

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 05/31/2024
NAME OF PROVIDER OR SUPPLIER ROSE SENIOR LIVING CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 1285 FAIRFAX MANOR DRIVE, CARMEL, , 46032			
(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. This visit included the Investigation of Complaint IN00414606. Complaint IN00414606 - No deficiencies related to the allegations are cited. Survey dates: May 29, 30 and 31, 2024. Facility number: 013719 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 5, 2024.	R 0000			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a	R 0092	In response to 410 IAC 16.2-5-1.3 (i) (1-2) Administration and Management- Noncompliance the facility notes that no residents have been harmed by this deficient practice, however, acknowledges	07/01/2024	

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	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 conduct monthly fire drills for 2 of 12 months reviewed for fire and disaster drills. (November and December 2023) Finding includes: The fire drill records were reviewed on 5/29/24. There was no documentation to show a fire drill had been held in November		the risk of potential harm. Facility will conduct monthly fire drills alternating shifts on a monthly basis. Fire drills will be conducted and documented by the Director of Plant Operations (DPO) or designee. Documentation will be kept in TELS database for record keeping purposes and a copy will be placed in the facilities Plant Operations Manual. Facility will continue to work in conjunction with the Carmel Fire Department twice annually to ensure community is current on all best practices. Furthermore, DPO will complete a documented in-service with designees to ensure full understanding of proper procedures in the event DPO is absent during a routine drill.	
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or December 2023.

During an interview, on 5/29/24 at 2:14 p.m., the Executive Director indicated the person who held the fire dills had been on leave during the months of November and December 2023.

During an interview, on 5/29/24 at 3:38 p.m., the Executive Director indicated fire drills were to be held every month and the shifts were to be alternated. He was not able to find the missing fire drill documentation. He indicated the facility did not have a policy and they follow the state regulations.

Based on record review and interview, the facility failed to conduct monthly fire drills for 2 of 12 months reviewed for fire and disaster drills. (November and December 2023)

Finding includes:

The fire drill records were reviewed on 5/29/24. There was no documentation to show a fire drill had been held in November or December 2023.

During an interview, on 5/29/24 at 2:14 p.m., the Executive Director indicated the person who held the fire dills had been on leave during the months of November and December 2023.

During an interview, on 5/29/24 at 3:38 p.m., the Executive

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	Director indicated fire drills were to be held every month and the shifts were to be alternated. He was not able to find the missing fire drill documentation. He indicated the facility did not have a policy and they follow the state regulations.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure reference checks were completed prior to employment for 1 of 5 employees reviewed for reference checks. (Cook 6) Finding includes: The employee records were reviewed on 5/29/24. Cook 6 was found to be missing references for employment. The Executive Director provided the employee records with reference sheets which had not been filled out. During an interview, on 5/30/24	R 0116	In response to 410 IAC 16.2-5-1.4(a) Personnel-Noncompliance, facility notes that no residents were harmed by this deficient practice, however, facility acknowledges the potential risk. BOM/HR Director or designee(s) will complete an audit of all current employee files to ensure all preemployment verification steps have been completed. This audit will be completed by 7/1/2024. All new hires will complete the preemployment screening process which is to include a comprehensive background check, three reference checks, physical and drug screen, and licensure verification (if required). All new employee files will be reviewed monthly with Executive Director to ensure proper completion of paperwork.	07/31/2024

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at 10:05 a.m., the Executive Director indicated the references should not have been blank.

A facility policy, titled "PRE-EMPLOYMENT REFERENCE CHECKS AND LICENSURE/CERTIFICATION VERIFICATION (HR085PP)," dated as last revised 8/2014 and received from the Executive Director on 5/31/24 at 10:00 a.m., indicated "...All candidates for employment will have positive reference checks completed...before making a conditional offer of employment...."

Based on interview and record review, the facility failed to ensure reference checks were completed prior to employment for 1 of 5 employees reviewed for reference checks. (Cook 6)

Finding includes:

The employee records were reviewed on 5/29/24. Cook 6 was found to be missing references for employment. The Executive Director provided the employee records with reference sheets which had not been filled out.

