

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2025	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 140 E 107TH AVENUE, CROWN POINT, , 46307					
(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: March 12 and 13, 2025 Facility number: 012940 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/19/25.	R 0000					
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on record review and	R 0042	R042 Residents' Rights - Noncomplianc e			03/24/2025	

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interview, the facility failed to ensure the most recent annual survey results were readily available for review. This had the potential to affect all 58 residents of the facility.

Finding includes:

A general tour of the facility was conducted at 3/12/25 at 9:52 a.m. and again on 3/13/25 at 8:35 a.m. A sign was posted that indicated the Survey Results Binder was near the entryway.

There were no binders located at or near the front entryway.

During an interview on 3/13/25 at 11:05 a.m., the Director of Nursing indicated a staff member had picked up the binder on 3/12/25 and did not return it to the table. It should have been on the table near the entryway.

Based on record review and interview, the facility failed to ensure the most recent annual survey results were readily available for review. This had the potential to affect all 58 residents of the facility.

Finding includes:

A general tour of the facility was conducted at 3/12/25 at 9:52 a.m. and again on 3/13/25 at 8:35 a.m. A sign was posted that indicated the Survey

What corrective actions will be accomplished for those residents found to have been affected by the noncompliant practice?

No residents were affected by this deficient practice however 58 residents had the potential to be affected by this noncompliant practice.

What corrective action will be taken?

The Survey Results Binder will remain out for resident viewing near the front entryway with the most recent annual survey and plan of correction.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Divisional Director of Operations

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	Results Binder was near the entryway. There were no binders located at or near the front entryway. During an interview on 3/13/25 at 11:05 a.m., the Director of Nursing indicated a staff member had picked up the binder on 3/12/25 and did not return it to the table. It should have been on the table near the entryway.		will re-educate the Executive Director on the facilities requirement to have the Survey Results Binder with the most recent annual survey results and plan of correction readily available at or near the front entryway for residents to review by 3/24/25 The Executive Director will be responsible for ensuring the Survey Results binder is at or near the front entryway daily. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Divisional of Operations to monitor compliance monthly x 6 months upon visits to the community that Survey Results Binder is at or near the front entryway. :	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2)	R 0092	R092	03/31/2025

(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:

(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.

(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.

Based on record review and interview, the facility failed to ensure fire drills were completed on each shift quarterly as required. This had the potential to affect all 58 residents in the facility.

Finding includes:

On 3/12/25 and 3/13/25 fire drills for the past year were

Administration and Management - Noncompliance

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

No residents were affected by the noncompliant practice, but 58 residents had the potential to be affected by this noncompliant practice.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

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requested for review.

During an interview on 3/13/25 at 11:25 a.m., the Maintenance Director indicated he had been there for a couple months. He provided a fire drill record completed on 3/5/25. He indicated he did not know where the remaining fire drills would be located.

During an interview on 3/13/25 at 12:45 p.m., the Director of Nursing indicated the Administrator would probably know about the fire drills but she was out of town and unavailable.

The current document, "Fire Drill Schedule", indicated, "...Fire Drills shall be performed MONTHLY. This includes each shift having one drill each quarter...."

Based on record review and interview, the facility failed to ensure fire drills were completed on each shift quarterly as required. This had the potential to affect all 58 residents in the facility.

Finding includes:

On 3/12/25 and 3/13/25 fire drills for the past year were requested for review.

During an interview on 3/13/25 at 11:25 a.m., the Maintenance Director indicated he had been

The Executive Director will re-educate the maintenance coordinator on the completion of fire drills on each shift quarterly as required by 3/31/25

The maintenance coordinator will be responsible for conducting and documenting drills.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Divisional Director of Operations will re-educate Executive Director on policy 410 IAC 16.2-5-1.3 completed by 3/24/25

The Executive Director is responsible for ensuring all fire drills are completed on each shift quarterly as required.

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	there for a couple months. He provided a fire drill record completed on 3/5/25. He indicated he did not know where the remaining fire drills would be located. During an interview on 3/13/25 at 12:45 p.m., the Director of Nursing indicated the Administrator would probably know about the fire drills but she was out of town and unavailable. The current document, "Fire Drill Schedule", indicated, "...Fire Drills shall be performed MONTHLY. This includes each shift having one drill each quarter...."		How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Executive director will monitor compliance monthly x 3 months and quarterly thereafter. Divisional Director of Operations will audit annually to ensure continued compliance.	
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm	R 0148	R148 Sanitation and Safety Standards - Deficiency What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	03/31/2025

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and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.

(3) All plumbing shall function properly and comply with state plumbing codes.

(4) At least yearly, heating and ventilating systems shall be inspected.

Based on record review and interview, the facility failed to ensure the HVAC (heating and ventilation system) was inspected annually. This had the potential to affect all 58 residents of the facility.

Finding includes:

On 3/12/24 and 3/13/24, the annual HVAC inspection was requested to review. It was not provided.

During an interview on 3/13/25 at 11:25 a.m., the Maintenance Director indicated he had been there for a couple of months and did not have knowledge of the annual HVAC inspection.

A maintenance schedule was provided by the Director of Nursing that indicated, "...check interior HVAC vent registers in all areas (excluding apartments) and clean as necessary...." This was to be completed annually in July.

No residents were affected by the noncompliant practice, but 58 residents had the potential to be affected by this deficient practice.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

The Executive Director will re-educate the maintenance coordinator on the completion of annual HVAC inspections as required 3/24/25.

The maintenance coordinator will be responsible for conducting and documenting annual HVAC inspections.

What measures will be put into place or what systemic

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	Based on record review and interview, the facility failed to ensure the HVAC (heating and ventilation system) was inspected annually. This had the potential to affect all 58 residents of the facility. Finding includes: On 3/12/24 and 3/13/24, the annual HVAC inspection was requested to review. It was not provided. During an interview on 3/13/25 at 11:25 a.m., the Maintenance Director indicated he had been there for a couple of months and did not have knowledge of the annual HVAC inspection. A maintenance schedule was provided by the Director of Nursing that indicated, "...check interior HVAC vent registers in all areas (excluding apartments) and clean as necessary...." This was to be completed annually in July.		changes the facility will make to ensure that the deficient practice does not recur. The Maintenance coordinator will perform HVAC inspection by 3/31/25. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The Executive Director is responsible for ensuring annual HVAC inspection thereafter by the maintenance coordinator. The Divisional Director of Operations will monitor documentation of annual HVAC inspections annually to ensure continued compliance.	
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h)	R 0151	R151 Sanitation and	03/31/2025

Safety Standards - Deficiency

(h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.

