STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT 56TH	4940 WEST 56TH STREET, INDIANAPOLIS, , 46254

(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 the Investigation of Complaints IN00363200, IN00363247, IN00362985, IN00362686 and IN00362246. Complaint IN00363200 - Substantiated. State Residential Findings related to the allegations are cited at R041, R240, R0272, R0273, R407. Complaint IN00363247 - Substantiated. State Residential Findings related to the allegations are cited at R006, R029, R0041, R091, R240, R272, R273 and R407. Complaint IN00362985 - Substantiated. State Residential Findings related to the allegations are cited at R0029, R240, R272, R273, and R407. Complaint IN00362686 - Substantiated. State Residential Findings related to the allegations are cited at R029, R0041, R240, R272, R273 and	R 0000	10/17/2021 POC Complaints (IN00362246, IN00362686, IN00362985, IN00363200, IN00363247) September 27-30, 2021 I would respectively request a desk review.	

	R407. Complaint IN00362246 - Substantiated. State Residential Findings related to the allegations are cited at R240, R272, R273, and R407. Unrelated deficiency is cited. Survey date: September 27, 28 and 29, 2021. Facility number: 014279 Residential Census: 103 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 6, 2021			
R 0006	Scope of Residential Care - Deficiency 410 IAC 16.2-5-0.5(f)(1-5) (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into	R 0006	R006 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Discharge plans are in process now for resident F to relocate to a skilled nursing facility. -**How other residents having**	10/17/2021

	a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, interview, and record review, the facility failed to timely discharge a resident who required long term care placement and maximum assistance for activities of daily living for 1 of 3 residents reviewed for appropriate placement (Resident F). Findings include: The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease. A progress note, dated 8/4/21 at 10:56 a.m., read "Resident returned from recent		**the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No other resident was affected by this deficient practice -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Residents will be re-assessed by DON/designee per policy before returning to community. If resident is not appropriate for our assisted living, discharge plans will begin immediately to find a community to meet the needs of the resident. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.**	

	hospitalization requiring extensive -[sic] max [sic] assist from staff with adls. referred [sic] to therapy who stated that resident requires long-term care assistance." Confidential interviews were conducted during the survey which indicated that Resident F was always in her bed. She did not fit the assisted living setting and needed to be in a long-term care facility. On 9/29/21 at 10:24 a.m., she was observed laying in her bed in her apartment. The apartment had a strong smell of urine She requests assistance with getting pulled up in bed and indicated she could not do it herself and that she could not get up out of bed due to her Parkinson's and something being wrong with her hip. Her hip hurt and it took 2 people to help her. An indwelling catheter drainage bag was attached to the side of the bed. There was a pink wash basin located under the drainage bag which contained yellow urine. On 9/29/21 at 10:30 a.m., CNA (Certified Nursing Assistant) 22 and QMA (Qualified Medication Aide) 23 were observed assisting her up in the bed. They put their arms under her shoulders and under her hips. They then lifted her up in the bed, she began crying in pain		This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** October 17, 2021	

	due to her left hip and leg hurting. They assisted with positioning to help with the pain and offered reassurance. She requested a cream that help her pain be applied to her hip. QMA 23 indicated she would tell the nurse and see what she could give her for pain. The basin under the catheter bag was emptied by QMA 23. Resident F indicated the drainage bag had been leaking for around 3 days and they did not have the supplies to change it here, so the doctor wanted her to go the clinic or the emergency room to have it changed. She wished they would schedule it or take her so it could get done. She had been told she may need to go to a nursing home so that she could get more care. During an interview on 9/29/21 at 10:55 a.m., CNA 22 indicated she has been bed bound for about a month to a month and a half. The nursing assistants did not transfer out of the bed because of her hip and leg pain. Therapy has been working with her, and they did get her up sometimes, but the aides did not get her up. It took 1 or 2 people to assist her with her bed mobility and dressing, 2 people was best because it made it easier for her During an interview on 9/29/21 at 11:15 a.m., the DON (Director of Nursing) indicated that when			

	she was admitted to the facility, she was on the cusp on needing LTC (Long Term Care). She went to the hospital and when she came back, she needed more care. She was being seen by therapy but was unsure of when she was referred to therapy. She had not reassessed her after her return from the hospital and that she had been told by staff that she needed total assistance with care, that was why therapy was seeing her. During an interview on 9/29/21 at 11:22 a.m., the RM (Rehab Manager) and PT (Physical Therapist) 24 indicated that she had made improvements with therapy. She had been assessed for physical therapy on 8/20/21, occupational therapy on 8/24/21, and speech therapy on 8/19/21. She had begun being seen for therapy on 9/1/21, after her insurance approved her treatments. Her sitting tolerance was not good. She currently was able to sit on the edge of the bed for 7 minutes with support. She required maximum assistance with transfers and the nursing staff were not transferring her. They had talked with her about the need for long term care, and she had resisted the idea. They were trying to get her more mobile before sending her to a LTC facility.			

	The Physical Therapy Evaluation and Plan of Care, dated 8/20/21, indicated that she required maximal assistance to roll from left to right in bed, to sit up on the side of the bed, and with toilet transfers. Her Mobility Function Score was 1 on a range of 0 to 12, with 12 being the highest function. Her Self Care Function Score was 0 on a range of 0 to 12, with 12 being the highest functioning. During an interview on 9/29/21 at 12:20 p.m., the DON indicated a discharge notice had not been issued to her. On 9/29/21 at 12:15 p.m., the DON provided the Residency Admission and Tenancy Requirements Policy, dated 2/2021, which read "...The community is licensed as a Residential Care Facility...As such, each resident of The Community must satisfy all of the following conditions for admission and residency: Each resident must be capable of self-preservation and independent daily living with assistance...The Community does not provide continuous intermediate or skilled nursing level of care and is not a 'comprehensive care facility'..." This State Tag relates to complaint IN00363247.			

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Based on observation, interview, and record review, the facility failed to timely discharge a resident who required long term care placement and maximum assistance for activities of daily living for 1 of 3 residents reviewed for appropriate placement (Resident F).

Findings include:

The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease.

A progress note, dated 8/4/21 at 10:56 a.m., read "Resident returned from recent hospitalization requiring extensive -[sic] max [sic] assist from staff with adls. referred [sic] to therapy who stated that resident requires long-term care assistance."

Confidential interviews were conducted during the survey which indicated that Resident F was always in her bed. She did not fit the assisted living setting and needed to be in a long-term care facility.

On 9/29/21 at 10:24 a.m., she was observed laying in her bed in her apartment. The apartment

	had a strong smell of urine She requests assistance with getting pulled up in bed and indicated she could not do it herself and that she could not get up out of bed due to her Parkinson's and something being wrong with her hip. Her hip hurt and it took 2 people to help her. An indwelling catheter drainage bag was attached to the side of the bed. There was a pink wash basin located under the drainage bag which contained yellow urine. On 9/29/21 at 10:30 a.m., CNA (Certified Nursing Assistant) 22 and QMA (Qualified Medication Aide) 23 were observed assisting her up in the bed. They put their arms under her shoulders and under her hips. They then lifted her up in the bed, she began crying in pain due to her left hip and leg hurting. They assisted with positioning to help with the pain and offered reassurance. She requested a cream that help her pain be applied to her hip. QMA 23 indicated she would tell the nurse and see what she could give her for pain. The basin under the catheter bag was emptied by QMA 23. Resident F indicated the drainage bag had been leaking for around 3 days and they did not have the supplies to change it here, so the doctor wanted her to go the clinic or the emergency room to have it changed. She wished			

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	not been issued to her. On 9/29/21 at 12:15 p.m., the DON provided the Residency Admission and Tenancy Requirements Policy, dated 2/2021, which read "...The community is licensed as a Residential Care Facility...As such, each resident of The Community must satisfy all of the following conditions for admission and residency: Each resident must be capable of self-preservation and independent daily living with assistance...The Community does not provide continuous intermediate or skilled nursing level of care and is not a 'comprehensive care facility'..." This State Tag relates to complaint IN00363247. .			
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure a resident was treated with respect and dignity for 1 of 3 residents reviewed for dignity. (Resident B)	R 0029	R029 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Administrator completed a grievance form for Resident B regarding this deficient practice	10/17/2021

	Findings include: During a confidential interview on 9/27/21 at 4:54 p.m., she indicated the DON was rude to Resident B. The clinical record for Resident B was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, hypertension. An interview was conducted with Resident B on 9/28/21 at 10:48 a.m. She indicated she felt she had been disrespected by the DON. She was "very rude" to her. There was an incident about 2 weeks ago, she was sitting outside with 3 other residents by the front walk way. As the DON was leaving the facility, she stopped by them and "ordered" Resident B to move away from the walk way. The DON stated if an emergency vehicle was needed to be called to the facility they would not be able to get through. The DON was very "demanding" and "very rude." Resident B indicated she stated to the DON if an emergency vehicle was called out she would move out of the way. There was no emergency vehicle in the parking lot. "Other residents sit out there in the same spot all the time, and she never says anything to them." Resident B had stated to the DON she needed to go home.		on 9/28/2021. DON was informed of this grievance and the grievance policy was followed and resolved. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No other resident was affected by this deficient practice -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON was re-educated on resident rights by Administrator on 9/28/2021. Resident rights will be reviewed at each monthly resident council meeting for 6 months to ensure rights are being met and open for discussion.	

	At that time, Resident B was sitting on her walker when the DON stated, "I'm not going anywhere until you get up and move." After, Resident B got up and moved to another area in front. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. She indicated she and 3 other residents were sitting out front by the front lobby door one evening. The DON was leaving the building and turned around and told Resident B to move away from the door. The DON was "very rude" about it. "She then said, I'm not going anywhere until you [Resident B] move." Resident E indicated she was upset the way the DON had spoken to Resident B that evening. An interview was conducted with the DON on 9/28/21 at 4:30 p.m. She indicated as she was leaving one evening, there were 4 residents sitting outside the front lobby door. She had told the residents they needed to move to either side of the walk way, because if there was emergency personnel needed; they would not be able to get through. She was asking for them to move due to safety reasons. Resident B had gotten upset about being asked to move. A "Resident's Personal Rights		-**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** October 17, 2021	

Policy and Procedure" policy was provided by the DON on 9/29/21 at 10:15 a.m. It indicated "...The statement of Resident's Personal Rights is included in the Resident's Admission Agreement. All of the resident's rights are applicable at the time of executing the Resident's Admission Agreement...Each resident shall have the right to: ...14. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality..."

This state finding relates to complaints IN00362686, IN00363247 and IN00362985.

Based on interview and record review, the facility failed to ensure a resident was treated with respect and dignity for 1 of 3 residents reviewed for dignity. (Resident B)

Findings include:

During a confidential interview on 9/27/21 at 4:54 p.m., she indicated the DON was rude to Resident B.

The clinical record for Resident B was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, hypertension.

