMA 4.

There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medications.

The September 2023 MAR indicated the following PRN medications were administered by QMAs:

- 9/11/23 at 8:49 a.m., Robafen CF Liquid 10 ml was administered by QMA 1.

- 9/11/23 at 4:08 p.m., morphine 0.5 ml was administered by QMA 5.

There was a lack of documentation to indicate the

	QMAs had received authorization from a licensed nurse or physician prior to administering the medication. 3. A closed record review for Resident 7 was completed on 9/13/23 at 2:55 p.m. Diagnoses included, but were not limited to, stage 4 lung cancer. The resident was on Hospice and passed away in the facility on 7/29/23. The July 2023 POS included the following orders: - Dilaudid (pain medication) 0.5 mg/0.5 ml every 2 hours as needed for pain/dyspnea (difficulty breathing) - acetaminophen (pain medication) 325 mg, take 2 tablets to equal 650 mg every 6 hours as needed - hydromorphone hydrochloride (pain medication) 2 mg/ml, give 1 syringe orally every 2 hours PRN - Lorazepam Intensol (anxiety medication) 2 mg/ml, take 0.25 ml every 2 hours as needed for anxiety/dyspnea The July 2023 MAR indicated the following PRN medications were administered by QMAs:			

	- 7/27/23 at 9:08 a.m., acetaminophen 650 mg was administered by QMA 2. - 7/27/23 at 11:12 a.m., Dilaudid 0.5 mg/0.5 ml was administered by QMA 6. - 7/27/23 at 3:38 p.m., Lorazepam Intensol 2 mg/ml was administered by QMA 8. - 7/28/23 at 7:26 p.m., hydromorphone hydrochloride 2 mg/ml was administered by QMA 7. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse or physician prior to administering the medication. Interview with LPN 1 on 9/13/23 at 2:02 p.m., indicated the nurses and QMAs do not document anywhere when the QMAs get authorization prior to administering PRN medications. Interview with QMA 1 on 9/13/23 at 2:05 p.m., indicated they get a verbal authorization from the nurses before administering PRN medications. They do not document anywhere they received the authorization.			

R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.	R 0356	1.All face sheets are being updated through our pharmacy system to include pertinent information. 2. All residents were audited in Emergency binder for accuracy 3.Concierge will update with each move in 4. Conciergewill audit monthly. 5. 10/13/2023	10/13/2023

	Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 4 of 5 residents reviewed. (Residents 3, 4, 5 and 6) Findings include: The resident Emergency Binder was reviewed on 9/14/23. The following information was missing: a. Resident 3 was missing hospital preference. b. Resident 4 was missing hospital preference. c. Resident 5 was missing hospital preference and emergency contact information. d. Resident 6 was missing Physician phone number, hospital preference, emergency contact information and photo. Interview with the Administrator on 9/14/23, indicated the items were missing and she would get the records for those residents updated. Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 4 of 5 residents reviewed. (Residents 3, 4, 5 and 6)			

	Findings include: The resident Emergency Binder was reviewed on 9/14/23. The following information was missing: a. Resident 3 was missing hospital preference. b. Resident 4 was missing hospital preference. c. Resident 5 was missing hospital preference and emergency contact information. d. Resident 6 was missing Physician phone number, hospital preference, emergency contact information and photo. Interview with the Administrator on 9/14/23, indicated the items were missing and she would get the records for those residents updated.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 4. Resident 4's record was	R 0409	1. Will fax doctors for immediate correction 2. Audited all residents that were potentially effected 3. Added to POS's to ensure compliance moving forward 4. Audit when assessments are due 5. 10/31/2023	10/31/2023

reviewed on 9/13/23 at 10:42 a.m. The resident had been admitted on 2/14/20. Diagnoses included, but were not limited to, hypertension (high blood pressure), hypothyroidism (thyroid disorder), osteoarthritis (joint disease), interstitial cystitis (bladder condition), and glaucoma (eye condition).

The record lacked any documentation an Annual Health Statement had been completed.

5. Resident 5's record was reviewed on 9/13/23 at 11:13 a.m. The resident had been admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.

The record lacked any documentation an Annual Health Statement had been completed.

Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the residents should have had a health statement upon admission, but was not aware they needed the statement annually.

3. Record review for Resident 3 was completed on 9/13/23 at

	10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, osteoarthritis. The resident was admitted to the facility on 5/15/19. The record lacked any documentation an Annual Health Statement had been completed. Interview with the Administrator on 9/14/23 at 10:30 a.m., indicated they did not complete Annual Health Statements on the residents yearly. They only completed them when residents were admitted. Based on record review and interview, the facility failed to ensure there was an admission and/or annual health statement in place for 5 of 8 records reviewed. (Residents 2, 8, 3, 4 and 5) Findings include: 1. Resident 2's record was reviewed on 9/13/23 at 10:00 a.m. The resident was admitted to the facility on 9/3/21. Diagnoses included, but were not limited to, Diabetes Mellitus and multiple myeloma.			

There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective stage.