Based on record review and interview, the facility failed to ensure pets were up to date on vaccinations for 1 of 4 pet vaccination records reviewed. (Room 409)

Finding includes:

The Pet Policy and pet vaccination records were reviewed on 3/13/25. Veterinary records indicated the cat in room 409 was last seen for an exam and vaccines on 2/19/21.

During an interview on 3/13/25 at 11:20 a.m., the Administrative Assistant indicated the facility had been attempting to contact the family to have the vaccines updated.

The current policy for pets indicated, "...3. In allowing residents to keep pets at Bickford, as indicated in the Admission Agreement, pets shall be cared for with respect to sanitation issues, safety hazards and in compliance with local codes. Prior to move in, and ongoing, the Resident must provide proof of current vaccination records...."

Based on record review and interview, the facility failed to

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

O residents were harmed by this deficient practice.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

The Executive Director will perform an audit of all pet vaccination records to ensure compliance by 3/31/25.

What measures will be put into place or what systemic changes the facility will make to

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	ensure pets were up to date on vaccinations for 1 of 4 pet vaccination records reviewed. (Room 409) Finding includes: The Pet Policy and pet vaccination records were reviewed on 3/13/25. Veterinary records indicated the cat in room 409 was last seen for an exam and vaccines on 2/19/21. During an interview on 3/13/25 at 11:20 a.m., the Administrative Assistant indicated the facility had been attempting to contact the family to have the vaccines updated. The current policy for pets indicated, "...3. In allowing residents to keep pets at Bickford, as indicated in the Admission Agreement, pets shall be cared for with respect to sanitation issues, safety hazards and in compliance with local codes. Prior to move in, and ongoing, the Resident must provide proof of current vaccination records...."		ensure that the deficient practice does not recur. Executive director to re-educate administrative assistant that any pet housed in the facility shall have periodic veterinary examinations and required immunizations by 3/31/25. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Executive Director to audit all pet records monthly x 6 months to ensure compliance.	
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	R 0241	R241 Health Services - Offense	03/31/2025

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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.

3. Resident 8's record was reviewed on 3/12/25 at 2:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, and dementia.

The Service Plan, dated 9/25/24, indicated the resident was cognitively intact, required medication management, and was independent with activities of daily living. She required blood sugar (bs) checks before each meal and received insulin.

A Physician's Order, dated 1/9/25, indicated Humalog Kwikpen (insulin) injection 100 units/milliliter, inject per sliding scale with meals: 200-250=6 units (U), 251-300=8U, 301-350=10U, 351-400=12U, 401 and above=14U and recheck in 2 hours.

The February and March 2025 Medication Administration Record (MAR) indicated the Humalog was administered on the following dates and times, however the number of units of insulin administered were not available for review.

- At 8:00 a.m. on 2/5 (bs -111),

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

3 were affected by the offense, but 58 residents had the potential to be affected by this offense.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

Health and Wellness Director will audit all resident physician orders and e-mars to ensure physician ordered parameters are noted and followed and insulin amount given is documented by med passers. Completed by 4/30/25

Health and Wellness Director is responsible for ensuring

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2/6 (bs - 98), 2/16 (bs -134), 2/17 (bs - 350), 2/18 (bs - 148), 2/26 (bs - 138), 2/27 (bs - 78), 3/1 (bs - 119), 3/2 (bs - 131), 3/10 (bs - 186), and 3/11/25 (bs - 144) - At 12:00 p.m. on 2/7 (bs - 230), 2/14 (bs - 221), 2/23 (bs - 252), 3/3 (bs - 213), 3/5 (bs - 255), 3/9 (bs - 248), and 3/10/25 (bs - 203) - At 5:00 p.m. on 2/8 (bs - 168), 2/9 (bs - 188), 2/13 (bs - 256), 2/14 (bs - 218), 2/19 (bs - 216), 2/22 (bs - 151), 2/23 (bs - 248), 3/4 (bs - 179), and 3/8 (bs - 208) A Physician's Order, dated 9/13/24, indicated Lantus Solostar (long-acting insulin) 100U/ml solution, inject 38 units subcutaneously twice daily and hold nighttime insulin for blood sugar less than 150. The February and March 2025 MAR indicated the Lantus Solostar was marked as administered at 7:00 p.m. when the resident's blood sugar (bs) was less than 150 on 2/13 (bs - 112) , 2/18 (bs - 112), 2/19 (bs - 111), 2/20 (bs - 100), 2/26 (bs - 122), 2/28 (bs - 112), and 3/4/25 (bs - 130). During an interview on 3/13/25 at 12:47 p.m., the Director of Nursing indicated she had no further information to provide. She was unable to see documentation of the amount of	medication is given that follows parameters on the physician orders. Health and Wellness Director is responsible for ensuring that the amount of insulin given is documented. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. Divisional Director of Health and Wellness will re-educate Director of Health and Wellness on documentation of insulin and administering medication within physician ordered parameters by 3/24/25. Health and Wellness Director to in-service all medication passers of documentation of insulin and administering medication within parameters noted in physician orders by
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	insulin given and was not able to pull a report to determine how many units were administered. 2. Record Review for Resident 5 was completed on 3/12/25 at 1:10 p.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease and stroke. The March 2025 Physician's Order Summary (POS) indicated an order for metoprolol (medication to lower blood pressure) 25 mg (milligrams). Give 1/2 tablet daily, hold for SBP (systolic blood pressure, top number of blood pressure reading) less than 115. The January 2025 Medication Administration Record (MAR) indicated the resident received the metoprolol when the blood pressure (BP) was out of parameters on the following dates and times: - 1/1/25 at 5:00-8:00 p.m., the BP was 94/58 - 1/8/25 at 5:00-8:00 p.m., the BP was 102/73 - 1/23/25 at 7:00-10:00 a.m., the BP was 105/60 The February 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times:		3/31/25. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Health and Wellness Director will audit 1 resident MAR with blood pressure parameters weekly x4 weeks, then monthly x 6 months. Health and Wellness Director will audit 1 resident MAR with insulin weekly x4 weeks, then monthly x 6 months Divisional Director of Health and Wellness will review e-mars during routine branch visits x's 2 months and annually thereafter to ensure compliance.	
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- 2/8/25 at 5:00-8:00 p.m., the BP was 93/64