An interview was conducted with Resident B on 9/28/21 at 10:48 a.m. She indicated she

	felt she had been disrespected by the DON. She was "very rude" to her. There was an incident about 2 weeks ago, she was sitting outside with 3 other residents by the front walk way. As the DON was leaving the facility, she stopped by them and "ordered" Resident B to move away from the walk way. The DON stated if an emergency vehicle was needed to be called to the facility they would not be able to get through. The DON was very "demanding" and "very rude." Resident B indicated she stated to the DON if an emergency vehicle was called out she would move out of the way. There was no emergency vehicle in the parking lot. "Other residents sit out there in the same spot all the time, and she never says anything to them." Resident B had stated to the DON she needed to go home. At that time, Resident B was sitting on her walker when the DON stated, "I'm not going anywhere until you get up and move." After, Resident B got up and moved to another area in front. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. She indicated she and 3 other residents were sitting out front by the front lobby door one evening. The DON was leaving the building and turned around and told Resident B to			

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	A "Resident's Personal Rights Policy and Procedure" policy was provided by the DON on 9/29/21 at 10:15 a.m. It indicated "...The statement of Resident's Personal Rights is included in the Resident's Admission Agreement. All of the resident's rights are applicable at the time of executing the Resident's Admission Agreement...Each resident shall have the right to: ...14. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality..." This state finding relates to complaints IN00362686, IN00363247 and IN00362985.			
R 0041	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on observation, interview	R 0041	R041 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	10/17/2021

	and record review, the facility failed to address and provide resolutions to grievances that have been made individually, in resident council and in food council. This has a potential to affect 103 to 103 residents that reside in the facility. (Resident D, E, G, JJ, LL, MM. NN, PP,) Findings include: The clinical record for Resident PP was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, stroke. An observation was made of Resident PP's apartment on 9/28/21 at 9:00 a.m. There were signs hung on the wall of the apartment asking guest that enter to not steal from her. An interview was conducted with Resident PP's rom on 9/28/21 at 9:02 a.m. She indicated residents' concerns are not addressed in the building. On June 5th she had to call the police and make a report about her purse had come up missing. She had all her identification in the purse taken and had to replace it all. The police encouraged her to lock everything up due to the staff have master keys and are able to come in her apartment when she was not home. She also has home health that provides housekeeping services		Residents have been re-educated on the grievance policy by Administrator/designee during food council and any concerns will be addressed. Any issue or concern will be addressed timely per policy. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents had the potential to be affected by this deficient practice. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Resident council and food committee meeting minutes will be reviewed after each meeting during morning meeting for 6 months by the department heads and grievance forms completed and given to the appropriate department for resolution. The	

	in her apartment as well. The Administrator was aware of the incident and did nothing about it. All she said was "Don't start [Resident PP]." An interview was conducted with the Administrator on 9/28/21 at 3:00 p.m. She indicated she was aware the police was notified of Resident PP's purse and identification was missing. This had occurred sometime this summer. She did not have any grievances for Resident PP, and she had not looked into the incident. After the police came out and made a report; Resident PP had not mentioned the incident again. The Resident Council Minutes were provided by the Activities Director on 9/28/21 at 3:00 p.m. The following concerns and requests were addressed in the resident council meetings: July 19, 2021 Resident Council Minutes: Administrative: requesting to meet, dining services: wait times for meals, August 23, 2021 Resident Council Minutes: nursing: call light response, locking of doors, staff knocking on doors,		administrator will review the grievance from for completion and resolution 48 hours later. Any other grievance will be handled in the same manner per policy. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be**	

	Administration: requesting to meet Administration, housekeeping: knocking and waiting for permission to enter, Maintenance: washing machine place on blocks, September 23, 2021 Resident Council Minutes: nursing: staff knocking on doors, call light response, administration: requesting involvement in meeting, maintenance: washing machine placed on pedestals, July 2021 and August 2021 Resident Council Minutes did not include documentation regarding the requests were honored and concerns addressed with resolutions. The Food Council Meetings were provided by the Dietary Manager on 9/28/21 at 3:00 p.m. The July 2021 Food Council Minutes indicated the following concerns: dining room: cold temperatures, orders: running out of food, food: too salty, not seasoned, noodles not in sauce, Quality of food: "mystery meals"		**completed** October 17, 2021	

	presentation of food: "sometimes looks like slop" The July 2021 Food Council Minutes did not include documentation the concerns brought up in the meeting were addressed with resolutions There was no documented Food Council Meeting in August 2021 provided and no September 2021 meeting scheduled on the September 2021 calendar. An interview was conducted with Resident JJ, LL, MM, and NN on 9/27/21 at 11:46 a.m. They indicated the food was "always" served cold. The food quality was "bad." The concerns the residents have in the building are not addressed. An interview was conducted with Resident G on 9/27/21 at 3:19 p.m. She indicated the food served here was the "worst." The food was too salty, spicy and cold. The kitchen was always running out of food as well. The staff does not address the residents' concerns. During a confidential interview on 9/27/21 at 4:54 p.m., she indicated all the residents have complaints of the food quality and portions. The residents concerns are not being addressed. An interview was conducted with Resident PP's on 9/28/21			

	at 9:02 a.m. She indicated the facility does have resident council and food council meetings monthly. After reviewing of the September activity calendar, Resident PP indicated the food council had not been scheduled to meet in September. She use to go to the resident council and food council, but feels "it is a waste of time." She stopped going, because no one ever addresses the concerns the residents have. She no longer addresses any concerns she has with administration, because they are not addressed. An interview was conducted with Resident D on 9/28/21 at 12:06 p.m. He indicated the hot temperature foods were not hot. The food served was cold and poor in quality. The kitchen runs out of food all the time. The food council meets monthly as well as resident council. The residents have not been able to meet for food council the last couple of months, because the former dietary manager would cancel. It has not been scheduled to start back up yet. The concerns addressed in resident council and food council are not "ever" addressed. An interview was conducted with Resident JJ on 9/27/21 at 2:17 p.m. She indicated she threw out the lunch meal. The			

	cabbage was undercooked. The concerns the residents have are "never" addressed. An interview was conducted with Resident MM on 9/28/21 at 11:34 a.m. She indicated the food was terrible. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. The meals served from the kitchen were cold. Any concerns the residents have with food or anything else are not addressed. The residents have discussed their concerns in resident council and food council and "nothing is ever done." She no longer turns any concerns or grievances into the administration. They do nothing about them. An interview was conducted with Activities Director (AD) and Dietary Manager (DM) on 9/28/21 at 2:45 p.m. The AD indicated he had only been working in the facility for 3 months. There had been a food council meeting when he had first started, but the former DM did not take any notes during the meeting. The current DM indicated she had spoken to the Administrator about the food council meetings, and they had been conducted. There was no documentation additional meetings took place. An interview was conducted			

	with the Administrator on 9/28/21 at 3:00 p.m. She indicated resident and food council meetings should meet monthly. The concerns the residents have are given to the appropriate department to address. The department manager does not document how the concern was addressed or resolution of the concern. The Administrator does not sign off the concern was addressed. A "Resident Grievance Policy and Procedure" policy was provided by the Administrator on 9/28/21 at 3:48 p.m. It indicated "All residents shall have the right to voice concerns and/or complaints which affect their lives at the facility without fear or discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will imitate the Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint. If such action is not satisfactory to the affected Resident, the Regional Director of [name of			

	corporation], the management company of the facility, shall further investigate the issue and shall provide the Resident with a written report of his/her analysis and any corrective action taken. Such a report shall be provided within 10 days of the date of the Administrator's report. If the concern and/or complaint still has not been resolved, the the Director of Operations or President of [name of corporation] shall convene a "Mediating Committee", consisting of at least three (3) the facility residents. This committee shall evaluate the issue in question and recommend a non-building resolution to the Resident and the facility management staff. The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these records for review by the HFS staff when requested..." A "Resident Committee Policy" was provided by the Administrator on 9/28/21 at 3:48 p.m. It indicated "...Purpose: The purpose of the Resident Committee is to voice opinions on the operation(s) of the community, give input into menu planning, register concerns or make suggestions. Policy: It is the policy of the community to conduct a Resident Committee			

	Meeting once per month. Notifications of the meetings will appear on the monthly activity calendar. All residents are encouraged to attend. Procedure:...c. The Resident Services Coordinator will record attendance in Care Merge in a timely manner. d. Recommendations made by the committee will be presented to the Administrator and taken under advisement. Consideration will be given to all suggestions. E. All areas of concern presented by the Committee will be answered by the Administrator or designee by the following monthly meeting. F. Each monthly meeting will include input into the menu and meal planning. G. No community affiliate or employee shall be a member if (sic) the Committee but may attend if invited...I. The meeting records shall be kept in the Administrator's office for a minimum of five years..." This state finding relates to complaints IN00362686, IN00363247 and IN00363200. Based on observation, interview and record review, the facility failed to address and provide resolutions to grievances that have been made individually, in resident council and in food council. This has a potential to affect 103 to 103 residents that reside in the facility. (Resident			

D, E, G, JJ, LL, MM. NN, PP,)

Findings include:

The clinical record for Resident PP was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, stroke.

An observation was made of Resident PP's apartment on 9/28/21 at 9:00 a.m. There were signs hung on the wall of the apartment asking guest that enter to not steal from her.

An interview was conducted with Resident PP's rom on 9/28/21 at 9:02 a.m. She indicated residents' concerns are not addressed in the building. On June 5th she had to call the police and make a report about her purse had come up missing. She had all her identification in the purse taken and had to replace it all. The police encouraged her to lock everything up due to the staff have master keys and are able to come in her apartment when she was not home. She also has home health that provides housekeeping services in her apartment as well. The Administrator was aware of the incident and did nothing about it. All she said was "Don't start [Resident PP]."

An interview was conducted with the Administrator on 9/28/21 at 3:00 p.m. She

	indicated she was aware the police was notified of Resident PP's purse and identification was missing. This had occurred sometime this summer. She did not have any grievances for Resident PP, and she had not looked into the incident. After the police came out and made a report; Resident PP had not mentioned the incident again. The Resident Council Minutes were provided by the Activities Director on 9/28/21 at 3:00 p.m. The following concerns and requests were addressed in the resident council meetings: July 19, 2021 Resident Council Minutes: Administrative: requesting to meet, dining services: wait times for meals, August 23, 2021 Resident Council Minutes: nursing: call light response, locking of doors, staff knocking on doors, Administration: requesting to meet Administration, housekeeping: knocking and waiting for permission to enter, Maintenance: washing machine place on blocks,			

	September 23, 2021 Resident Council Minutes: nursing: staff knocking on doors, call light response, administration: requesting involvement in meeting, maintenance: washing machine placed on pedestals, July 2021 and August 2021 Resident Council Minutes did not include documentation regarding the requests were honored and concerns addressed with resolutions. The Food Council Meetings were provided by the Dietary Manager on 9/28/21 at 3:00 p.m. The July 2021 Food Council Minutes indicated the following concerns: dining room: cold temperatures, orders: running out of food, food: too salty, not seasoned, noodles not in sauce, Quality of food: "mystery meals" presentation of food: "sometimes looks like slop" The July 2021 Food Council Minutes did not include documentation the concerns brought up in the meeting were addressed with resolutions			

	There was no documented Food Council Meeting in August 2021 provided and no September 2021 meeting scheduled on the September 2021 calendar. An interview was conducted with Resident JJ, LL, MM, and NN on 9/27/21 at 11:46 a.m. They indicated the food was "always" served cold. The food quality was "bad." The concerns the residents have in the building are not addressed. An interview was conducted with Resident G on 9/27/21 at 3:19 p.m. She indicated the food served here was the "worst." The food was too salty, spicy and cold. The kitchen was always running out of food as well. The staff does not address the residents' concerns. During a confidential interview on 9/27/21 at 4:54 p.m., she indicated all the residents have complaints of the food quality and portions. The residents concerns are not being addressed. An interview was conducted with Resident PP's on 9/28/21 at 9:02 a.m. She indicated the facility does have resident council and food council meetings monthly. After reviewing of the September activity calendar, Resident PP indicated the food council had not been scheduled to meet in			

	September. She use to go to the resident council and food council, but feels "it is a waste of time." She stopped going, because no one ever addresses the concerns the residents have. She no longer addresses any concerns she has with administration, because they are not addressed. An interview was conducted with Resident D on 9/28/21 at 12:06 p.m. He indicated the hot temperature foods were not hot. The food served was cold and poor in quality. The kitchen runs out of food all the time. The food council meets monthly as well as resident council. The residents have not been able to meet for food council the last couple of months, because the former dietary manager would cancel. It has not been scheduled to start back up yet. The concerns addressed in resident council and food council are not "ever" addressed. An interview was conducted with Resident JJ on 9/27/21 at 2:17 p.m. She indicated she threw out the lunch meal. The cabbage was undercooked. The concerns the residents have are "never" addressed.			