During an interview, on 5/30/24 at 10:05 a.m., the Executive Director indicated the references should not have been blank.

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	A facility policy, titled "PRE-EMPLOYMENT REFERENCE CHECKS AND LICENSURE/CERTIFICATION VERIFICATION (HR085PP)," dated as last revised 8/2014 and received from the Executive Director on 5/31/24 at 10:00 a.m., indicated "...All candidates for employment will have positive reference checks completed...before making a conditional offer of employment...."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at	R 0117	1 BOM/HR Director, DOHS, and designee(s) will conduct an audit to determine the current CPR/First Aid staff of call clinical staff members. This audit will be completed by July 20th, 2024. 2 Facility will assist all FT clinical staff members that do not possess both, CPR and First Aid Certifications, obtain this certification by July 20th, 2024. 3 Facility will assist all PT/PRN clinical staff members that do not possess both, CPR and First	08/20/2024

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least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on interview and record review, the facility failed to ensure staff on duty had first aid certification for 9 of 21 shifts reviewed for first aid certification. (between 5/22/24 and 5/28/24)

Findings include:

The records for CPR and first aid were reviewed on 5/29/24.

The facility was unable to provide first aid certification for the following shifts:

a. There was no employee with first aid certification in the facility for the evening and night shifts on 5/25/24 after 6:30 p.m., and no first aid coverage on 5/26/24 for the full evening shift.

b. There was no employee with first aid certification in the facility for the night shifts on 5/22/24, 5/23/24, 5/24/24, 5/25/24, 5/26/24, 5/27/24 and 5/28/24.

During an interview, on 5/31/24 at 9:56 a.m., the Executive Director was unable to provide a policy addressing first aid coverage and indicated the

Aid Certifications, obtain this certification by August 20th, 2024.

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Records for current CPR and First Aid Certification will be kept and maintained within each individual employee's employment file by the Director of Human Resources.

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	facility followed the State of Indiana regulations. Based on interview and record review, the facility failed to ensure staff on duty had first aid certification for 9 of 21 shifts reviewed for first aid certification. (between 5/22/24 and 5/28/24) Findings include: The records for CPR and first aid were reviewed on 5/29/24. The facility was unable to provide first aid certification for the following shifts: a. There was no employee with first aid certification in the facility for the evening and night shifts on 5/25/24 after 6:30 p.m., and no first aid coverage on 5/26/24 for the full evening shift. b. There was no employee with first aid certification in the facility for the night shifts on 5/22/24, 5/23/24, 5/24/24, 5/25/24, 5/26/24, 5/27/24 and 5/28/24. During an interview, on 5/31/24 at 9:56 a.m., the Executive Director was unable to provide a policy addressing first aid coverage and indicated the facility followed the State of Indiana regulations.			
R 0118	Personnel - Deficiency	R 0118	In response to 410 IAC 16.2-5-1.4 (c) Personnel-Deficiency, facility	07/01/2024

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410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure a staff member working as a CNA held a valid certification as a CNA/HHA for 1 of 5 staff reviewed for certification. (CNA 1) Findings include: The employee records were reviewed on 5/29/24. During the record review, CNA 1 was found to be missing a certification as a CNA or HHA (Home Health Aide). CNA 1 had a start date of 7/26/23. The facility was not able to provide a valid CNA or HHA certification for the employee. During an interview, on 5/31/24 at 10:05 a.m., the Executive Director indicated he was not able to say if CNA 1 did or did	notes that no residents were harmed by this deficient practice, however, facility does acknowledge the potential risk. Facility also notes that the referenced caregiver was immediately removed from the schedule. Caregiver has been enrolled in an accredited course to obtain appropriate licensure and will remain off clinical scheduled until coursework is satisfactorily completed, and licensure is approved/recognized by the Indiana Professional Licensing Agency (IPLA). Facility completed a licensure audit on 5/30/2024 and found all other licenses to be valid and active. Licenses have been uploaded to employee database and BOM/HR Director or designee will conduct monthly audits to ensure all required licenses remain in good standing.
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not perform a high level of care in some capacity for the residents in the facility. She worked for the facility for six months and had no valid state certification. He indicated she came from another state and was supposed to get her Indiana Certification. She was supposed to be certified as a CNA/HHA.