- 2/21/25 at 5:00-8:00 p.m., the BP was 98/66

- 2/24/25 at 5:00-8:00 p.m., the BP was 98/68

- 2/25/25 at 5:00-8:00 p.m., the BP was 91/70

The March 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times:

- 3/7/25 at 5:00-8:00 p.m., the BP was 99/64

During an interview on 3/13/25 at 1:00 p.m., the Director of Nursing indicated she could not provide any documentation that the metoprolol was held and not given outside of parameters on the above dates and times.

Based on observation, record review, and interview, the facility failed to ensure Physician Orders were followed during medication pass for 1 of 5 residents observed during medication pass. (Resident 10 and QMA 1) Physician Orders were also not followed related to a blood pressure medication given outside parameters and not documenting the amount of insulin given for 2 of 7 records reviewed. (Residents 5 and 8)

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Findings include:

1. On 3/13/25 at 8:55 a.m., QMA 1 was observed preparing Resident 10's medications. Included in the medications were Vitamin D3 1000 international units (IU) and rivastigmine patch 13.3 milligrams (mg)/ 24 hours. The QMA gave the medications to the resident, who took them whole with water. She then placed the rivastigmine patch on the resident's right chest.

The resident's record was reviewed on 3/13/25 at 9:55 a.m. The current Physician's Orders, dated 3/13/25, indicated Vitamin D3 2000 IU daily and rivastigmine patch 4.6 mg/ 24 hours.

During an interview on 3/13/25 at 10:45 a.m., the QMA indicated the Vitamin D3 was entered into the Medication Administration Record incorrectly as 1000 IU and would need to be corrected. She also indicated she may have given the resident the incorrect rivastigmine patch. The QMA went to Resident 10's room and removed the patch, which she indicated was incorrect.

3. Resident 8's record was reviewed on 3/12/25 at 2:16 p.m. Diagnoses included, but were not limited to, type 2

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diabetes mellitus, high blood pressure, and dementia.

The Service Plan, dated 9/25/24, indicated the resident was cognitively intact, required medication management, and was independent with activities of daily living. She required blood sugar (bs) checks before each meal and received insulin.

A Physician's Order, dated 1/9/25, indicated Humalog Kwikpen (insulin) injection 100 units/milliliter, inject per sliding scale with meals: 200-250=6 units (U), 251-300=8U, 301-350=10U, 351-400=12U, 401 and above=14U and recheck in 2 hours.

The February and March 2025 Medication Administration Record (MAR) indicated the Humalog was administered on the following dates and times, however the number of units of insulin administered were not available for review.

- At 8:00 a.m. on 2/5 (bs -111), 2/6 (bs - 98), 2/16 (bs -134), 2/17 (bs - 350), 2/18 (bs - 148), 2/26 (bs - 138), 2/27 (bs - 78), 3/1 (bs - 119), 3/2 (bs - 131), 3/10 (bs - 186), and 3/11/25 (bs - 144)

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- At 12:00 p.m. on 2/7 (bs - 230), 2/14 (bs - 221), 2/23 (bs - 252), 3/3 (bs - 213), 3/5 (bs - 255), 3/9 (bs - 248), and 3/10/25 (bs - 203)

- At 5:00 p.m. on 2/8 (bs - 168), 2/9 (bs - 188), 2/13 (bs - 256), 2/14 (bs - 218), 2/19 (bs - 216), 2/22 (bs - 151), 2/23 (bs - 248), 3/4 (bs - 179), and 3/8 (bs - 208)

A Physician's Order, dated 9/13/24, indicated Lantus Solostar (long-acting insulin) 100U/ml solution, inject 38 units subcutaneously twice daily and hold nighttime insulin for blood sugar less than 150.

The February and March 2025 MAR indicated the Lantus Solostar was marked as administered at 7:00 p.m. when the resident's blood sugar (bs) was less than 150 on 2/13 (bs - 112) , 2/18 (bs - 112), 2/19 (bs - 111), 2/20 (bs - 100), 2/26 (bs - 122), 2/28 (bs - 112), and 3/4/25 (bs - 130).

During an interview on 3/13/25 at 12:47 p.m., the Director of Nursing indicated she had no further information to provide. She was unable to see documentation of the amount of insulin given and was not able to pull a report to determine how many units were administered.

2. Record Review for Resident 5 was completed on 3/12/25 at 1:10 p.m. Diagnoses included,

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but were not limited to, stage 3 chronic kidney disease and stroke.

The March 2025 Physician's Order Summary (POS) indicated an order for metoprolol (medication to lower blood pressure) 25 mg (milligrams). Give 1/2 tablet daily, hold for SBP (systolic blood pressure, top number of blood pressure reading) less than 115.

The January 2025 Medication Administration Record (MAR) indicated the resident received the metoprolol when the blood pressure (BP) was out of parameters on the following dates and times:

- 1/1/25 at 5:00-8:00 p.m., the BP was 94/58

- 1/8/25 at 5:00-8:00 p.m., the BP was 102/73

- 1/23/25 at 7:00-10:00 a.m., the BP was 105/60

The February 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times:

- 2/8/25 at 5:00-8:00 p.m., the BP was 93/64

- 2/21/25 at 5:00-8:00 p.m., the BP was 98/66

- 2/24/25 at 5:00-8:00 p.m., the

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BP was 98/68

- 2/25/25 at 5:00-8:00 p.m., the
BP was 91/70

The March 2025 MAR indicated
the resident received the
metoprolol when the BP was out
of parameters on the following
dates and times:

- 3/7/25 at 5:00-8:00 p.m., the
BP was 99/64

During an interview on 3/13/25
at 1:00 p.m., the Director of
Nursing indicated she could not
provide any documentation that
the metoprolol was held and not
given outside of parameters on
the above dates and times.