	An interview was conducted with Resident MM on 9/28/21 at 11:34 a.m. She indicated the food was terrible. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. The meals served from the kitchen were cold. Any concerns the residents have with food or anything else are not addressed. The residents have discussed their concerns in resident council and food council and "nothing is ever done." She no longer turns any concerns or grievances into the administration. They do nothing about them. An interview was conducted with Activities Director (AD) and Dietary Manager (DM) on 9/28/21 at 2:45 p.m. The AD indicated he had only been working in the facility for 3 months. There had been a food council meeting when he had first started, but the former DM did not take any notes during the meeting. The current DM indicated she had spoken to the Administrator about the food council meetings, and they had been conducted. There was no documentation additional meetings took place. An interview was conducted with the Administrator on 9/28/21 at 3:00 p.m. She indicated resident and food council meetings should meet			

	monthly. The concerns the residents have are given to the appropriate department to address. The department manager does not document how the concern was addressed or resolution of the concern. The Administrator does not sign off the concern was addressed. A "Resident Grievance Policy and Procedure" policy was provided by the Administrator on 9/28/21 at 3:48 p.m. It indicated "All residents shall have the right to voice concerns and/or complaints which affect their lives at the facility without fear or discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will imitate the Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint. If such action is not satisfactory to the affected Resident, the Regional Director of [name of corporation], the management company of the facility, shall further investigate the issue and shall provide the Resident with a			

	written report of his/her analysis and any corrective action taken. Such a report shall be provided within 10 days of the date of the Administrator's report. If the concern and/or complaint still has not been resolved, the the Director of Operations or President of [name of corporation] shall convene a "Mediating Committee", consisting of at least three (3) the facility residents. This committee shall evaluate the issue in question and recommend a non-building resolution to the Resident and the facility management staff. The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these records for review by the HFS staff when requested..." A "Resident Committee Policy" was provided by the Administrator on 9/28/21 at 3:48 p.m. It indicated "...Purpose: The purpose of the Resident Committee is to voice opinions on the operation(s) of the community, give input into menu planning, register concerns or make suggestions. Policy: It is the policy of the community to conduct a Resident Committee Meeting once per month. Notifications of the meetings will appear on the monthly activity calendar. All residents are			

	encouraged to attend. Procedure:...c. The Resident Services Coordinator will record attendance in Care Merge in a timely manner. d. Recommendations made by the committee will be presented to the Administrator and taken under advisement. Consideration will be given to all suggestions. E. All areas of concern presented by the Committee will be answered by the Administrator or designee by the following monthly meeting. F. Each monthly meeting will include input into the menu and meal planning. G. No community affiliate or employee shall be a member if (sic) the Committee but may attend if invited...I. The meeting records shall be kept in the Administrator's office for a minimum of five years..." This state finding relates to complaints IN00362686, IN00363247 and IN00363200.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered.	R 0091	R091 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	10/17/2021

	(2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to implement their Resident Code Status Identification System policy for 2 of 3 residents whose code status were reviewed. (Residents N and P) Findings include: 1. The clinical record for Resident P was reviewed on 9/28/21 at 11:13 a.m. She was admitted to the facility on 8/20/21. Resident P's face sheet and current orders did not indicate her code status. Her 7/14/21 POST (physician orders for scope of treatment) form indicated she was DNR (do not resuscitate,) but was not signed by the physician. An interview was conducted with LPN (Licensed Practical Nurse) 7 on 9/28/21 at 11:40 a.m. She indicated she knew a resident's code status by whether they had a red dot or a green dot on the outside of their hard chart. Red dots were DNR		Resident P and Resident N have had their code status updated per POST form. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** An audit is being conducted by the DON and will be completed by 11/1/2021 to ensure all code statuses reflect resident POST form and plan of care. Any finding will be corrected immediately. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Any new admits with no primary care physician will be seen by our Nurse Practitioner within one week to ensure the code status gets reviewed and signed. DON will audit all new admits charts for 6 months to ensure code status are complete and reflect residents plan of care and	

	and green dots were full code. Resident P's hard chart had no dot on the outside. An interview was conducted with the DON (Director of Nursing) on 9/28/21 at 12:04 p.m. She indicated residents' code status should be on their face sheets. Resident P's face sheet needed updated, but since her POST form was not signed by the physician, she would need to be full code in an emergency, even though she selected DNR. Ideally, POST forms would be signed and valid upon admission. 2. The clinical record for Resident N was reviewed on 9/28/21 at 11:20 a.m. She was admitted to the facility on 9/10/21. Resident N's face sheet indicated her code status was DNR (do not resuscitate.) Her 8/11/21 POST (physician orders for scope of treatment) form indicated she was DNR, but was not signed by the physician. An interview was conducted with LPN (Licensed Practical Nurse) 7 on 9/28/21 at 11:40 a.m. She indicated she knew a resident's code status by whether they had a red dot or a green dot on the outside of their hard chart. Red dots were DNR		POST form. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed**	

	and green dots were full code. Resident N had no hard chart in the nurse's office. An interview was conducted and with the DON (Director of Nursing) on 9/28/21 at 12:04 p.m. A vanilla folder containing Resident N's clinical information, including her POST form, was reviewed with the DON at this time. She indicated since Resident N's POST form was not signed by the physician, she would need to be full code in an emergency, even though she selected DNR. Ideally, POST forms would be signed and valid upon admission. The Resident Code Status Identification System policy was provided by the DON on 9/28/21 at 12:25 p.m. It read, "The purpose of this policy is to provide guidelines and procedures for the decision to initiate, terminate or withhold cardiopulmonary resuscitative measures....It is the responsibility of licensed nursing personnel to identify the current code status for each resident upon admission....PROCEDURE: A. Upon admission of a resident, licensed nursing personnel will identify current code status. A resident will be classified as DNR only if a valid, signed physician's order is provided and placed in resident's medical record....C. If a resident is a		October 17, 2021	

	DNR, a RED dot will be placed on the front of the pull cord box in the bathroom of the resident's apartment. If a resident is a Full Code, a GREEN dot will be placed on the front of the pull cord box in the bathroom of the resident's apartment. The residents name will be entered on the dot for accurate identification. Initials are not the (sic) be used. D. A matching dot indicating current code status will be placed on the spine of the medical record. E. An entry will be made on the service plan indicating the resident's code status. F. If a resident is found unresponsive and pulse and respirations are absent, staff will proceed with resuscitation measures according to the status identified by the dot while another staff member will verify code status by checking the resident's medical record concurrently....It is the responsibility of the Nursing Supervisor or designee to ensure that the identification system is kept updated upon admission and/or discharge of a resident as well as when a change in code status occurs per resident request." This Residential Tag relates to Complaint IN00363247. Based on interview and record review, the facility failed to implement their Resident Code Status Identification System			

policy for 2 of 3 residents whose code status were reviewed. (Residents N and P)

Findings include:

1. The clinical record for Resident P was reviewed on 9/28/21 at 11:13 a.m. She was admitted to the facility on 8/20/21.

Resident P's face sheet and current orders did not indicate her code status. Her 7/14/21 POST (physician orders for scope of treatment) form indicated she was DNR (do not resuscitate,) but was not signed by the physician.

An interview was conducted with LPN (Licensed Practical Nurse) 7 on 9/28/21 at 11:40 a.m. She indicated she knew a resident's code status by whether they had a red dot or a green dot on the outside of their hard chart. Red dots were DNR and green dots were full code.

Resident P's hard chart had no dot on the outside.

An interview was conducted with the DON (Director of Nursing) on 9/28/21 at 12:04 p.m. She indicated residents' code status should be on their face sheets. Resident P's face sheet needed updated, but since her POST form was not signed by the physician, she would need to be full code in an

emergency, even though she selected DNR. Ideally, POST forms would be signed and valid upon admission.

2. The clinical record for Resident N was reviewed on 9/28/21 at 11:20 a.m. She was admitted to the facility on 9/10/21.

Resident N's face sheet indicated her code status was DNR (do not resuscitate.)

Her 8/11/21 POST (physician orders for scope of treatment) form indicated she was DNR, but was not signed by the physician.

An interview was conducted with LPN (Licensed Practical Nurse) 7 on 9/28/21 at 11:40 a.m. She indicated she knew a resident's code status by whether they had a red dot or a green dot on the outside of their hard chart. Red dots were DNR and green dots were full code. Resident N had no hard chart in the nurse's office.