The Indiana Professional Licensing Agency web site was accessed, on 5/31/24, and CNA 1 did not show a valid CNA/HHA.

The time records for CNA 1 showed she had worked in the facility from 7/2023 to 5/2024 without a certification as a CNA/HHA.

A facility policy, titled "PRE-EMPLOYMENT REFERENCE CHECKS AND LICENSURE/CERTIFICATION VERIFICATION (HR085PP)," dated as last revised 8/2014 and received from the Executive Director on 5/31/24 at 10:00 a.m., indicated "...License and certification verification should be completed...to avoid unnecessary complications if licenses or certifications are invalid...."

Based on interview and record review, the facility failed to ensure a staff member working as a CNA held a valid

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certification as a CNA/HHA for 1 of 5 staff reviewed for certification. (CNA 1)

Findings include:

The employee records were reviewed on 5/29/24. During the record review, CNA 1 was found to be missing a certification as a CNA or HHA (Home Health Aide).

CNA 1 had a start date of 7/26/23. The facility was not able to provide a valid CNA or HHA certification for the employee.

During an interview, on 5/31/24 at 10:05 a.m., the Executive Director indicated he was not able to say if CNA 1 did or did not perform a high level of care in some capacity for the residents in the facility. She worked for the facility for six months and had no valid state certification. He indicated she came from another state and was supposed to get her Indiana Certification. She was supposed to be certified as a CNA/HHA.

The Indiana Professional Licensing Agency web site was accessed, on 5/31/24, and CNA 1 did not show a valid CNA/HHA.

The time records for CNA 1 showed she had worked in the facility from 7/2023 to 5/2024

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	without a certification as a CNA/HHA. A facility policy, titled "PRE-EMPLOYMENT REFERENCE CHECKS AND LICENSURE/CERTIFICATION VERIFICATION (HR085PP)," dated as last revised 8/2014 and received from the Executive Director on 5/31/24 at 10:00 a.m., indicated "...License and certification verification should be completed...to avoid unnecessary complications if licenses or certifications are invalid...."			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure a resident's service plan was reviewed and updated at least semi-annually for 1 of 10 residents reviewed for service plans. (Resident 3) Finding includes:	R 0214	16.2-5-2(a) Evaluation-Deficiency, facility notes that no residents were harmed by this deficient practice, however, facility acknowledges the potential risk of harm. Facility notes that all residents are assessed prior to admission, upon admission, on a semi-annual basis, or upon a change in condition. On or before July 1, 2024, all RSL residents in either assisted living or memory care shall have their assessment dates reviewed by the DOHS or their designee for compliance with the above stated regulation. The review will be conducted and	08/01/2024

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The record for Resident 3 was reviewed on 5/30/24 at 2:21 p.m. Diagnoses included, but were not limited to, Parkinson's disease and chronic obstructive pulmonary disease.

The resident's last documented service plan was on 7/20/23. The service plan indicated the next scheduled service plan was to be on 4/17/24. There was no service plan for April 2024 in the record.

During an interview, on 5/31/24 at 10:35 a.m., the Director of Nursing indicated the service plan was to be done every 6 months and if there was a change in condition.

A facility policy, titled "QUALITY OF LIFE ASSESSMENT (QLA) (NUR069PP)," dated as last reviewed 1/21/15 and received from the Executive Director on 5/31/24 at 10:00 a.m., indicated "...Residents shall be assessed prior to admission, on admission and on the required schedule...."

Based on interview and record review, the facility failed to ensure a resident's service plan was reviewed and updated at least semi-annually for 1 of 10 residents reviewed for service plans. (Resident 3)

Finding includes:

The record for Resident 3 was

verified using RSL's Yardi EMR system.