Based on observation, record
review, and interview, the facility
failed to ensure Physician
Orders were followed during
medication pass for 1 of 5
residents observed during
medication pass. (Resident 10
and QMA 1) Physician Orders
were also not followed related to
a blood pressure medication
given outside parameters and
not documenting the amount of
insulin given for 2 of 7 records
reviewed. (Residents 5 and 8)

Findings include:

1. On 3/13/25 at 8:55 a.m.,
QMA 1 was observed preparing
Resident 10's medications.
Included in the medications
were Vitamin D3 1000

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international units (IU) and rivastigmine patch 13.3 milligrams (mg)/ 24 hours. The QMA gave the medications to the resident, who took them whole with water. She then placed the rivastigmine patch on the resident's right chest.

The resident's record was reviewed on 3/13/25 at 9:55 a.m. The current Physician's Orders, dated 3/13/25, indicated Vitamin D3 2000 IU daily and rivastigmine patch 4.6 mg/ 24 hours.

During an interview on 3/13/25 at 10:45 a.m., the QMA indicated the Vitamin D3 was entered into the Medication Administration Record incorrectly as 1000 IU and would need to be corrected. She also indicated she may have given the resident the incorrect rivastigmine patch. The QMA went to Resident 10's room and removed the patch, which she indicated was incorrect.

3. Resident 8's record was reviewed on 3/12/25 at 2:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, and dementia.

The Service Plan, dated 9/25/24, indicated the resident was cognitively intact, required medication management, and

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was independent with activities of daily living. She required blood sugar (bs) checks before each meal and received insulin.

A Physician's Order, dated 1/9/25, indicated Humalog Kwikpen (insulin) injection 100 units/milliliter, inject per sliding scale with meals: 200-250=6 units (U), 251-300=8U, 301-350=10U, 351-400=12U, 401 and above=14U and recheck in 2 hours.

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- At 12:00 p.m. on 2/7 (bs - 230), 2/14 (bs - 221), 2/23 (bs - 252), 3/3 (bs - 213), 3/5 (bs - 255), 3/9 (bs - 248), and 3/10/25 (bs - 203)

- At 5:00 p.m. on 2/8 (bs - 168), 2/9 (bs - 188), 2/13 (bs - 256), 2/14 (bs - 218), 2/19 (bs - 216), 2/22 (bs - 151), 2/23 (bs - 248), 3/4 (bs - 179), and 3/8 (bs - 208)

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A Physician's Order, dated 9/13/24, indicated Lantus Solostar (long-acting insulin) 100U/ml solution, inject 38 units subcutaneously twice daily and hold nighttime insulin for blood sugar less than 150.

The February and March 2025 MAR indicated the Lantus Solostar was marked as administered at 7:00 p.m. when the resident's blood sugar (bs) was less than 150 on 2/13 (bs - 112) , 2/18 (bs - 112), 2/19 (bs - 111), 2/20 (bs - 100), 2/26 (bs - 122), 2/28 (bs - 112), and 3/4/25 (bs - 130).

During an interview on 3/13/25 at 12:47 p.m., the Director of Nursing indicated she had no further information to provide. She was unable to see documentation of the amount of insulin given and was not able to pull a report to determine how many units were administered.

2. Record Review for Resident 5 was completed on 3/12/25 at 1:10 p.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease and stroke.

The March 2025 Physician's Order Summary (POS) indicated an order for metoprolol (medication to lower blood pressure) 25 mg (milligrams). Give 1/2 tablet daily, hold for SBP (systolic blood pressure,

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top number of blood pressure reading) less than 115.

The January 2025 Medication Administration Record (MAR) indicated the resident received the metoprolol when the blood pressure (BP) was out of parameters on the following dates and times:

- 1/1/25 at 5:00-8:00 p.m., the BP was 94/58
- 1/8/25 at 5:00-8:00 p.m., the BP was 102/73
- 1/23/25 at 7:00-10:00 a.m., the BP was 105/60

The February 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times:

- 2/8/25 at 5:00-8:00 p.m., the BP was was 93/64
- 2/21/25 at 5:00-8:00 p.m., the BP was 98/66
- 2/24/25 at 5:00-8:00 p.m., the BP was 98/68
- 2/25/25 at 5:00-8:00 p.m., the BP was 91/70

The March 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times:

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- 3/7/25 at 5:00-8:00 p.m., the BP was 99/64

During an interview on 3/13/25 at 1:00 p.m., the Director of Nursing indicated she could not provide any documentation that the metoprolol was held and not given outside of parameters on the above dates and times.

Based on observation, record review, and interview, the facility failed to ensure Physician Orders were followed during medication pass for 1 of 5 residents observed during medication pass. (Resident 10 and QMA 1) Physician Orders were also not followed related to a blood pressure medication given outside parameters and not documenting the amount of insulin given for 2 of 7 records reviewed. (Residents 5 and 8)

Findings include:

1. On 3/13/25 at 8:55 a.m., QMA 1 was observed preparing Resident 10's medications. Included in the medications were Vitamin D3 1000 international units (IU) and rivastigmine patch 13.3 milligrams (mg)/ 24 hours. The QMA gave the medications to the resident, who took them whole with water. She then placed the rivastigmine patch on the resident's right chest.

The resident's record was reviewed on 3/13/25 at 9:55

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a.m. The current Physician's Orders, dated 3/13/25, indicated Vitamin D3 2000 IU daily and rivastigmine patch 4.6 mg/ 24 hours.

During an interview on 3/13/25 at 10:45 a.m., the QMA indicated the Vitamin D3 was entered into the Medication Administration Record incorrectly as 1000 IU and would need to be corrected. She also indicated she may have given the resident the incorrect rivastigmine patch. The QMA went to Resident 10's room and removed the patch, which she indicated was incorrect.