An interview was conducted and with the DON (Director of Nursing) on 9/28/21 at 12:04 p.m. A vanilla folder containing Resident N's clinical information, including her POST form, was reviewed with the DON at this time. She indicated since Resident N's POST form was not signed by the physician, she would need to be full code

	in an emergency, even though she selected DNR. Ideally, POST forms would be signed and valid upon admission. The Resident Code Status Identification System policy was provided by the DON on 9/28/21 at 12:25 p.m. It read, "The purpose of this policy is to provide guidelines and procedures for the decision to initiate, terminate or withhold cardiopulmonary resuscitative measures....It is the responsibility of licensed nursing personnel to identify the current code status for each resident upon admission....PROCEDURE: A. Upon admission of a resident, licensed nursing personnel will identify current code status. A resident will be classified as DNR only if a valid, signed physician's order is provided and placed in resident's medical record....C. If a resident is a DNR, a RED dot will be placed on the front of the pull cord box in the bathroom of the resident's apartment. If a resident is a Full Code, a GREEN dot will be placed on the front of the pull cord box in the bathroom of the resident's apartment. The residents name will be entered on the dot for accurate identification. Initials are not the (sic) be used. D. A matching dot indicating current code status will be placed on the spine of the medical record. E. An entry			

	will be made on the service plan indicating the resident's code status. F. If a resident is found unresponsive and pulse and respirations are absent, staff will proceed with resuscitation measures according to the status identified by the dot while another staff member will verify code status by checking the resident's medical record concurrently....It is the responsibility of the Nursing Supervisor or designee to ensure that the identification system is kept updated upon admission and/or discharge of a resident as well as when a change in code status occurs per resident request." This Residential Tag relates to Complaint IN00363247.			
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: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and	R 0217	<u>R217</u> -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident F service plan was reviewed and updated to reflect residents plan of care. -**How other residents having**	10/17/2021

	(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 develop a service plan for 1 of 3 residents reviewed for appropriate placement (Resident F) Findings include: The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's		**the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** DON/Designee will complete a full audit of resident's charts on 10/8/21to confirm that each service plan reflects the residents plan of care for appropriate placement. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Residents will be re-assessed by DON/designee per policy before returning to community. If resident is not appropriate for our assisted living, discharge plans will begin immediately to find a community to meet the needs of the resident. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into**	

	diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease. She was admitted to the facility on 7/7/21. The clinical record did not contain a service plan. During an interview on 9/29/21 at 12:20 p.m., the DON (Director of Nursing) indicated a service plan had not been created for her since her admission. The Service Plan Policy, revised 4/2016, was provided by the DON on 9/29/21 at 12:15 p.m., which read "...Purpose: Policy: Each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs. This plan will be available for staff review to assist in the daily care/services provided to the resident. Responsibility: Procedure: A. Within 24 hours of admission, an Initial Service Plan will be completed that identifies potential immediate problems. B. Within seven days of completion of assessment tool (i.e., RAI), all areas will be addressed via the Service Plan. Licensed nursing will also complete documentation in the resident's progress notes. C. The nursing staff along with the resident and/or family members		**place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** October 17, 2021	

	will identify resident problems, needs and strengths. D. For each problem, need or strength a resident-centered goal is developed. Whenever possible, the goal should be measurable (i.e., walk from nurse's station to room by (date). E. Staff approaches are to be developed for each problem/strength/need. When possible, more than one discipline per approach is to be documented on the Service Plan or All disciplines are responsible for that approach. Approaches and services will be entered to the CNA worksheet for nursing staff reference..." Based on interview and record review, the facility failed to develop a service plan for 1 of 3 residents reviewed for appropriate placement (Resident F) Findings include: The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease. She was admitted to the facility on 7/7/21. The clinical record did not contain a service plan. During an interview on 9/29/21 at 12:20 p.m., the DON (Director of Nursing) indicated a service plan had not been created for			

	her since her admission. The Service Plan Policy, revised 4/2016, was provided by the DON on 9/29/21 at 12:15 p.m., which read "...Purpose: Policy: Each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs. This plan will be available for staff review to assist in the daily care/services provided to the resident. Responsibility: Procedure: A. Within 24 hours of admission, an Initial Service Plan will be completed that identifies potential immediate problems. B. Within seven days of completion of assessment tool (i.e., RAI), all areas will be addressed via the Service Plan. Licensed nursing will also complete documentation in the resident's progress notes. C. The nursing staff along with the resident and/or family members will identify resident problems, needs and strengths. D. For each problem, need or strength a resident-centered goal is developed. Whenever possible, the goal should be measurable (i.e., walk from nurse's station to room by (date). E. Staff approaches are to be developed for each problem/strength/need. When possible, more than one discipline per approach is to be documented on the Service			

	Plan or All disciplines are responsible for that approach. Approaches and services will be entered to the CNA worksheet for nursing staff reference..."			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease. On 9/29/21 at 10:24 a.m., she was observed laying in her bed in her apartment. The apartment had a strong smell of urine. She was laying in bed and an empty indwelling catheter drainage bag attached to the side of the bed. There was a pink wash basin, located under the drainage bag, which contained yellow urine. On 9/29/21 at 10:30 a.m., QMA (Qualified Medication Aide) 23 was observed assisting her with care. She indicated to Resident F that she was going to empty the urine from her catheter. She then emptied the basin under the catheter bag into the toilet.	R 0240	R240 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B has her inhaler and receives it as ordered. Resident L will have blood sugar checked as ordered and insulin given as ordered per MD order. Resident Q, M, E, will receive his injection/medicine as ordered by the MD. Resident C no longer lives at this community Resident F catheter care will be done per policy and as	10/17/2021

	Resident F indicated the drainage bag had been leaking for around 3 days and they did not have the supplies to change it here, so the doctor wanted her to go the clinic or the emergency room to have it changed. She wished they would schedule it or take her so it could get done. She asked QMA 23 to make sure the basin was under the drainage bag so that urine did not get onto the floor. The clinical record did not contain physician's orders addressing care of the indwelling catheter. The clinical record did not contain any documentation of the catheter drainage bag leaking. During an interview on 9/29/21 at 11:15 a.m., the DON (Director of Nursing) indicated the staff had told her about the catheter bag leaking that morning. She was unsure how long it had been leaking and that home health provided the care for her catheter. On 9/29/21 at 12:15 p.m., the DON provided the Catheter Care Policy, revised 2/2021, which read "... Purpose: The purpose of this policy and procedure is to prevent infection of the resident's urinary tract. Policy: It is the policy of this		ordered by MD. Resident will DC this month to a SNF. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by this deficient practice. DON/Designee performed a chart and medication audit on 10/7 and 10/8/2021. Any findings were corrected, and all licensed nursing staff educated on medication administration policy by DON. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All licensed nursing staff educated on medication administration policy by DON on 10/8/2021. DON/Designee will perform medication administration and chart audits weekly for 6 months.	

	community to provide assistance with catheter care including education, monitoring, hygiene assistances as well as maintenance of urological appliances and system. Catheter care will be provided in such a manner to promote cleanliness, comfort and to minimize risk associated with use of an intermittent or indwelling urological appliance. Responsibility: A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter. C. It is the responsibility of the nursing staff to empty the resident's catheter bas if the resident is unable to complete the task themselves. D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter..." This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200. 4. The clinical record for Resident M was reviewed on 9/28/21 at 2:54 p.m. The diagnoses included, but were not limited to, type 2 diabetes. The 2/26/21 service plan indicated he had the potential		-**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** October 17, 2021	

for hyper/hypoglycemia and other complications related to altered metabolic state and a diagnosis of diabetes. The services to be provided included to assist/administer medications as ordered.

The physician's orders indicated Trulicity 0.75 mg/0.5 ml pen, inject 0.5ml subcutaneously every Monday, effective 3/26/21.

The September, 2021 MAR (medication administration record) indicated he received the above medication 9/6/21 and 9/20/21 and did not receive it on 9/13/21 or 9/27/21.

An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated it was agency staff working on 9/13/21 and 9/27/21, and they no longer worked at the facility. It looked to her like the medication was not administered as ordered.

5. The clinical record for Resident E was reviewed on 9/28/21 at 2:40 p.m. The diagnoses included, but were not limited to, polyosteoarthritis.

The 8/10/20 service plan indicated nursing would administer her medications with the objective that her medication regimen would be followed, as ordered by her physician.

	The physician's orders indicated for one 50 mg tablet of Tramadol to be administered 4 times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. The August, and September, 2021 MARs (medication administration records) indicated she was not administered 12 doses of the above medication, with no reason as to why. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. She indicated she missed several doses of Tramadol the previous week, and nursing would try to give her the 9:00 p.m. dose with the 5:00 p.m. dose. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated she was unsure why Resident E's Tramadol was not signed off, so to her it looked like it was not administered. Four of the administrations were by facility staff who needed to be educated, and the other 8 were by agency staff who no longer worked at the facility. 6. The clinical record for Resident C was reviewed on 9/28/21 at 12:48 p.m. The diagnoses included, but were not limited to, hypertension. She no longer resided at the facility.			

	An interview was conducted with Family Member 15 on 9/27/21 at 3:08 p.m. She indicated the facility was supposed to obtain Resident C's blood pressure, beginning in June, 2021, and call the physician if it was over a certain number, but they never did. The 5/18/21 Level of Service Assessment/Evaluation indicated she did not require any treatment procedures and administered her own medications. The 6/1/21 prescription from a prescription pad copied onto an 8 1/2 by 11 inch piece of paper read, "Attn (Attention): Assisted Living Check blood pressure once weekly for 6 weeks," and to call if SBP (systolic blood pressure) was greater than 165 or DBP (diastolic blood pressure) was greater than 105. There was a note at the top of the piece of paper that read, "Please add to EMAR (electronic medication administration record.)" Resident C's clinical record did not include weekly blood pressures in the vitals tab of the electronic health record after the 6/1/21 physician's order, and there was no EMAR at all. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 10:11			

	a.m. She indicated she could not find any weekly blood pressures for Resident C resulting from the 6/1/21 order to obtain them, and Resident C had no EMAR, as she administered her own medications. A "Medication, Oversight, Assistance and Administration" policy was provided by the Director of Nursing on 9/29/21 at 9:05 a.m. It indicate "...Purpose: The purpose of this procedure is to ensure that medications are stored in a safe, secure, and orderly manner...Administration. Medication administration shall be provided by a license nurse. Medication administration may include assisting residents in the removal of the medication from the container and assisting the resident in consuming (i.e. placing a dose in a container and placing the container to the mouth of the resident) or applying the medication when requested to do so by the resident, injections. If medication administration is provided, the licensed nurse will document the administration including the medication, dose, route, date, and time of the administration of on the Medication Assistance Record..." Based on interview and record review, the facility failed to			

	administer medications and obtain blood pressures, as ordered, for 6 of 7 residents medications reviewed, and timely care for a leaking indwelling catheter for 1 of 1 resident reviewed for urinary catheters (Residents B, C, E, F, L, M and Q) Findings include: During a confidential interview on 9/27/21 at 4:54 p.m., she indicated the residents are not getting their medications as ordered. Residents that require insulin administrations are not receiving their insulins. Resident B's inhaler had not been available to administer for several weeks. The Director of Nursing was aware and did not address. 1. The clinical record for Resident B was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, hypertension. A service plan dated 9/30/20 for Resident B indicated the resident needed assistance with medication administration and staff will follow medication regimen as physician ordered.			

A physician order dated 5/28/21 indicated Resident B would receive 1 puff of 100-250 micrograms of breo ellipta inhaler twice a day.

The July 2021 Medication Administration Record (MAR) indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer:

7/5/21, 7/6/21, 7/7/21, 7/8/21, 7/9/21, 7/11/21, 7/12/21, 7/13/21, 7/14/21, 7/15/21, 7/17/21, 7/19/21, 7/20/21, 7/22/21, 7/23/21, 7/24/21, 7/25/21, 7/26/21, 7/27/21, 7/28/21, 7/29/21, 7/30/21, and 7/31/21

The August 2021 MAR indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer:

8/1/21, 8/3/21, 28/4/21, 8/5/21, 8/7/21, 8/16/21 - "resident away", 8/23/21, 8/29/21, and 8/30/21

There was no documentation the physician was notified the resident did not receive her breo ellipta.