Prior to August 1, 2024, any resident in either assisted living or memory care found to be out of compliance with the requisite assessment schedule shall have a re-assessment completed by DOHS or designee(s).

Auditing for continued compliance past August 1, 2024, will be completed on a bi-weekly basis for the remainder of 2024 and then monthly starting January 1, 2025. This audit will be maintained by the DOHS or their designee.

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	reviewed on 5/30/24 at 2:21 p.m. Diagnoses included, but were not limited to, Parkinson's disease and chronic obstructive pulmonary disease. The resident's last documented service plan was on 7/20/23. The service plan indicated the next scheduled service plan was to be on 4/17/24. There was no service plan for April 2024 in the record. During an interview, on 5/31/24 at 10:35 a.m., the Director of Nursing indicated the service plan was to be done every 6 months and if there was a change in condition. A facility policy, titled "QUALITY OF LIFE ASSESSMENT (QLA) (NUR069PP)," dated as last reviewed 1/21/15 and received from the Executive Director on 5/31/24 at 10:00 a.m., indicated "...Residents shall be assessed prior to admission, on admission and on the required schedule...."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:	R 0217	16.2-5-2(e) (1-5) Evaluation—Deficiency, facility acknowledges that not all service plans were signed or acknowledged by the resident, responsible party, or Power of Attorney (POA). Facility will take the following steps to ensure complete	08/01/2024

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(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were signed by the resident,	compliance with the above-mentioned regulation. Prior to July 1, 2024, a comprehensive audit of all assisted living and memory care residents shall be undertaken by the DOHS and appropriately designated clinical staff to assess the compliance with the above-mentioned rule. On or before August 1, 2024, all residents, responsible parties, or POA shall be contacted by a member of the clinical staff to be notified of the last completed assessment, when the next assessment is scheduled, and the resident's current level of care. A copy of the current service plan will be provided to the resident, responsible party, or POA by: 1) USPS mail to a requested address; 2) sent via electronic mail to a requested email address; or, 3) printed and left at the community. On or before August 1, 2024, each of the current service plans with signatures by the appropriate above-mentioned parties or, at least, notes acknowledging with	
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	responsible party, or Power of Attorney (POA) for 1 of 10 residents reviewed for service plans. (Resident 4) Findings include: Resident 4 was admitted to the facility on 3/7/22. A current service plan, dated 1/15/24, was found to be missing the signature of the resident, responsible party, or POA. During an interview, on 5/31/24 at 10:35 a.m., the Director of Nursing indicated the service plan should be signed. A facility policy, titled "QUALITY OF LIFE ASSESSMENT (QLA) (NUR069PP)," dated as last reviewed 1/21/15 and received from the Executive Director on 5/31/24 at 10:00 a.m., did not address having to have the service plans signed. Based on interview and record review, the facility failed to ensure service plans were signed by the resident, responsible party, or Power of Attorney (POA) for 1 of 10 residents reviewed for service plans. (Resident 4) Findings include: Resident 4 was admitted to the facility on 3/7/22.		whom the discussion of the new service plan, the level of care, and time/date of the discussion will be documented, scanned, and uploaded into Yardi EMR. All reasonable attempts will be made to ensure the timely delivery and signature of the service plans prior to a written acknowledgement is uploaded into Yardi EMR.	
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	A current service plan, dated 1/15/24, was found to be missing the signature of the resident, responsible party, or POA. During an interview, on 5/31/24 at 10:35 a.m., the Director of Nursing indicated the service plan should be signed. A facility policy, titled "QUALITY OF LIFE ASSESSMENT (QLA) (NUR069PP)," dated as last reviewed 1/21/15 and received from the Executive Director on 5/31/24 at 10:00 a.m., did not address having to have the service plans signed.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview and record review, the facility failed to ensure the correct dose of a blood pressure medication was provided to 1 of 5 residents reviewed for medication administration. (Resident 1) Finding includes: During the observation of the	R 0247	16.2-5-4(e) (7) Health Services– Deficiency, facility notes that no residents were harmed by this deficient practice, however, facility acknowledges the risk of harm. In response to the incident described in relation to R 247, a comprehensive education auditing program and further staff education have been implemented. On February 27, 2024, a meeting of all Qualified Medication Aides (QMA) was conducted. QMA 5 attended this meeting which was to discuss the RSL Medication Competency provided by Life	08/20/2024