3. Resident 8's record was reviewed on 3/12/25 at 2:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, and dementia.

The Service Plan, dated 9/25/24, indicated the resident was cognitively intact, required medication management, and was independent with activities of daily living. She required blood sugar (bs) checks before each meal and received insulin.

A Physician's Order, dated 1/9/25, indicated Humalog Kwikpen (insulin) injection 100 units/milliliter, inject per sliding scale with meals: 200-250=6 units (U), 251-300=8U,

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301-350=10U, 351-400=12U, 401 and above=14U and recheck in 2 hours.

The February and March 2025 Medication Administration Record (MAR) indicated the Humalog was administered on the following dates and times, however the number of units of insulin administered were not available for review.

- At 8:00 a.m. on 2/5 (bs -111), 2/6 (bs - 98), 2/16 (bs -134), 2/17 (bs - 350), 2/18 (bs - 148), 2/26 (bs - 138), 2/27 (bs - 78), 3/1 (bs - 119), 3/2 (bs - 131), 3/10 (bs - 186), and 3/11/25 (bs - 144)

- At 12:00 p.m. on 2/7 (bs - 230), 2/14 (bs - 221), 2/23 (bs - 252), 3/3 (bs - 213), 3/5 (bs - 255), 3/9 (bs - 248), and 3/10/25 (bs - 203)

- At 5:00 p.m. on 2/8 (bs - 168), 2/9 (bs - 188), 2/13 (bs - 256), 2/14 (bs - 218), 2/19 (bs - 216), 2/22 (bs - 151), 2/23 (bs - 248), 3/4 (bs - 179), and 3/8 (bs - 208)

A Physician's Order, dated 9/13/24, indicated Lantus Solostar (long-acting insulin) 100U/ml solution, inject 38 units subcutaneously twice daily and hold nighttime insulin for blood sugar less than 150.

The February and March 2025 MAR indicated the Lantus Solostar was marked as

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administered at 7:00 p.m. when the resident's blood sugar (bs) was less than 150 on 2/13 (bs - 112) , 2/18 (bs - 112), 2/19 (bs - 111), 2/20 (bs - 100), 2/26 (bs - 122), 2/28 (bs - 112), and 3/4/25 (bs - 130).

During an interview on 3/13/25 at 12:47 p.m., the Director of Nursing indicated she had no further information to provide. She was unable to see documentation of the amount of insulin given and was not able to pull a report to determine how many units were administered.

2. Record Review for Resident 5 was completed on 3/12/25 at 1:10 p.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease and stroke.

The March 2025 Physician's Order Summary (POS) indicated an order for metoprolol (medication to lower blood pressure) 25 mg (milligrams). Give 1/2 tablet daily, hold for SBP (systolic blood pressure, top number of blood pressure reading) less than 115.

The January 2025 Medication Administration Record (MAR) indicated the resident received the metoprolol when the blood pressure (BP) was out of parameters on the following dates and times:

- 1/1/25 at 5:00-8:00 p.m., the

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BP was 94/58

- 1/8/25 at 5:00-8:00 p.m., the
BP was 102/73

- 1/23/25 at 7:00-10:00 a.m., the
BP was 105/60

The February 2025 MAR
indicated the resident received
the metoprolol when the BP was
out of parameters on the
following dates and times:

- 2/8/25 at 5:00-8:00 p.m., the
BP was was 93/64

- 2/21/25 at 5:00-8:00 p.m., the
BP was 98/66

- 2/24/25 at 5:00-8:00 p.m., the
BP was 98/68

- 2/25/25 at 5:00-8:00 p.m., the
BP was 91/70

The March 2025 MAR indicated
the resident received the
metoprolol when the BP was out
of parameters on the following
dates and times:

- 3/7/25 at 5:00-8:00 p.m., the
BP was 99/64

During an interview on 3/13/25
at 1:00 p.m., the Director of
Nursing indicated she could not
provide any documentation that
the metoprolol was held and not
given outside of parameters on
the above dates and times.

Based on observation, record

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review, and interview, the facility failed to ensure Physician Orders were followed during medication pass for 1 of 5 residents observed during medication pass. (Resident 10 and QMA 1) Physician Orders were also not followed related to a blood pressure medication given outside parameters and not documenting the amount of insulin given for 2 of 7 records reviewed. (Residents 5 and 8)

Findings include:

1. On 3/13/25 at 8:55 a.m., QMA 1 was observed preparing Resident 10's medications. Included in the medications were Vitamin D3 1000 international units (IU) and rivastigmine patch 13.3 milligrams (mg)/ 24 hours. The QMA gave the medications to the resident, who took them whole with water. She then placed the rivastigmine patch on the resident's right chest.

The resident's record was reviewed on 3/13/25 at 9:55 a.m. The current Physician's Orders, dated 3/13/25, indicated Vitamin D3 2000 IU daily and rivastigmine patch 4.6 mg/ 24 hours.

During an interview on 3/13/25 at 10:45 a.m., the QMA indicated the Vitamin D3 was entered into the Medication Administration Record

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incorrectly as 1000 IU and would need to be corrected. She also indicated she may have given the resident the incorrect rivastigmine patch. The QMA went to Resident 10's room and removed the patch, which she indicated was incorrect.

3. Resident 8's record was reviewed on 3/12/25 at 2:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, and dementia.

The Service Plan, dated 9/25/24, indicated the resident was cognitively intact, required medication management, and was independent with activities of daily living. She required blood sugar (bs) checks before each meal and received insulin.

A Physician's Order, dated 1/9/25, indicated Humalog Kwikpen (insulin) injection 100 units/milliliter, inject per sliding scale with meals: 200-250=6 units (U), 251-300=8U, 301-350=10U, 351-400=12U, 401 and above=14U and recheck in 2 hours.