An interview was conducted with Resident B on 9/28/21 at 10:48 a.m. She indicated she had went a couple of months

without receiving her breo ellipta inhaler.

An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure the delay in getting the breo ellipta inhaler. The physician should be notified if medication are unable to be administered.

2. The clinical record for Resident L was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident L included, but was not limited to, type 2 diabetes mellitus.

A service plan dated 1/16/21 indicated staff was to assist Resident L with administration of medications.

A physician order dated 7/15/20 indicated Resident L was to receive a sliding scale of novolog three times a day. The sliding scale was the following: 10-130 blood sugar reading = 0 units, 131-180 blood sugar readings = 2 units, 181-240 blood sugar readings = 4 units, 241-300 blood sugar reading = 6 units, 301-350 blood sugar reading = 8 units, 351-400 blood sugar reading = 10 units, greater than 400 blood sugar reading = 12 units and notify physician.

A physician order dated 7/24/21 indicated Resident L was to receive 40 units of Levemir

	insulin once a day. The August 2021 MAR indicated the following days and times blood sugar readings were not obtained to administer novolog sliding if needed: 8/1/21 - 12:00 p.m., 8/3/21 - 12:00 p.m., 8/4/21 - 8:00 a.m., 12:00 p.m., 8/5/21 - 8:00 a.m., 12:00 p.m., 8/6/21 - 8:00 a.m., 8/9/21 - 8:00 a.m., 8/10/21 - 8:00 a.m., 12:00 p.m., 8/12/21 - 8:00 a.m., 12:00 p.m., 8/14/21 - 8:00 a.m., 12:00 p.m., 8/17/21 - 12:00 p.m., 8/18/21 - 12:00 p.m., 8/19/21 - 12:00 p.m., 8/24/21 - 12:00 p.m., 8/26/21 - 12:00 p.m., 8/27/21 - 12:00 p.m., 8/28/21 -12:00 p.m., and 8/29/21 - 12:00 p.m.,			

	The following days the resident's Levemir insulin was not administered: 8/6/21 and 8/9/21. The September 2021 MAR indicated the following days and times Resident L had not received blood sugar readings to administer novolog sliding scale insulin if needed: 9/3/21 - 12:00 p.m., 9/7/21 - 12:00 p.m., 9/14/21 - 12:00 p.m., 9/16/21 - 12:00 p.m., 9/22/21 - 12:00 p.m.., 9/23/21 - 12:00 p.m., and 9/24/21 - 12:00 p.m., There was no documentation the resident was not available or physician was notified the blood sugar was not obtained nor sliding scale insulin was administered. An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated the staff were having trouble with recording blood sugars that do not fall in the parameters of the sliding scale, but unsure if that was the case. The physician should be notified if the medication were not			

	administered. 3. The clinical record for Resident Q was reviewed on 9/27/21 at 2:15 p.m. The diagnosis for Resident Q included, but was not limited to, type 2 diabetes mellitus. A service plan dated 3/23/21 indicated Resident Q was to receive staff assistance with the administration of his medications. A physician order dated 3/23/21 indicated Resident Q was to receive 3 milligrams of trulicity injection once a week. The staff was to administer on Wednesdays. The August 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 8/4/21. The September 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 9/8/21, 9/15/21, and 9/22/21. There was no documentation in the clinical record notifying the physician Resident Q had not received his trulicity injections. An interview was conducted with Resident Q on 9/29/21 at 10:31 a.m. He indicated he was suppose to get his injection of trulicity once a week on Wednesdays. He has not gotten			

	it in awhile. An interview was conducted with Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure why Resident Q had not gotten his trulicity injection on Wednesdays as ordered. The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease. On 9/29/21 at 10:24 a.m., she was observed laying in her bed in her apartment. The apartment had a strong smell of urine. She was laying in bed and an empty indwelling catheter drainage bag attached to the side of the bed. There was a pink wash basin, located under the drainage bag, which contained yellow urine. On 9/29/21 at 10:30 a.m., QMA (Qualified Medication Aide) 23 was observed assisting her with care. She indicated to Resident F that she was going to empty the urine from her catheter. She then emptied the basin under the catheter bag into the toilet. Resident F indicated the drainage bag had been leaking for around 3 days and they did not have the supplies to change it here, so the doctor wanted her to go the clinic or the			

	emergency room to have it changed. She wished they would schedule it or take her so it could get done. She asked QMA 23 to make sure the basin was under the drainage bag so that urine did not get onto the floor. The clinical record did not contain physician's orders addressing care of the indwelling catheter. The clinical record did not contain any documentation of the catheter drainage bag leaking. During an interview on 9/29/21 at 11:15 a.m., the DON (Director of Nursing) indicated the staff had told her about the catheter bag leaking that morning. She was unsure how long it had been leaking and that home health provided the care for her catheter. On 9/29/21 at 12:15 p.m., the DON provided the Catheter Care Policy, revised 2/2021, which read "... Purpose: The purpose of this policy and procedure is to prevent infection of the resident's urinary tract. Policy: It is the policy of this community to provide assistance with catheter care including education, monitoring, hygiene assistances as well as maintenance of urological appliances and system.			

	Catheter care will be provided in such a manner to promote cleanliness, comfort and to minimize risk associated with use of an intermittent or indwelling urological appliance. Responsibility: A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter. C. It is the responsibility of the nursing staff to empty the resident's catheter bas if the resident is unable to complete the task themselves. D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter..." This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200. 4. The clinical record for Resident M was reviewed on 9/28/21 at 2:54 p.m. The diagnoses included, but were not limited to, type 2 diabetes. The 2/26/21 service plan indicated he had the potential for hyper/hypoglycemia and other complications related to altered metabolic state and a diagnosis of diabetes. The services to be provided included to assist/administer medications			

as ordered.

The physician's orders indicated Trulicity 0.75 mg/0.5 ml pen, inject 0.5ml subcutaneously every Monday, effective 3/26/21.

The September, 2021 MAR (medication administration record) indicated he received the above medication 9/6/21 and 9/20/21 and did not receive it on 9/13/21 or 9/27/21.

An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated it was agency staff working on 9/13/21 and 9/27/21, and they no longer worked at the facility. It looked to her like the medication was not administered as ordered.

5. The clinical record for Resident E was reviewed on 9/28/21 at 2:40 p.m. The diagnoses included, but were not limited to, polyosteoarthritis.

The 8/10/20 service plan indicated nursing would administer her medications with the objective that her medication regimen would be followed, as ordered by her physician.

The physician's orders indicated for one 50 mg tablet of Tramadol to be administered 4 times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.

	The August, and September, 2021 MARs (medication administration records) indicated she was not administered 12 doses of the above medication, with no reason as to why. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. She indicated she missed several doses of Tramadol the previous week, and nursing would try to give her the 9:00 p.m. dose with the 5:00 p.m. dose. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated she was unsure why Resident E's Tramadol was not signed off, so to her it looked like it was not administered. Four of the administrations were by facility staff who needed to be educated, and the other 8 were by agency staff who no longer worked at the facility. 6. The clinical record for Resident C was reviewed on 9/28/21 at 12:48 p.m. The diagnoses included, but were not limited to, hypertension. She no longer resided at the facility. An interview was conducted with Family Member 15 on 9/27/21 at 3:08 p.m. She indicated the facility was supposed to obtain Resident C's			

	blood pressure, beginning in June, 2021, and call the physician if it was over a certain number, but they never did. The 5/18/21 Level of Service Assessment/Evaluation indicated she did not require any treatment procedures and administered her own medications. The 6/1/21 prescription from a prescription pad copied onto an 8 1/2 by 11 inch piece of paper read, "Attn (Attention): Assisted Living Check blood pressure once weekly for 6 weeks," and to call if SBP (systolic blood pressure) was greater than 165 or DBP (diastolic blood pressure) was greater than 105. There was a note at the top of the piece of paper that read, "Please add to EMAR (electronic medication administration record.)" Resident C's clinical record did not include weekly blood pressures in the vitals tab of the electronic health record after the 6/1/21 physician's order, and there was no EMAR at all. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 10:11 a.m. She indicated she could not find any weekly blood pressures for Resident C resulting from the 6/1/21 order to obtain them, and Resident C			

had no EMAR, as she administered her own medications.

A "Medication, Oversight, Assistance and Administration" policy was provided by the Director of Nursing on 9/29/21 at 9:05 a.m. It indicate "...Purpose: The purpose of this procedure is to ensure that medications are stored in a safe, secure, and orderly manner...Administration. Medication administration shall be provided by a license nurse. Medication administration may include assisting residents in the removal of the medication from the container and assisting the resident in consuming (i.e. placing a dose in a container and placing the container to the mouth of the resident) or applying the medication when requested to do so by the resident, injections. If medication administration is provided, the licensed nurse will document the administration including the medication, dose, route, date, and time of the administration of on the Medication Assistance Record..."

Based on interview and record review, the facility failed to administer medications and obtain blood pressures, as ordered, for 6 of 7 residents medications reviewed, and timely care for a leaking

indwelling catheter for 1 of 1 resident reviewed for urinary catheters (Residents B, C, E, F, L, M and Q)

Findings include:

During a confidential interview on 9/27/21 at 4:54 p.m., she indicated the residents are not getting their medications as ordered. Residents that require insulin administrations are not receiving their insulins. Resident B's inhaler had not been available to administer for several weeks. The Director of Nursing was aware and did not address.

1. The clinical record for Resident B was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, hypertension.

A service plan dated 9/30/20 for Resident B indicated the resident needed assistance with medication administration and staff will follow medication regimen as physician ordered.

A physician order dated 5/28/21 indicated Resident B would receive 1 puff of 100-250 micrograms of breo ellipta inhaler twice a day.

The July 2021 Medication Administration Record (MAR) indicated in documented notes Resident B did not receive the

breo ellipta the following days, because the medication was not available to administer:

7/5/21, 7/6/21, 7/7/21, 7/8/21, 7/9/21, 7/11/21, 7/12/21, 7/13/21, 7/14/21, 7/15/21, 7/17/21, 7/19/21, 7/20/21, 7/22/21, 7/23/21, 7/24/21, 7/25/21, 7/26/21, 7/27/21, 7/28/21, 7/29/21, 7/30/21, and 7/31/21

The August 2021 MAR indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer:

8/1/21, 8/3/21, 28/4/21, 8/5/21, 8/7/21, 8/16/21 - "resident away", 8/23/21, 8/29/21, and 8/30/21

There was no documentation the physician was notified the resident did not receive her breo ellipta.

An interview was conducted with Resident B on 9/28/21 at 10:48 a.m. She indicated she had went a couple of months without receiving her breo ellipta inhaler.

An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure the delay in getting the breo ellipta inhaler. The physician should be notified if medication are unable

to be administered.

2. The clinical record for Resident L was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident L included, but was not limited to, type 2 diabetes mellitus.

A service plan dated 1/16/21 indicated staff was to assist Resident L with administration of medications.

A physician order dated 7/15/20 indicated Resident L was to receive a sliding scale of novolog three times a day. The sliding scale was the following: 10-130 blood sugar reading = 0 units, 131-180 blood sugar readings = 2 units, 181-240 blood sugar readings = 4 units, 241-300 blood sugar reading = 6 units, 301-350 blood sugar reading = 8 units, 351-400 blood sugar reading = 10 units, greater than 400 blood sugar reading = 12 units and notify physician.