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medication pass, on 5/29/24 at 10:33 a.m., QMA 5 was observed to prepare medications for Resident 1. The following medications were observed to be prepared for administration to Resident 1: Amlodipine (a blood pressure medication) 10 mg (milligrams) x 1. Aspirin 81 mg x 1. Cervovite senior (a vitamin) x 1. Esmeptra Mag 40 mg delayed release (a medication for gastric reflux) x 1. Ferrous sulfate 325-65 mg (an iron supplement) x 1. Gabapentin 300 mg (a medication for neuropathy) x 1. Gemtessa 75 mg (a medication for overactive bladder) x 1. Metoprolol 100 mg extended release (a blood pressure medication) x 1. Potassium chloride extended release 10 milliequivalents (mEq) (a supplement) x 2. Losartan potassium 100 mg (a blood pressure medication) x 1. Timolol maleate 0.5 percent solution (eye drops).	Care Services (LCS) in the management of RSL Carmel. On March 13, 2024, in an individual meeting with the DOHS, QMA 5 was educated on the RSL Medication Competency and was observed by the DOHS to have passed all areas of instruction, including Med Setup, Med Pass, and Documentation & Reporting. On May 27, 2024, a meeting of all QMAs was held and the RSL Carmel Medication Competency was discussed with all in attendance. QMA 5 was present at this education meeting. Within the 30-day period following the implementation of this POC or by July 20, 2024, all full-time QMAs will have the RSL Medication Competency discussed and observed by the DOHS, Nurse Manager, or their designee. Within the 60-day period following the implementation of this POC or by August 20, 2024, all part-time QMAs will	
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Torsemide 20 mg (a medication used to treat fluid retention) x 1 and ½ tablets for a total dose of 30 mg. The medication pass was interrupted at 10:33 a.m., after QMA 5 closed his computer, locked his cart, and began to walk to the resident's room. He indicated he was going to administer the medications. Upon returning to the medication cart, the blood pressure medication order and bubble card for amlodipine was reviewed with QMA 5. Resident 1 had an order for amlodipine 5 milligrams (mg) in the record. The medication bubble pack was 10 mg. The pills were not split in half in the container. QMA 5 verified the dosage on the medication card as 10 mg and indicated it was the wrong dose. He indicated the procedure for medication check was to verify three (3) times for the right resident, medication, dose, and time. The new dose of the medication was initiated on 5/18/24. He indicated, after checking his cart, the resident did not have a 5 mg dose. There were 7 of 31 pills left in the medication bubble pack. On 5/29/24 at 10:53 a.m., the Nurse Manager came to the unit. She indicated the facility did have an order for 5 mg of amlodipine and she would find out what happened with the new	have the RSL Medication Competency observed, discussed, and signed off by the DOHS, Nurse Manager, or their designee. The RSL Medication Competency will be completed during the orientation period of each newly hired RSL QMA. Each full and part-time QMA will be re-educated on the RSL Medication Competency by the DOHS, Nurse Manager, or their designee, on an annual basis starting in January 2025. All RSL Medication Competency education and resulting documentation shall be maintained within each individual employee's Human Resources employment file.	
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medication dose. The Nurse Manager took all the medications for destruction. The 10 mg dose of amlodipine was not administered.

The record for Resident 1 was reviewed on 5/30/24 at 2:33 p.m. Diagnoses included, but were not limited to, chronic atrial fibrillation (an irregular heartbeat), hypertension (high blood pressure), and hyperlipidemia (high cholesterol).