The February and March 2025 Medication Administration Record (MAR) indicated the Humalog was administered on the following dates and times, however the number of units of insulin administered were not

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	available for review. - At 8:00 a.m. on 2/5 (bs -111), 2/6 (bs - 98), 2/16 (bs -134), 2/17 (bs - 350), 2/18 (bs - 148), 2/26 (bs - 138), 2/27 (bs - 78), 3/1 (bs - 119), 3/2 (bs - 131), 3/10 (bs - 186), and 3/11/25 (bs - 144) - At 12:00 p.m. on 2/7 (bs - 230), 2/14 (bs - 221), 2/23 (bs - 252), 3/3 (bs - 213), 3/5 (bs - 255), 3/9 (bs - 248), and 3/10/25 (bs - 203) - At 5:00 p.m. on 2/8 (bs - 168), 2/9 (bs - 188), 2/13 (bs - 256), 2/14 (bs - 218), 2/19 (bs - 216), 2/22 (bs - 151), 2/23 (bs - 248), 3/4 (bs - 179), and 3/8 (bs - 208) A Physician's Order, dated 9/13/24, indicated Lantus Solostar (long-acting insulin) 100U/ml solution, inject 38 units subcutaneously twice daily and hold nighttime insulin for blood sugar less than 150. The February and March 2025 MAR indicated the Lantus Solostar was marked as administered at 7:00 p.m. when the resident's blood sugar (bs) was less than 150 on 2/13 (bs - 112) , 2/18 (bs - 112), 2/19 (bs - 111), 2/20 (bs - 100), 2/26 (bs - 122), 2/28 (bs - 112), and 3/4/25 (bs - 130). During an interview on 3/13/25 at 12:47 p.m., the Director of Nursing indicated she had no			
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further information to provide.
She was unable to see documentation of the amount of insulin given and was not able to pull a report to determine how many units were administered.

2. Record Review for Resident 5 was completed on 3/12/25 at 1:10 p.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease and stroke.

The March 2025 Physician's Order Summary (POS) indicated an order for metoprolol (medication to lower blood pressure) 25 mg (milligrams). Give 1/2 tablet daily, hold for SBP (systolic blood pressure, top number of blood pressure reading) less than 115.

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The March 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times:

- 3/7/25 at 5:00-8:00 p.m., the BP was 99/64

During an interview on 3/13/25 at 1:00 p.m., the Director of Nursing indicated she could not provide any documentation that the metoprolol was held and not given outside of parameters on the above dates and times.

Based on observation, record review, and interview, the facility failed to ensure Physician Orders were followed during medication pass for 1 of 5 residents observed during medication pass. (Resident 10 and QMA 1) Physician Orders were also not followed related to a blood pressure medication given outside parameters and not documenting the amount of

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insulin given for 2 of 7 records reviewed. (Residents 5 and 8)

Findings include:

1. On 3/13/25 at 8:55 a.m., QMA 1 was observed preparing Resident 10's medications. Included in the medications were Vitamin D3 1000 international units (IU) and rivastigmine patch 13.3 milligrams (mg)/ 24 hours. The QMA gave the medications to the resident, who took them whole with water. She then placed the rivastigmine patch on the resident's right chest.

The resident's record was reviewed on 3/13/25 at 9:55 a.m. The current Physician's Orders, dated 3/13/25, indicated Vitamin D3 2000 IU daily and rivastigmine patch 4.6 mg/ 24 hours.

During an interview on 3/13/25 at 10:45 a.m., the QMA indicated the Vitamin D3 was entered into the Medication Administration Record incorrectly as 1000 IU and would need to be corrected. She also indicated she may have given the resident the incorrect rivastigmine patch. The QMA went to Resident 10's room and removed the patch, which she indicated was incorrect.

3. Resident 8's record was reviewed on 3/12/25 at 2:16

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p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, and dementia.

The Service Plan, dated 9/25/24, indicated the resident was cognitively intact, required medication management, and was independent with activities of daily living. She required blood sugar (bs) checks before each meal and received insulin.

A Physician's Order, dated 1/9/25, indicated Humalog Kwikpen (insulin) injection 100 units/milliliter, inject per sliding scale with meals: 200-250=6 units (U), 251-300=8U, 301-350=10U, 351-400=12U, 401 and above=14U and recheck in 2 hours.

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- At 12:00 p.m. on 2/7 (bs - 230), 2/14 (bs - 221), 2/23 (bs - 252), 3/3 (bs - 213), 3/5 (bs -

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255), 3/9 (bs - 248), and 3/10/25 (bs - 203)

- At 5:00 p.m. on 2/8 (bs - 168), 2/9 (bs - 188), 2/13 (bs - 256), 2/14 (bs - 218), 2/19 (bs - 216), 2/22 (bs - 151), 2/23 (bs - 248), 3/4 (bs - 179), and 3/8 (bs - 208)

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The February and March 2025 MAR indicated the Lantus Solostar was marked as administered at 7:00 p.m. when the resident's blood sugar (bs) was less than 150 on 2/13 (bs - 112) , 2/18 (bs - 112), 2/19 (bs - 111), 2/20 (bs - 100), 2/26 (bs - 122), 2/28 (bs - 112), and 3/4/25 (bs - 130).

During an interview on 3/13/25 at 12:47 p.m., the Director of Nursing indicated she had no further information to provide. She was unable to see documentation of the amount of insulin given and was not able to pull a report to determine how many units were administered.

2. Record Review for Resident 5 was completed on 3/12/25 at 1:10 p.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease and stroke.

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- 1/23/25 at 7:00-10:00 a.m., the BP was 105/60

The February 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times:

- 2/8/25 at 5:00-8:00 p.m., the BP was 93/64

- 2/21/25 at 5:00-8:00 p.m., the

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BP was 98/66

- 2/24/25 at 5:00-8:00 p.m., the
BP was 98/68

- 2/25/25 at 5:00-8:00 p.m., the
BP was 91/70

The March 2025 MAR indicated
the resident received the
metoprolol when the BP was out
of parameters on the following
dates and times:

- 3/7/25 at 5:00-8:00 p.m., the
BP was 99/64

During an interview on 3/13/25
at 1:00 p.m., the Director of
Nursing indicated she could not
provide any documentation that
the metoprolol was held and not
given outside of parameters on
the above dates and times.