A physician order dated 7/24/21 indicated Resident L was to receive 40 units of Levemir insulin once a day.

The August 2021 MAR indicated the following days and times blood sugar readings were not obtained to administer novolog sliding if needed:

8/1/21 - 12:00 p.m.,

	8/3/21 - 12:00 p.m., 8/4/21 - 8:00 a.m., 12:00 p.m., 8/5/21 - 8:00 a.m., 12:00 p.m., 8/6/21 - 8:00 a.m., 8/9/21 - 8:00 a.m., 8/10/21 - 8:00 a.m., 12:00 p.m., 8/12/21 - 8:00 a.m., 12:00 p.m., 8/14/21 - 8:00 a.m., 12:00 p.m., 8/17/21 - 12:00 p.m., 8/18/21 - 12:00 p.m., 8/19/21 - 12:00 p.m., 8/24/21 - 12:00 p.m., 8/26/21 - 12:00 p.m., 8/27/21 - 12:00 p.m., 8/28/21 -12:00 p.m., and 8/29/21 - 12:00 p.m., The following days the resident's Levemir insulin was not administered: 8/6/21 and 8/9/21. The September 2021 MAR indicated the following days and times Resident L had not received blood sugar readings to administer novolog sliding scale insulin if needed:			

	9/3/21 - 12:00 p.m., 9/7/21 - 12:00 p.m., 9/14/21 - 12:00 p.m., 9/16/21 - 12:00 p.m., 9/22/21 - 12:00 p.m.., 9/23/21 - 12:00 p.m., and 9/24/21 - 12:00 p.m., There was no documentation the resident was not available or physician was notified the blood sugar was not obtained nor sliding scale insulin was administered. An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated the staff were having trouble with recording blood sugars that do not fall in the parameters of the sliding scale, but unsure if that was the case. The physician should be notified if the medication were not administered. 3. The clinical record for Resident Q was reviewed on 9/27/21 at 2:15 p.m. The diagnosis for Resident Q included, but was not limited to, type 2 diabetes mellitus. A service plan dated 3/23/21 indicated Resident Q was to receive staff assistance with the administration of his			

medications.

A physician order dated 3/23/21 indicated Resident Q was to receive 3 milligrams of trulicity injection once a week. The staff was to administer on Wednesdays.

The August 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 8/4/21.

The September 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 9/8/21, 9/15/21, and 9/22/21.

There was no documentation in the clinical record notifying the physician Resident Q had not received his trulicity injections.

An interview was conducted with Resident Q on 9/29/21 at 10:31 a.m. He indicated he was suppose to get his injection of trulicity once a week on Wednesdays. He has not gotten it in awhile.

An interview was conducted with Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure why Resident Q had not gotten his trulicity injection on Wednesdays as ordered.

The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's

	diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease. On 9/29/21 at 10:24 a.m., she was observed laying in her bed in her apartment. The apartment had a strong smell of urine. She was laying in bed and an empty indwelling catheter drainage bag attached to the side of the bed. There was a pink wash basin, located under the drainage bag, which contained yellow urine. On 9/29/21 at 10:30 a.m., QMA (Qualified Medication Aide) 23 was observed assisting her with care. She indicated to Resident F that she was going to empty the urine from her catheter. She then emptied the basin under the catheter bag into the toilet. Resident F indicated the drainage bag had been leaking for around 3 days and they did not have the supplies to change it here, so the doctor wanted her to go the clinic or the emergency room to have it changed. She wished they would schedule it or take her so it could get done. She asked QMA 23 to make sure the basin was under the drainage bag so that urine did not get onto the floor.			

	The clinical record did not contain physician's orders addressing care of the indwelling catheter. The clinical record did not contain any documentation of the catheter drainage bag leaking. During an interview on 9/29/21 at 11:15 a.m., the DON (Director of Nursing) indicated the staff had told her about the catheter bag leaking that morning. She was unsure how long it had been leaking and that home health provided the care for her catheter. On 9/29/21 at 12:15 p.m., the DON provided the Catheter Care Policy, revised 2/2021, which read "... Purpose: The purpose of this policy and procedure is to prevent infection of the resident's urinary tract. Policy: It is the policy of this community to provide assistance with catheter care including education, monitoring, hygiene assistances as well as maintenance of urological appliances and system. Catheter care will be provided in such a manner to promote cleanliness, comfort and to minimize risk associated with use of an intermittent or indwelling urological appliance. Responsibility: A. It is the responsibility of the licensed nursing staff to secure a			

physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter. C. It is the responsibility of the nursing staff to empty the resident's catheter bas if the resident is unable to complete the task themselves. D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter..."

This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200.

4. The clinical record for Resident M was reviewed on 9/28/21 at 2:54 p.m. The diagnoses included, but were not limited to, type 2 diabetes.

The 2/26/21 service plan indicated he had the potential for hyper/hypoglycemia and other complications related to altered metabolic state and a diagnosis of diabetes. The services to be provided included to assist/administer medications as ordered.

The physician's orders indicated Trulicity 0.75 mg/0.5 ml pen, inject 0.5ml subcutaneously every Monday, effective 3/26/21.

The September, 2021 MAR (medication administration

record) indicated he received the above medication 9/6/21 and 9/20/21 and did not receive it on 9/13/21 or 9/27/21.

An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated it was agency staff working on 9/13/21 and 9/27/21, and they no longer worked at the facility. It looked to her like the medication was not administered as ordered.

5. The clinical record for Resident E was reviewed on 9/28/21 at 2:40 p.m. The diagnoses included, but were not limited to, polyosteoarthritis.

The 8/10/20 service plan indicated nursing would administer her medications with the objective that her medication regimen would be followed, as ordered by her physician.

The physician's orders indicated for one 50 mg tablet of Tramadol to be administered 4 times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.

The August, and September, 2021 MARs (medication administration records) indicated she was not administered 12 doses of the above medication, with no reason as to why.

An interview was conducted with Resident E on 9/28/21 at

	3:15 p.m. She indicated she missed several doses of Tramadol the previous week, and nursing would try to give her the 9:00 p.m. dose with the 5:00 p.m. dose. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated she was unsure why Resident E's Tramadol was not signed off, so to her it looked like it was not administered. Four of the administrations were by facility staff who needed to be educated, and the other 8 were by agency staff who no longer worked at the facility. 6. The clinical record for Resident C was reviewed on 9/28/21 at 12:48 p.m. The diagnoses included, but were not limited to, hypertension. She no longer resided at the facility. An interview was conducted with Family Member 15 on 9/27/21 at 3:08 p.m. She indicated the facility was supposed to obtain Resident C's blood pressure, beginning in June, 2021, and call the physician if it was over a certain number, but they never did. The 5/18/21 Level of Service Assessment/Evaluation indicated she did not require any treatment procedures and administered her own			

	medications. The 6/1/21 prescription from a prescription pad copied onto an 8 1/2 by 11 inch piece of paper read, "Attn (Attention): Assisted Living Check blood pressure once weekly for 6 weeks," and to call if SBP (systolic blood pressure) was greater than 165 or DBP (diastolic blood pressure) was greater than 105. There was a note at the top of the piece of paper that read, "Please add to EMAR (electronic medication administration record.)" Resident C's clinical record did not include weekly blood pressures in the vitals tab of the electronic health record after the 6/1/21 physician's order, and there was no EMAR at all. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 10:11 a.m. She indicated she could not find any weekly blood pressures for Resident C resulting from the 6/1/21 order to obtain them, and Resident C had no EMAR, as she administered her own medications. A "Medication, Oversight, Assistance and Administration" policy was provided by the Director of Nursing on 9/29/21 at 9:05 a.m. It indicate "...Purpose: The purpose of this			

	procedure is to ensure that medications are stored in a safe, secure, and orderly manner...Administration. Medication administration shall be provided by a license nurse. Medication administration may include assisting residents in the removal of the medication from the container and assisting the resident in consuming (i.e. placing a dose in a container and placing the container to the mouth of the resident) or applying the medication when requested to do so by the resident, injections. If medication administration is provided, the licensed nurse will document the administration including the medication, dose, route, date, and time of the administration of on the Medication Assistance Record..." Based on interview and record review, the facility failed to administer medications and obtain blood pressures, as ordered, for 6 of 7 residents medications reviewed, and timely care for a leaking indwelling catheter for 1 of 1 resident reviewed for urinary catheters (Residents B, C, E, F, L, M and Q) Findings include: During a confidential interview on 9/27/21 at 4:54 p.m., she indicated the residents are not			

getting their medications as ordered. Residents that require insulin administrations are not receiving their insulins. Resident B's inhaler had not been available to administer for several weeks. The Director of Nursing was aware and did not address.

1. The clinical record for Resident B was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, hypertension.

A service plan dated 9/30/20 for Resident B indicated the resident needed assistance with medication administration and staff will follow medication regimen as physician ordered.

A physician order dated 5/28/21 indicated Resident B would receive 1 puff of 100-250 micrograms of breo ellipta inhaler twice a day.

The July 2021 Medication Administration Record (MAR) indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer:

7/5/21, 7/6/21, 7/7/21, 7/8/21, 7/9/21, 7/11/21, 7/12/21, 7/13/21, 7/14/21, 7/15/21, 7/17/21, 7/19/21, 7/20/21, 7/22/21, 7/23/21, 7/24/21, 7/25/21, 7/26/21, 7/27/21,

	7/28/21, 7/29/21, 7/30/21, and 7/31/21 The August 2021 MAR indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer: 8/1/21, 8/3/21, 28/4/21, 8/5/21, 8/7/21, 8/16/21 - "resident away", 8/23/21, 8/29/21, and 8/30/21 There was no documentation the physician was notified the resident did not receive her breo ellipta. An interview was conducted with Resident B on 9/28/21 at 10:48 a.m. She indicated she had went a couple of months without receiving her breo ellipta inhaler. An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure the delay in getting the breo ellipta inhaler. The physician should be notified if medication are unable to be administered. 2. The clinical record for Resident L was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident L included, but was not limited to, type 2 diabetes mellitus. A service plan dated 1/16/21			

indicated staff was to assist Resident L with administration of medications.

A physician order dated 7/15/20 indicated Resident L was to receive a sliding scale of novolog three times a day. The sliding scale was the following: 10-130 blood sugar reading = 0 units, 131-180 blood sugar readings = 2 units, 181-240 blood sugar readings = 4 units, 241-300 blood sugar reading = 6 units, 301-350 blood sugar reading = 8 units, 351-400 blood sugar reading = 10 units, greater than 400 blood sugar reading = 12 units and notify physician.

A physician order dated 7/24/21 indicated Resident L was to receive 40 units of Levemir insulin once a day.