A physician's order, discontinued on 5/17/24, indicated to give amlodipine 10 mg daily.

A physician's order, initiated on 5/18/24, indicated to give amlodipine 5 mg daily.

The Medication Administration Record (MAR), for May 2024, indicated the amlodipine 10 mg was stopped and not given after 5/16/24.

The MAR, for May 2024, indicated amlodipine 5 mg was started on 5/18/24 and showed documentation of the dose being given from 5/18/24 to 5/29/24 (11 days). The dose for May 29 was not given, it was destroyed.

During a telephone interview, on 5/30/24 at 10:05 a.m., Pharmacy Technician 6 indicated the correct dose of

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amlodipine was sent to the facility on 5/30/24 and was the only fill and delivery of the dose. The 10 mg amlodipine was sent to the pharmacy on 5/8/24. The written order for amlodipine 5 mg was received by the pharmacy on 5/17/24, which was the date of the written prescription. She indicated when the order processed, it did not get sent to be filled by the pharmacy and they did not send the adjusted dose of 5 mg until 5/30/24.

A facility policy, titled "MEDICATION ADMINISTRATION (NUR021PP)," dated as last reviewed 4/29/23 and received from the Executive Director on 5/30/24 at 9:30 a.m., indicated "...Verify the medication label with the MOR/E-MAR (medication administration record) ...Check the MOR/E-MAR, then the medication label, then the MOR/E-MAR before providing the medication to the resident...."

Based on observation, interview and record review, the facility failed to ensure the correct dose of a blood pressure medication was provided to 1 of 5 residents reviewed for medication administration. (Resident 1)

Finding includes:

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During the observation of the medication pass, on 5/29/24 at 10:33 a.m., QMA 5 was observed to prepare medications for Resident 1.

The following medications were observed to be prepared for administration to Resident 1:

Amlodipine (a blood pressure medication) 10 mg (milligrams) x 1.

Aspirin 81 mg x 1.

Cervovite senior (a vitamin) x 1.

Esmeptra Mag 40 mg delayed release (a medication for gastric reflux) x 1.

Ferrous sulfate 325-65 mg (an iron supplement) x 1.

Gabapentin 300 mg (a medication for neuropathy) x 1.

Gemtessa 75 mg (a medication for overactive bladder) x 1.

Metoprolol 100 mg extended release (a blood pressure medication) x 1.

Potassium chloride extended release 10 milliequivalents (mEq) (a supplement) x 2.

Losartan potassium 100 mg (a blood pressure medication) x 1.

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Timolol maleate 0.5 percent solution (eye drops).

Torsemide 20 mg (a medication used to treat fluid retention) x 1 and ½ tablets for a total dose of 30 mg.

The medication pass was interrupted at 10:33 a.m., after QMA 5 closed his computer, locked his cart, and began to walk to the resident's room. He indicated he was going to administer the medications. Upon returning to the medication cart, the blood pressure medication order and bubble card for amlodipine was reviewed with QMA 5. Resident 1 had an order for amlodipine 5 milligrams (mg) in the record. The medication bubble pack was 10 mg. The pills were not split in half in the container. QMA 5 verified the dosage on the medication card as 10 mg and indicated it was the wrong dose. He indicated the procedure for medication check was to verify three (3) times for the right resident, medication, dose, and time. The new dose of the medication was initiated on 5/18/24. He indicated, after checking his cart, the resident did not have a 5 mg dose. There were 7 of 31 pills left in the medication bubble pack.

On 5/29/24 at 10:53 a.m., the Nurse Manager came to the unit. She indicated the facility

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did have an order for 5 mg of amlodipine and she would find out what happened with the new medication dose. The Nurse Manager took all the medications for destruction. The 10 mg dose of amlodipine was not administered.

The record for Resident 1 was reviewed on 5/30/24 at 2:33 p.m. Diagnoses included, but were not limited to, chronic atrial fibrillation (an irregular heartbeat), hypertension (high blood pressure), and hyperlipidemia (high cholesterol).