Based on observation, record
review, and interview, the facility
failed to ensure Physician
Orders were followed during
medication pass for 1 of 5
residents observed during
medication pass. (Resident 10
and QMA 1) Physician Orders
were also not followed related to
a blood pressure medication
given outside parameters and
not documenting the amount of
insulin given for 2 of 7 records
reviewed. (Residents 5 and 8)

Findings include:

1. On 3/13/25 at 8:55 a.m.,
QMA 1 was observed preparing

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	Resident 10's medications. Included in the medications were Vitamin D3 1000 international units (IU) and rivastigmine patch 13.3 milligrams (mg)/ 24 hours. The QMA gave the medications to the resident, who took them whole with water. She then placed the rivastigmine patch on the resident's right chest. The resident's record was reviewed on 3/13/25 at 9:55 a.m. The current Physician's Orders, dated 3/13/25, indicated Vitamin D3 2000 IU daily and rivastigmine patch 4.6 mg/ 24 hours. During an interview on 3/13/25 at 10:45 a.m., the QMA indicated the Vitamin D3 was entered into the Medication Administration Record incorrectly as 1000 IU and would need to be corrected. She also indicated she may have given the resident the incorrect rivastigmine patch. The QMA went to Resident 10's room and removed the patch, which she indicated was incorrect.			
R 0270	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(c)(1-3) (c) The facility must meet: (1) daily dietary requirements and	R 0270		04/01/2025

requests, with consideration of food allergies;

(2) reasonable religious, ethnic, and personal preferences; and

(3) the temporary need for meals delivered to the resident ' s room.

Based on observation, record review, and interview, the facility failed to ensure modified diets were prepared properly according to the recipe and were the proper consistency. This had the potential to affect 1 resident who resided in the facility and received a puree diet.

Finding includes:

On 3/12/25 at 11:50 a.m., Server 1 was observed preparing a puree modified diet. She took one baked fish fillet from a serving pan, put it in the blender, poured an unmeasured amount of 2% milk directly from the gallon into the blender, and turned the blender on for 10 seconds. She poured the fish puree into a bowl with solid pieces of fish visible as she was pouring. She added one packet of thickener to the bowl and stirred the fish. She then placed the bowl on the serving cart. The puree consistency was liquid with whole pieces visible.

She washed the blender and then began to prepare the puree cooked spinach. She took one

R270 Food and Nutritional Services - Deficiency

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

No residents were harmed by this deficient practice but had the potential to harm 1 resident.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

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scoop of spinach from the serving pan, put it in the blender, poured an unmeasured amount of 2% milk directly from the gallon into the blender and turned on the blender for 10 seconds. She poured the spinach into a small bowl, added half a packet of thickener, and stirred the spinach. She then placed the bowl on the serving cart. The puree consistency was gel like and not blended together with the diced pieces of spinach visible.

During an interview at that time, Server 1 indicated she was done with the puree, and it was ready to serve. When asked about the consistency, she indicated maybe the baked fish puree was too thin. She provided the puree recipe book for review. She indicated she had been instructed not to add water, only milk, because water did not have any protein. She was also supposed to use milk if broth was not available. At this time, Server 1 was stopped and asked to consult the Kitchen Manager regarding the puree preparation, recipe, and consistency.

Divisional Director of dining services to in-service Dietary Director on pureed diet recipes by 3/28/25

Kitchen staff will be in-service on modified diets including preparation of pureed diets and following recipes by 4/1/25.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Dietary Director to observe preparation of pureed diets 3 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure recipes are followed.

How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.

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	During an interview on 3/12/24 at 12:10 p.m., the Director of Nursing was made aware of the puree preparation concerns. No further information was provided. A facility recipe for pureed baked fish, received as current, indicated to use fish stock and instant thickener when preparing the puree. "...2. Blend cooked fish with hot broth until smooth. Stir in puree appeal..." A facility recipe for pureed vegetables, received as current, indicated to use water and margarine when preparing the puree. "1. Measure 1/2 c [cup] drained vegetables, 1 tsp [teaspoon] of water/vegetable liquid, and 1 tsp margarine for each pureed serving needed. Using a food processor, add vegetables, margarine and half the liquid. Stop and scrape down sides. Add remaining liquid and blend until smooth..." Based on observation, record review, and interview, the facility failed to ensure modified diets were prepared properly according to the recipe and were the proper consistency. This had the potential to affect 1 resident who resided in the facility and received a puree diet. Finding includes: On 3/12/25 at 11:50 a.m.,		Executive Director will observe a pureed diet preparation audit monthly x 3 months to ensure continued compliance in the preparation of modified diets per recipe. Divisional Director of Operations will observe pureed diet preparation during routine branch visits x3 months and annually thereafter to ensure compliance.	
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Server 1 was observed preparing a puree modified diet. She took one baked fish fillet from a serving pan, put it in the blender, poured an unmeasured amount of 2% milk directly from the gallon into the blender, and turned the blender on for 10 seconds. She poured the fish puree into a bowl with solid pieces of fish visible as she was pouring. She added one packet of thickener to the bowl and stirred the fish. She then placed the bowl on the serving cart. The puree consistency was liquid with whole pieces visible.

She washed the blender and then began to prepare the puree cooked spinach. She took one scoop of spinach from the serving pan, put it in the blender, poured an unmeasured amount of 2% milk directly from the gallon into the blender and turned on the blender for 10 seconds. She poured the spinach into a small bowl, added half a packet of thickener, and stirred the spinach. She then placed the bowl on the serving cart. The puree consistency was gel like and not blended together with the diced pieces of spinach visible.

During an interview at that time, Server 1 indicated she was done with the puree, and it was ready to serve. When asked about the consistency, she

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indicated maybe the baked fish puree was too thin. She provided the puree recipe book for review. She indicated she had been instructed not to add water, only milk, because water did not have any protein. She was also supposed to use milk if broth was not available. At this time, Server 1 was stopped and asked to consult the Kitchen Manager regarding the puree preparation, recipe, and consistency.

During an interview on 3/12/24 at 12:10 p.m., the Director of Nursing was made aware of the puree preparation concerns. No further information was provided.

A facility recipe for pureed baked fish, received as current, indicated to use fish stock and instant thickener when preparing the puree. "...2. Blend cooked fish with hot broth until smooth. Stir in puree appeal..."