The August 2021 MAR indicated the following days and times blood sugar readings were not obtained to administer novolog sliding if needed:

8/1/21 - 12:00 p.m.,

8/3/21 - 12:00 p.m.,

8/4/21 - 8:00 a.m., 12:00 p.m.,

8/5/21 - 8:00 a.m., 12:00 p.m.,

8/6/21 - 8:00 a.m.,

8/9/21 - 8:00 a.m.,

	8/10/21 - 8:00 a.m., 12:00 p.m., 8/12/21 - 8:00 a.m., 12:00 p.m., 8/14/21 - 8:00 a.m., 12:00 p.m., 8/17/21 - 12:00 p.m., 8/18/21 - 12:00 p.m., 8/19/21 - 12:00 p.m., 8/24/21 - 12:00 p.m., 8/26/21 - 12:00 p.m., 8/27/21 - 12:00 p.m., 8/28/21 -12:00 p.m., and 8/29/21 - 12:00 p.m., The following days the resident's Levemir insulin was not administered: 8/6/21 and 8/9/21. The September 2021 MAR indicated the following days and times Resident L had not received blood sugar readings to administer novolog sliding scale insulin if needed: 9/3/21 - 12:00 p.m., 9/7/21 - 12:00 p.m., 9/14/21 - 12:00 p.m., 9/16/21 - 12:00 p.m., 9/22/21 - 12:00 p.m...,			

9/23/21 - 12:00 p.m., and

9/24/21 - 12:00 p.m.,

There was no documentation the resident was not available or physician was notified the blood sugar was not obtained nor sliding scale insulin was administered.

An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated the staff were having trouble with recording blood sugars that do not fall in the parameters of the sliding scale, but unsure if that was the case. The physician should be notified if the medication were not administered.

3. The clinical record for Resident Q was reviewed on 9/27/21 at 2:15 p.m. The diagnosis for Resident Q included, but was not limited to, type 2 diabetes mellitus.

A service plan dated 3/23/21 indicated Resident Q was to receive staff assistance with the administration of his medications.

A physician order dated 3/23/21 indicated Resident Q was to receive 3 milligrams of trulicity injection once a week. The staff was to administer on Wednesdays.

The August 2021 MAR indicated

Resident Q had not received the 3 milligrams of trulicity on 8/4/21.

The September 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 9/8/21, 9/15/21, and 9/22/21.

There was no documentation in the clinical record notifying the physician Resident Q had not received his trulicity injections.

An interview was conducted with Resident Q on 9/29/21 at 10:31 a.m. He indicated he was suppose to get his injection of trulicity once a week on Wednesdays. He has not gotten it in awhile.

An interview was conducted with Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure why Resident Q had not gotten his trulicity injection on Wednesdays as ordered.

The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease.

On 9/29/21 at 10:24 a.m., she was observed laying in her bed in her apartment. The apartment had a strong smell of urine. She was laying in bed and an empty

	indwelling catheter drainage bag attached to the side of the bed. There was a pink wash basin, located under the drainage bag, which contained yellow urine. On 9/29/21 at 10:30 a.m., QMA (Qualified Medication Aide) 23 was observed assisting her with care. She indicated to Resident F that she was going to empty the urine from her catheter. She then emptied the basin under the catheter bag into the toilet. Resident F indicated the drainage bag had been leaking for around 3 days and they did not have the supplies to change it here, so the doctor wanted her to go the clinic or the emergency room to have it changed. She wished they would schedule it or take her so it could get done. She asked QMA 23 to make sure the basin was under the drainage bag so that urine did not get onto the floor. The clinical record did not contain physician's orders addressing care of the indwelling catheter. The clinical record did not contain any documentation of the catheter drainage bag leaking. During an interview on 9/29/21 at 11:15 a.m., the DON (Director of Nursing) indicated the staff had told her about the catheter			

	bag leaking that morning. She was unsure how long it had been leaking and that home health provided the care for her catheter.			

	On 9/29/21 at 12:15 p.m., the DON provided the Catheter Care Policy, revised 2/2021, which read "... Purpose: The purpose of this policy and procedure is to prevent infection of the resident's urinary tract. Policy: It is the policy of this community to provide assistance with catheter care including education, monitoring, hygiene assistances as well as maintenance of urological appliances and system. Catheter care will be provided in such a manner to promote cleanliness, comfort and to minimize risk associated with use of an intermittent or indwelling urological appliance. Responsibility: A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter. C. It is the responsibility of the nursing staff to empty the resident's catheter bas if the resident is unable to complete the task themselves. D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter..." This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200.			

	4. The clinical record for Resident M was reviewed on 9/28/21 at 2:54 p.m. The diagnoses included, but were not limited to, type 2 diabetes. The 2/26/21 service plan indicated he had the potential for hyper/hypoglycemia and other complications related to altered metabolic state and a diagnosis of diabetes. The services to be provided included to assist/administer medications as ordered. The physician's orders indicated Trulicity 0.75 mg/0.5 ml pen, inject 0.5ml subcutaneously every Monday, effective 3/26/21. The September, 2021 MAR (medication administration record) indicated he received the above medication 9/6/21 and 9/20/21 and did not receive it on 9/13/21 or 9/27/21. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated it was agency staff working on 9/13/21 and 9/27/21, and they no longer worked at the facility. It looked to her like the medication was not administered as ordered.			

	5. The clinical record for Resident E was reviewed on 9/28/21 at 2:40 p.m. The diagnoses included, but were not limited to, polyosteoarthritis. The 8/10/20 service plan indicated nursing would administer her medications with the objective that her medication regimen would be followed, as ordered by her physician. The physician's orders indicated for one 50 mg tablet of Tramadol to be administered 4 times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. The August, and September, 2021 MARs (medication administration records) indicated she was not administered 12 doses of the above medication, with no reason as to why. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. She indicated she missed several doses of Tramadol the previous week, and nursing would try to give her the 9:00 p.m. dose with the 5:00 p.m. dose. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated she was unsure why Resident E's Tramadol was not signed off, so to her it looked like it was not administered. Four of the			

	administrations were by facility staff who needed to be educated, and the other 8 were by agency staff who no longer worked at the facility. 6. The clinical record for Resident C was reviewed on 9/28/21 at 12:48 p.m. The diagnoses included, but were not limited to, hypertension. She no longer resided at the facility. An interview was conducted with Family Member 15 on 9/27/21 at 3:08 p.m. She indicated the facility was supposed to obtain Resident C's blood pressure, beginning in June, 2021, and call the physician if it was over a certain number, but they never did. The 5/18/21 Level of Service Assessment/Evaluation indicated she did not require any treatment procedures and administered her own medications. The 6/1/21 prescription from a prescription pad copied onto an 8 1/2 by 11 inch piece of paper read, "Attn (Attention): Assisted Living Check blood pressure once weekly for 6 weeks," and to call if SBP (systolic blood pressure) was greater than 165 or DBP (diastolic blood pressure) was greater than 105. There was a note at the top of the piece of paper that read, "Please add to EMAR			

	(electronic medication administration record.)" Resident C's clinical record did not include weekly blood pressures in the vitals tab of the electronic health record after the 6/1/21 physician's order, and there was no EMAR at all. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 10:11 a.m. She indicated she could not find any weekly blood pressures for Resident C resulting from the 6/1/21 order to obtain them, and Resident C had no EMAR, as she administered her own medications. A "Medication, Oversight, Assistance and Administration" policy was provided by the Director of Nursing on 9/29/21 at 9:05 a.m. It indicate "...Purpose: The purpose of this procedure is to ensure that medications are stored in a safe, secure, and orderly manner...Administration. Medication administration shall be provided by a license nurse. Medication administration may include assisting residents in the removal of the medication from the container and assisting the resident in consuming (i.e. placing a dose in a container and placing the container to the mouth of the resident) or applying the medication when			

	requested to do so by the resident, injections. If medication administration is provided, the licensed nurse will document the administration including the medication, dose, route, date, and time of the administration of on the Medication Assistance Record..." Based on interview and record review, the facility failed to administer medications and obtain blood pressures, as ordered, for 6 of 7 residents medications reviewed, and timely care for a leaking indwelling catheter for 1 of 1 resident reviewed for urinary catheters (Residents B, C, E, F, L, M and Q) Findings include: During a confidential interview on 9/27/21 at 4:54 p.m., she indicated the residents are not getting their medications as ordered. Residents that require insulin administrations are not receiving their insulins. Resident B's inhaler had not been available to administer for several weeks. The Director of Nursing was aware and did not address. 1. The clinical record for Resident B was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to,			

hypertension.

A service plan dated 9/30/20 for Resident B indicated the resident needed assistance with medication administration and staff will follow medication regimen as physician ordered.

A physician order dated 5/28/21 indicated Resident B would receive 1 puff of 100-250 micrograms of breo ellipta inhaler twice a day.

The July 2021 Medication Administration Record (MAR) indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer:

7/5/21, 7/6/21, 7/7/21, 7/8/21, 7/9/21, 7/11/21, 7/12/21, 7/13/21, 7/14/21, 7/15/21, 7/17/21, 7/19/21, 7/20/21, 7/22/21, 7/23/21, 7/24/21, 7/25/21, 7/26/21, 7/27/21, 7/28/21, 7/29/21, 7/30/21, and 7/31/21

The August 2021 MAR indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer:

8/1/21, 8/3/21, 28/4/21, 8/5/21, 8/7/21, 8/16/21 - "resident away", 8/23/21, 8/29/21, and 8/30/21

There was no documentation the physician was notified the resident did not receive her breo ellipta.

An interview was conducted with Resident B on 9/28/21 at 10:48 a.m. She indicated she had went a couple of months without receiving her breo ellipta inhaler.

An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure the delay in getting the breo ellipta inhaler. The physician should be notified if medication are unable to be administered.

2. The clinical record for Resident L was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident L included, but was not limited to, type 2 diabetes mellitus.

A service plan dated 1/16/21 indicated staff was to assist Resident L with administration of medications.