A physician's order, discontinued on 5/17/24, indicated to give amlodipine 10 mg daily.

A physician's order, initiated on 5/18/24, indicated to give amlodipine 5 mg daily.

The Medication Administration Record (MAR), for May 2024, indicated the amlodipine 10 mg was stopped and not given after 5/16/24.

The MAR, for May 2024, indicated amlodipine 5 mg was started on 5/18/24 and showed documentation of the dose being given from 5/18/24 to 5/29/24 (11 days). The dose for May 29 was not given, it was destroyed.

During a telephone interview, on

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	5/30/24 at 10:05 a.m., Pharmacy Technician 6 indicated the correct dose of amlodipine was sent to the facility on 5/30/24 and was the only fill and delivery of the dose. The 10 mg amlodipine was sent to the pharmacy on 5/8/24. The written order for amlodipine 5 mg was received by the pharmacy on 5/17/24, which was the date of the written prescription. She indicated when the order processed, it did not get sent to be filled by the pharmacy and they did not send the adjusted dose of 5 mg until 5/30/24. A facility policy, titled "MEDICATION ADMINISTRATION (NUR021PP)," dated as last reviewed 4/29/23 and received from the Executive Director on 5/30/24 at 9:30 a.m., indicated "...Verify the medication label with the MOR/E-MAR (medication administration record) ...Check the MOR/E-MAR, then the medication label, then the MOR/E-MAR before providing the medication to the resident...."			
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	R 0273	16.2-5-5.1(f) Food and Nutritional Services – Deficiency, facility notes that no residents were harmed by this deficient practice, however, facility	07/20/2024

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' 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 ensure food preparation and serving areas were maintained in accordance with state and local sanitation and safe food handling standards in 1 of 1 kitchen observed.

Findings include:

1. During an observation of the kitchen, on 5/29/24 at 11:23 a.m., the Executive Director and Driver 2 were both observed in the kitchen without hair covering/nets over their hair.

During an interview, on 5/29/24 at 11:23 a.m., the Executive Director indicated "technically" they were to wear hair covering/nets when in the kitchen.

2. During the kitchen observation, on 5/29/24 at 11:27 a.m., Cook 3 was observed working in the kitchen without facial hair covering. Cook 3 had a beard. Vendor Employee 4 was observed in the kitchen, on a ladder, working on the ceiling area, he did not have a hair or beard covering. At that time, Vendor Employee 4 indicated he was not aware he needed to use the items.

acknowledges the potential risk of harm. Facility notes that Director of Culinary Services (DOCS) does possess a current Food Service Sanitation Manager Certification that was obtained in March of 2024. Facility will take the following steps to satisfy and maintain the requirements necessary to comply with the regulation.

1
Sous Chef will register and complete a Food Service Manager course approved by the American National Standards Institute (ANSI). Certification will be completed by July 20th, 2024. This certification will be renewed by the Sous Chef and Director of Culinary Services as required by the certification.

2
The remainder of the food production team which includes Lead Cook, Line Cooks, and Prep Cooks will complete a Food Handler Certification training by August 20th, 2024. These certifications will be monitored and maintained by the DOCS as required by the certification.

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OMB NO. 0938-0391

During an interview, on 5/29/24 at 11:15 a.m., the Dietary Manager indicated everyone in the kitchen was to have facial and head hair covered.

3. During an observation of the kitchen, on 5/30/24 beginning at 8:45 a.m., with the Dietary Manager in attendance, the following observations were made:

a. The meat slicer and floor mixer were found to be uncovered. They were not in use. At that time, the Dietary Manager indicated he did not know they needed to be covered.

b. Two (2) trash cans were found situated at the end of the food preparation table; they each were found to be missing panels which allowed them to be closed when not in use.