A facility recipe for pureed vegetables, received as current, indicated to use water and margarine when preparing the puree. "1. Measure 1/2 c [cup] drained vegetables, 1 tsp [teaspoon] of water/vegetable liquid, and 1 tsp margarine for each pureed serving needed. Using a food processor, add vegetables, margarine and half the liquid. Stop and scrape down sides. Add remaining

	liquid and blend until smooth..."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain proper food sanitation related to low food holding temperature. This had the potential to affect the 58 residents who received food from the kitchen. Finding includes: On 3/12/25 at 11:45 a.m., Cook 1 was observed taking the food temperatures on the steam table prior to serving lunch. She took a thermometer and placed it in one of the baked fish fillets. She indicated the temperature was 100 F (degrees Fahrenheit). She then moved on and checked the temperatures of the remaining food on the steam table and indicated she was ready to begin serving the food. During an interview at that time, Cook 1 indicated the baked fish temperature should be between 75 F to 100 F and it was ok to	R 0273	R273 Food and Nutritional Services - Deficiency What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 58 residents had the potential to be affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken	04/01/2025

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serve. Server 1, who was also in the kitchen during this time, indicated she thought the temperature had to be 175 F. At this time, Cook 1 was stopped and asked to consult the Kitchen Manager to determine the correct food temperature. During a continued interview at 11:55 a.m., Cook 1 indicated she had spoken with the Kitchen Manager and the baked fish temperature should be 140 F, so she would put the fish back into the oven.

During an interview on 3/12/24 at 12:10 p.m., the Director of Nursing was made aware of the food temperature concern. No further information was provided.

A facility recipe for baked fish, received as current, indicated "...Hold seafood for hot service at 140 degrees F or higher..."

The Retail Food Establishment Sanitation Requirements, dated 11/13/04, indicated "...Holding temperatures...Potentially hazardous food; hot and cold holding...Sec. 187. (a) Except during preparation, cooking, or cooling... potentially hazardous food shall be maintained as follows: (1) At one hundred thirty-five (135) degrees Fahrenheit or above..."

Based on observation, interview, and record review, the

Divisional Director of dining services to inservice Dietary Director on proper food holding temperature by 3/28/25

Kitchen staff will be in-service on proper food holding temperature by 4/1/25.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Dietary Director to observe temping of proteins
3 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure recipes are followed.

Dietary will monitor the temping log 3 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure recipes are followed.

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facility failed to maintain proper food sanitation related to low food holding temperature. This had the potential to affect the 58 residents who received food from the kitchen.

Finding includes:

On 3/12/25 at 11:45 a.m., Cook 1 was observed taking the food temperatures on the steam table prior to serving lunch. She took a thermometer and placed it in one of the baked fish fillets. She indicated the temperature was 100 F (degrees Fahrenheit). She then moved on and checked the temperatures of the remaining food on the steam table and indicated she was ready to begin serving the food.

During an interview at that time, Cook 1 indicated the baked fish temperature should be between 75 F to 100 F and it was ok to serve. Server 1, who was also in the kitchen during this time, indicated she thought the temperature had to be 175 F. At this time, Cook 1 was stopped and asked to consult the Kitchen Manager to determine the correct food temperature. During a continued interview at 11:55 a.m., Cook 1 indicated she had spoken with the Kitchen Manager and the baked fish temperature should be 140 F, so she would put the fish back into the oven.

How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.

Executive Director will observe the cook temp the proteins monthly x 3 months to ensure proper temping procedures.

Executive Director will audit the temp log monthly x 3 months to ensure proper documentation of temps.

Divisional Director of Operations will audit temp log during routine branch visits x's 2 months and annually thereafter to ensure compliance.

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	During an interview on 3/12/24 at 12:10 p.m., the Director of Nursing was made aware of the food temperature concern. No further information was provided. A facility recipe for baked fish, received as current, indicated "...Hold seafood for hot service at 140 degrees F or higher..." The Retail Food Establishment Sanitation Requirements, dated 11/13/04, indicated "...Holding temperatures...Potentially hazardous food; hot and cold holding...Sec. 187. (a) Except during preparation, cooking, or cooling... potentially hazardous food shall be maintained as follows: (1) At one hundred thirty-five (135) degrees Fahrenheit or above..."			
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	R 0356	R356 Clinical Records - Noncompliance What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	03/31/2025

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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.

Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 3 of 5 residents reviewed. (Residents 4, 6 and 7)

Findings include:

The resident Emergency Binder was reviewed on 3/12/25 at 11:10 a.m.

a. Resident 4 was missing a photograph.

b. Resident 6 was missing a hospital preference.

c. Resident 7 was missing allergy information. Resident 7's record was reviewed on 3/12/25 at 1:05 p.m. Her allergies were

58 residents had the potential to be affected by this noncompliant practice.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

Health and Wellness Director will audit Emergency Binder to ensure that it contains all the necessary information for all residents by 3/31/25.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Divisional Director of Health and Wellness to re-educate Health and Wellness Director and Executive

listed as: latex, belladonna and Zosyn.

During an interview on 3/12/25 at 3:00 p.m., Director of Nursing was made aware of the missing items from the Emergency Binder. No additional information was provided.

Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 3 of 5 residents reviewed. (Residents 4, 6 and 7)

Findings include:

The resident Emergency Binder was reviewed on 3/12/25 at 11:10 a.m.

- a. Resident 4 was missing a photograph.
- b. Resident 6 was missing a hospital preference.
- c. Resident 7 was missing allergy information. Resident 7's record was reviewed on 3/12/25 at 1:05 p.m. Her allergies were listed as: latex, belladonna and Zosyn.

During an interview on 3/12/25 at 3:00 p.m., Director of Nursing was made aware of the missing items from the Emergency Binder. No additional information was provided.

Director on all necessary information to be contained in the emergency binder by 3/24/25.

How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.

Executive Director will audit Emergency Binder for all necessary information monthly x's 6 months.

Divisional Director of Health and Wellness with review Emergency Binder during routine visits x's 3 months and annually thereafter to ensure compliance.

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FORM APPROVED

OMB NO. 0938-0391

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
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