2. Resident 8's record was reviewed on 9/14/23 at 8:47 a.m. The resident was admitted to the facility on 10/12/19. Diagnoses included, but were not limited to, Diabetes Mellitus, renal insufficiency and arthritis.

There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective stage.

Interview with the Administrator, on 9/14/23 at 10:30 a.m., indicated they only required the Physician statement on admission and did not update it after that.

4. Resident 4's record was reviewed on 9/13/23 at 10:42 a.m. The resident had been admitted on 2/14/20. Diagnoses included, but were not limited to, hypertension (high blood pressure), hypothyroidism (thyroid disorder), osteoarthritis (joint disease), interstitial cystitis (bladder condition), and glaucoma (eye condition).

The record lacked any documentation an Annual Health Statement had been

completed.

5. Resident 5's record was reviewed on 9/13/23 at 11:13 a.m. The resident had been admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.

The record lacked any documentation an Annual Health Statement had been completed.

Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the residents should have had a health statement upon admission, but was not aware they needed the statement annually.

3. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, osteoarthritis. The resident was admitted to the facility on 5/15/19.

The record lacked any documentation an Annual Health Statement had been completed.

Interview with the Administrator on 9/14/23 at 10:30 a.m.,

	indicated they did not complete Annual Health Statements on the residents yearly. They only completed them when residents were admitted. Based on record review and interview, the facility failed to ensure there was an admission and/or annual health statement in place for 5 of 8 records reviewed. (Residents 2, 8, 3, 4 and 5) Findings include: 1. Resident 2's record was reviewed on 9/13/23 at 10:00 a.m. The resident was admitted to the facility on 9/3/21. Diagnoses included, but were not limited to, Diabetes Mellitus and multiple myeloma. There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective stage. 2. Resident 8's record was reviewed on 9/14/23 at 8:47 a.m. The resident was admitted to the facility on 10/12/19. Diagnoses included, but were not limited to, Diabetes Mellitus, renal insufficiency and arthritis. There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective			

stage.

Interview with the Administrator, on 9/14/23 at 10:30 a.m., indicated they only required the Physician statement on admission and did not update it after that.

4. Resident 4's record was reviewed on 9/13/23 at 10:42 a.m. The resident had been admitted on 2/14/20. Diagnoses included, but were not limited to, hypertension (high blood pressure), hypothyroidism (thyroid disorder), osteoarthritis (joint disease), interstitial cystitis (bladder condition), and glaucoma (eye condition).

The record lacked any documentation an Annual Health Statement had been completed.

5. Resident 5's record was reviewed on 9/13/23 at 11:13 a.m. The resident had been admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.

The record lacked any documentation an Annual Health Statement had been completed.

Interview with the Executive

Director on 9/14/23 at 12:02 p.m., indicated that the residents should have had a health statement upon admission, but was not aware they needed the statement annually.

3. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, osteoarthritis. The resident was admitted to the facility on 5/15/19.

The record lacked any documentation an Annual Health Statement had been completed.

Interview with the Administrator on 9/14/23 at 10:30 a.m., indicated they did not complete Annual Health Statements on the residents yearly. They only completed them when residents were admitted.

Based on record review and interview, the facility failed to ensure there was an admission and/or annual health statement in place for 5 of 8 records reviewed. (Residents 2, 8, 3, 4 and 5)

Findings include:

1. Resident 2's record was reviewed on 9/13/23 at 10:00 a.m. The resident was admitted to the facility on 9/3/21.

	Diagnoses included, but were not limited to, Diabetes Mellitus and multiple myeloma. There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective stage. 2. Resident 8's record was reviewed on 9/14/23 at 8:47 a.m. The resident was admitted to the facility on 10/12/19. Diagnoses included, but were not limited to, Diabetes Mellitus, renal insufficiency and arthritis. There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective stage. Interview with the Administrator, on 9/14/23 at 10:30 a.m., indicated they only required the Physician statement on admission and did not update it after that.			

	4. Resident 4's record was reviewed on 9/13/23 at 10:42 a.m. The resident had been admitted on 2/14/20. Diagnoses included, but were not limited to, hypertension (high blood pressure), hypothyroidism (thyroid disorder), osteoarthritis (joint disease), interstitial cystitis (bladder condition), and glaucoma (eye condition). The record lacked any documentation an Annual Health Statement had been completed. 5. Resident 5's record was reviewed on 9/13/23 at 11:13 a.m. The resident had been admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke. The record lacked any documentation an Annual Health Statement had been completed. Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the residents should have had a health statement upon admission, but was not aware they needed the statement annually. 3. Record review for Resident 3			

	was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, osteoarthritis. The resident was admitted to the facility on 5/15/19. The record lacked any documentation an Annual Health Statement had been completed. Interview with the Administrator on 9/14/23 at 10:30 a.m., indicated they did not complete Annual Health Statements on the residents yearly. They only completed them when residents were admitted. Based on record review and interview, the facility failed to ensure there was an admission and/or annual health statement in place for 5 of 8 records reviewed. (Residents 2, 8, 3, 4 and 5) Findings include: 1. Resident 2's record was reviewed on 9/13/23 at 10:00 a.m. The resident was admitted to the facility on 9/3/21. Diagnoses included, but were not limited to, Diabetes Mellitus and multiple myeloma. There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective			

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The record lacked any documentation an Annual Health Statement had been completed.