4. On 5/30/24 at 8:56 a.m., the Dietary Manager was observed to bring two (2) new trash can lids from a storage area, place them on the prep table, and assemble the closing panels on both lids. The lids were noted to have a dried yellow substance and green specks of material. At that time, the Dietary Manager identified the debris on the lids as food, dried water spots, or mold. He put the lids on the cans. The Dietary Manager then walked away from the prep

3

DOCS to complete mandatory in-service with all culinary service team members. In-service will cover proper food storage, handling, and sanitation practices as recommended by ANSI. This in-service will be completed by September 20th, 2024, and completed semi-annually moving forward.

4

To ensure continued compliance, DOCS (or designee) will conduct monthly food storage, handling, and sanitation audits.

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table. He was not observed to clean the table. There was a staff member cutting beef at the other end of the table.

5. On 5/30/24 at 9:10 a.m., a clear plastic storage container with chopped onions was found in the walk-in cooler open to the air. At that time, the Dietary Manager indicated it should not be open. Also found in the walk-in cooler was a plastic bag containing three (3) chicken breasts stored exposed/open to air. At 9:11 a.m., the Dietary Manager indicated he did not know why it was left open.

6. The dry storage/pantry area was observed to have the following:

a. one 5-pound box of waffle mix was found on the shelf without an open date and was open to air. The box was approximately half full.

b. one 192-ounce plastic container of honey was found on the shelf open without a date.

c. one 128-ounce container of soy sauce with approximately 1/8 left was found on the shelf open without a date.

d. a one-gallon container of browning and seasoning sauce, dated as opened on 1/1/23, was found on the shelf. The manufacturer's expiration date

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was 5/6/23.

e. one 128-ounce container of liquid smoke, ½ full, was found on the shelf with no open date.

f. a one-gallon container of Worchester sauce, 7/8 full, was found on the shelf open without a date.

g. a box of cream of wheat hot cereal mix was found on the shelf open without a date. The box seal had been broken.

During an interview, on 5/30/24 at 11:49 a.m., the Dietary Manager indicated items in storage were to be sealed from air, they were to have an open date, and expired items were to be removed from stock and discarded.

7. During an observation of the kitchen, on 5/31/24 at 9:24 a.m., three (3) wheeled, three tier carts were found parked in front of and up against the electrical box. There was a sign posted which indicated to keep items three (3) feet from the panel doors.

During an interview, on 5/31/24 at 9:25 a.m., the Dietary Manager indicated engineering personnel did not want anything in the way of their access to the panel and it was not a hazard.

During an interview, on 5/30/24 at 12:02 p.m., the Dietary

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Manager indicated equipment should be covered when not in use.

During an interview, on 5/30/24 at 1:54 p.m., the Dietary Manager indicated he spoke with his corporate regional chef who told him there are no policies related to hair coverings, labeling and dating items, disposing of expired items, sealing items/not leaving open to air, cleaning surfaces, putting lids on trash cans and covering equipment not in use. The facility followed state guidelines.

During an interview, on 5/31/24 at 9:56 a.m., the Executive Director indicated the facility followed state and local health department regulations for kitchens and restaurants. The Executive Director indicated the carts found stored in front of the electrical panels were not to be stored that close to the panel doors because it was the Fire Code, no items were to be stored within 36 inches of the electrical panel.

An email, dated 5/29/24 and received from the Dietary Manager on 5/30/24 at 1:59 p.m., from the Regional Culinary Director indicated "...this is NOT P&P (policy and procedure) ...but this is what...P&P refers to for guidance...food employees shall wear hair restraints, such

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as hats, hair coverings or nets, beard restraints, and clothing that covers body hair...."

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d. a one-gallon container of browning and seasoning sauce, dated as opened on 1/1/23, was found on the shelf. The manufacturer's expiration date was 5/6/23.

e. one 128-ounce container of liquid smoke, ½ full, was found on the shelf with no open date.

f. a one-gallon container of Worcester sauce, 7/8 full, was found on the shelf open without a date.

g. a box of cream of wheat hot cereal mix was found on the shelf open without a date. The box seal had been broken.

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Director indicated "...this is NOT P&P (policy and procedure) ...but this is what...P&P refers to for guidance...food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair...."			
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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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