5. Resident 5's record was reviewed on 9/13/23 at 11:13 a.m. The resident had been

	admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke. The record lacked any documentation an Annual Health Statement had been completed. Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the residents should have had a health statement upon admission, but was not aware they needed the statement annually. 3. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, osteoarthritis. The resident was admitted to the facility on 5/15/19. The record lacked any documentation an Annual Health Statement had been completed.			

	Interview with the Administrator on 9/14/23 at 10:30 a.m., indicated they did not complete Annual Health Statements on the residents yearly. They only completed them when residents were admitted. Based on record review and interview, the facility failed to ensure there was an admission and/or annual health statement in place for 5 of 8 records reviewed. (Residents 2, 8, 3, 4 and 5) Findings include: 1. Resident 2's record was reviewed on 9/13/23 at 10:00 a.m. The resident was admitted to the facility on 9/3/21. Diagnoses included, but were not limited to, Diabetes Mellitus and multiple myeloma. There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective stage. 2. Resident 8's record was reviewed on 9/14/23 at 8:47 a.m. The resident was admitted to the facility on 10/12/19. Diagnoses included, but were not limited to, Diabetes Mellitus, renal insufficiency and arthritis. There was no annual health statement by the Physician to indicate the resident was free of			

	infectious diseases or tuberculosis in the infective stage. Interview with the Administrator, on 9/14/23 at 10:30 a.m., indicated they only required the Physician statement on admission and did not update it after that. 4. Resident 4's record was reviewed on 9/13/23 at 10:42 a.m. The resident had been admitted on 2/14/20. Diagnoses included, but were not limited to, hypertension (high blood pressure), hypothyroidism (thyroid disorder), osteoarthritis (joint disease), interstitial cystitis (bladder condition), and glaucoma (eye condition). The record lacked any documentation an Annual Health Statement had been completed. 5. Resident 5's record was reviewed on 9/13/23 at 11:13 a.m. The resident had been admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.			

	The record lacked any documentation an Annual Health Statement had been completed. Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the residents should have had a health statement upon admission, but was not aware they needed the statement annually. 3. Record review for Resident 3 was completed on 9/13/23 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, diabetes, hyperlipidemia, osteoarthritis. The resident was admitted to the facility on 5/15/19. The record lacked any documentation an Annual Health Statement had been completed. Interview with the Administrator on 9/14/23 at 10:30 a.m., indicated they did not complete Annual Health Statements on the residents yearly. They only completed them when residents were admitted. Based on record review and interview, the facility failed to ensure there was an admission and/or annual health statement in place for 5 of 8 records reviewed. (Residents 2, 8, 3, 4 and 5)			

	Findings include: 1. Resident 2's record was reviewed on 9/13/23 at 10:00 a.m. The resident was admitted to the facility on 9/3/21. Diagnoses included, but were not limited to, Diabetes Mellitus and multiple myeloma. There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective stage. 2. Resident 8's record was reviewed on 9/14/23 at 8:47 a.m. The resident was admitted to the facility on 10/12/19. Diagnoses included, but were not limited to, Diabetes Mellitus, renal insufficiency and arthritis. There was no annual health statement by the Physician to indicate the resident was free of infectious diseases or tuberculosis in the infective stage. Interview with the Administrator, on 9/14/23 at 10:30 a.m., indicated they only required the Physician statement on admission and did not update it after that.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g)	R 0410	1.TB was inserted on 09/15/2023. Second step will be give on or before 10/06/2023.	10/06/2023

	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a resident received a second step tuberculosis (TB) test on admission for 1 of 8 residents reviewed for admission TB test or screenings. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 9/13/23 at 11:13 a.m. The resident was admitted on 2/17/23. Diagnoses included,		2. All charts will be audited by 09/25 to ensure compliance with all other residents. 3. DON/ADON will put in place a new admissions checklist. 4. DON/ADON will audit for compliance monthly moving forward. 5. 10/06/2023	

but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.

There was no documentation the resident had received a second step TB test upon admission.

Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the resident should have had a second step TB test completed on admission.

Based on record review and interview, the facility failed to ensure a resident received a second step tuberculosis (TB) test on admission for 1 of 8 residents reviewed for admission TB test or screenings. (Resident 5)

Finding includes:

The record for Resident 5 was reviewed on 9/13/23 at 11:13 a.m. The resident was admitted on 2/17/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), diabetes, osteoarthritis (joint disease), renal insufficiency (kidney disease), macular degeneration (eye condition), and stroke.

There was no documentation

	the resident had received a second step TB test upon admission. Interview with the Executive Director on 9/14/23 at 12:02 p.m., indicated that the resident should have had a second step TB test completed on admission.			

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