A physician order dated 7/15/20 indicated Resident L was to receive a sliding scale of novolog three times a day. The sliding scale was the following: 10-130 blood sugar reading = 0 units, 131-180 blood sugar readings = 2 units, 181-240 blood sugar readings = 4 units, 241-300 blood sugar reading = 6 units, 301-350 blood sugar

	reading = 8 units, 351-400 blood sugar reading = 10 units, greater than 400 blood sugar reading = 12 units and notify physician. A physician order dated 7/24/21 indicated Resident L was to receive 40 units of Levemir insulin once a day. The August 2021 MAR indicated the following days and times blood sugar readings were not obtained to administer novolog sliding if needed: 8/1/21 - 12:00 p.m., 8/3/21 - 12:00 p.m., 8/4/21 - 8:00 a.m., 12:00 p.m., 8/5/21 - 8:00 a.m., 12:00 p.m., 8/6/21 - 8:00 a.m., 8/9/21 - 8:00 a.m., 8/10/21 - 8:00 a.m., 12:00 p.m., 8/12/21 - 8:00 a.m., 12:00 p.m., 8/14/21 - 8:00 a.m., 12:00 p.m., 8/17/21 - 12:00 p.m., 8/18/21 - 12:00 p.m., 8/19/21 - 12:00 p.m., 8/24/21 - 12:00 p.m., 8/26/21 - 12:00 p.m.,			

	8/27/21 - 12:00 p.m., 8/28/21 -12:00 p.m., and 8/29/21 - 12:00 p.m., The following days the resident's Levemir insulin was not administered: 8/6/21 and 8/9/21. The September 2021 MAR indicated the following days and times Resident L had not received blood sugar readings to administer novolog sliding scale insulin if needed: 9/3/21 - 12:00 p.m., 9/7/21 - 12:00 p.m., 9/14/21 - 12:00 p.m., 9/16/21 - 12:00 p.m., 9/22/21 - 12:00 p.m.., 9/23/21 - 12:00 p.m., and 9/24/21 - 12:00 p.m., There was no documentation the resident was not available or physician was notified the blood sugar was not obtained nor sliding scale insulin was administered. An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated the staff were having trouble with recording blood			

	sugars that do not fall in the parameters of the sliding scale, but unsure if that was the case. The physician should be notified if the medication were not administered. 3. The clinical record for Resident Q was reviewed on 9/27/21 at 2:15 p.m. The diagnosis for Resident Q included, but was not limited to, type 2 diabetes mellitus. A service plan dated 3/23/21 indicated Resident Q was to receive staff assistance with the administration of his medications. A physician order dated 3/23/21 indicated Resident Q was to receive 3 milligrams of trulicity injection once a week. The staff was to administer on Wednesdays. The August 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 8/4/21. The September 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 9/8/21, 9/15/21, and 9/22/21. There was no documentation in the clinical record notifying the physician Resident Q had not received his trulicity injections. An interview was conducted			

	with Resident Q on 9/29/21 at 10:31 a.m. He indicated he was suppose to get his injection of trulicity once a week on Wednesdays. He has not gotten it in awhile. An interview was conducted with Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure why Resident Q had not gotten his trulicity injection on Wednesdays as ordered. The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease. On 9/29/21 at 10:24 a.m., she was observed laying in her bed in her apartment. The apartment had a strong smell of urine. She was laying in bed and an empty indwelling catheter drainage bag attached to the side of the bed. There was a pink wash basin, located under the drainage bag, which contained yellow urine. On 9/29/21 at 10:30 a.m., QMA (Qualified Medication Aide) 23 was observed assisting her with care. She indicated to Resident F that she was going to empty the urine from her catheter. She then emptied the basin under the catheter bag into the toilet. Resident F indicated the			

	drainage bag had been leaking for around 3 days and they did not have the supplies to change it here, so the doctor wanted her to go the clinic or the emergency room to have it changed. She wished they would schedule it or take her so it could get done. She asked QMA 23 to make sure the basin was under the drainage bag so that urine did not get onto the floor. The clinical record did not contain physician's orders addressing care of the indwelling catheter. The clinical record did not contain any documentation of the catheter drainage bag leaking. During an interview on 9/29/21 at 11:15 a.m., the DON (Director of Nursing) indicated the staff had told her about the catheter bag leaking that morning. She was unsure how long it had been leaking and that home health provided the care for her catheter. On 9/29/21 at 12:15 p.m., the DON provided the Catheter Care Policy, revised 2/2021, which read "... Purpose: The purpose of this policy and procedure is to prevent infection of the resident's urinary tract. Policy: It is the policy of this community to provide			

	assistance with catheter care including education, monitoring, hygiene assistances as well as maintenance of urological appliances and system. Catheter care will be provided in such a manner to promote cleanliness, comfort and to minimize risk associated with use of an intermittent or indwelling urological appliance. Responsibility: A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter. C. It is the responsibility of the nursing staff to empty the resident's catheter bas if the resident is unable to complete the task themselves. D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter..." This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200. 4. The clinical record for Resident M was reviewed on 9/28/21 at 2:54 p.m. The diagnoses included, but were not limited to, type 2 diabetes. The 2/26/21 service plan indicated he had the potential for hyper/hypoglycemia and			

other complications related to altered metabolic state and a diagnosis of diabetes. The services to be provided included to assist/administer medications as ordered.

The physician's orders indicated Trulicity 0.75 mg/0.5 ml pen, inject 0.5ml subcutaneously every Monday, effective 3/26/21.

The September, 2021 MAR (medication administration record) indicated he received the above medication 9/6/21 and 9/20/21 and did not receive it on 9/13/21 or 9/27/21.

An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated it was agency staff working on 9/13/21 and 9/27/21, and they no longer worked at the facility. It looked to her like the medication was not administered as ordered.

5. The clinical record for Resident E was reviewed on 9/28/21 at 2:40 p.m. The diagnoses included, but were not limited to, polyosteoarthritis.

The 8/10/20 service plan indicated nursing would administer her medications with the objective that her medication regimen would be followed, as ordered by her physician.

The physician's orders indicated

for one 50 mg tablet of Tramadol to be administered 4 times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.

The August, and September, 2021 MARs (medication administration records) indicated she was not administered 12 doses of the above medication, with no reason as to why.

An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. She indicated she missed several doses of Tramadol the previous week, and nursing would try to give her the 9:00 p.m. dose with the 5:00 p.m. dose.

An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated she was unsure why Resident E's Tramadol was not signed off, so to her it looked like it was not administered. Four of the administrations were by facility staff who needed to be educated, and the other 8 were by agency staff who no longer worked at the facility.

6. The clinical record for Resident C was reviewed on 9/28/21 at 12:48 p.m. The diagnoses included, but were not limited to, hypertension. She no longer resided at the facility.

An interview was conducted

	with Family Member 15 on 9/27/21 at 3:08 p.m. She indicated the facility was supposed to obtain Resident C's blood pressure, beginning in June, 2021, and call the physician if it was over a certain number, but they never did. The 5/18/21 Level of Service Assessment/Evaluation indicated she did not require any treatment procedures and administered her own medications. The 6/1/21 prescription from a prescription pad copied onto an 8 1/2 by 11 inch piece of paper read, "Attn (Attention): Assisted Living Check blood pressure once weekly for 6 weeks," and to call if SBP (systolic blood pressure) was greater than 165 or DBP (diastolic blood pressure) was greater than 105. There was a note at the top of the piece of paper that read, "Please add to EMAR (electronic medication administration record.)" Resident C's clinical record did not include weekly blood pressures in the vitals tab of the electronic health record after the 6/1/21 physician's order, and there was no EMAR at all. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 10:11 a.m. She indicated she could			

not find any weekly blood pressures for Resident C resulting from the 6/1/21 order to obtain them, and Resident C had no EMAR, as she administered her own medications.

A "Medication, Oversight, Assistance and Administration" policy was provided by the Director of Nursing on 9/29/21 at 9:05 a.m. It indicate "...Purpose: The purpose of this procedure is to ensure that medications are stored in a safe, secure, and orderly manner...Administration. Medication administration shall be provided by a license nurse. Medication administration may include assisting residents in the removal of the medication from the container and assisting the resident in consuming (i.e. placing a dose in a container and placing the container to the mouth of the resident) or applying the medication when requested to do so by the resident, injections. If medication administration is provided, the licensed nurse will document the administration including the medication, dose, route, date, and time of the administration of on the Medication Assistance Record..."

Based on interview and record review, the facility failed to administer medications and

obtain blood pressures, as ordered, for 6 of 7 residents medications reviewed, and timely care for a leaking indwelling catheter for 1 of 1 resident reviewed for urinary catheters (Residents B, C, E, F, L, M and Q)

Findings include:

During a confidential interview on 9/27/21 at 4:54 p.m., she indicated the residents are not getting their medications as ordered. Residents that require insulin administrations are not receiving their insulins. Resident B's inhaler had not been available to administer for several weeks. The Director of Nursing was aware and did not address.

1. The clinical record for Resident B was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, hypertension.

A service plan dated 9/30/20 for Resident B indicated the resident needed assistance with medication administration and staff will follow medication regimen as physician ordered.

A physician order dated 5/28/21 indicated Resident B would receive 1 puff of 100-250 micrograms of breo ellipta inhaler twice a day.

	The July 2021 Medication Administration Record (MAR) indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer: 7/5/21, 7/6/21, 7/7/21, 7/8/21, 7/9/21, 7/11/21, 7/12/21, 7/13/21, 7/14/21, 7/15/21, 7/17/21, 7/19/21, 7/20/21, 7/22/21, 7/23/21, 7/24/21, 7/25/21, 7/26/21, 7/27/21, 7/28/21, 7/29/21, 7/30/21, and 7/31/21 The August 2021 MAR indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer: 8/1/21, 8/3/21, 28/4/21, 8/5/21, 8/7/21, 8/16/21 - "resident away", 8/23/21, 8/29/21, and 8/30/21 There was no documentation the physician was notified the resident did not receive her breo ellipta. An interview was conducted with Resident B on 9/28/21 at 10:48 a.m. She indicated she had went a couple of months without receiving her breo ellipta inhaler. An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She			

indicated she was unsure the delay in getting the breo ellipta inhaler. The physician should be notified if medication are unable to be administered.

2. The clinical record for Resident L was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident L included, but was not limited to, type 2 diabetes mellitus.

A service plan dated 1/16/21 indicated staff was to assist Resident L with administration of medications.

A physician order dated 7/15/20 indicated Resident L was to receive a sliding scale of novolog three times a day. The sliding scale was the following: 10-130 blood sugar reading = 0 units, 131-180 blood sugar readings = 2 units, 181-240 blood sugar readings = 4 units, 241-300 blood sugar reading = 6 units, 301-350 blood sugar reading = 8 units, 351-400 blood sugar reading = 10 units, greater than 400 blood sugar reading = 12 units and notify physician.

A physician order dated 7/24/21 indicated Resident L was to receive 40 units of Levemir insulin once a day.

The August 2021 MAR indicated the following days and times blood sugar readings were not obtained to administer novolog

	sliding if needed: 8/1/21 - 12:00 p.m., 8/3/21 - 12:00 p.m., 8/4/21 - 8:00 a.m., 12:00 p.m., 8/5/21 - 8:00 a.m., 12:00 p.m., 8/6/21 - 8:00 a.m., 8/9/21 - 8:00 a.m., 8/10/21 - 8:00 a.m., 12:00 p.m., 8/12/21 - 8:00 a.m., 12:00 p.m., 8/14/21 - 8:00 a.m., 12:00 p.m., 8/17/21 - 12:00 p.m., 8/18/21 - 12:00 p.m., 8/19/21 - 12:00 p.m., 8/24/21 - 12:00 p.m., 8/26/21 - 12:00 p.m., 8/27/21 - 12:00 p.m., 8/28/21 -12:00 p.m., and 8/29/21 - 12:00 p.m., The following days the resident's Levemir insulin was not administered: 8/6/21 and 8/9/21. The September 2021 MAR indicated the following days and times Resident L had not			

	received blood sugar readings to administer novolog sliding scale insulin if needed: 9/3/21 - 12:00 p.m., 9/7/21 - 12:00 p.m., 9/14/21 - 12:00 p.m., 9/16/21 - 12:00 p.m., 9/22/21 - 12:00 p.m.., 9/23/21 - 12:00 p.m., and 9/24/21 - 12:00 p.m., There was no documentation the resident was not available or physician was notified the blood sugar was not obtained nor sliding scale insulin was administered. An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated the staff were having trouble with recording blood sugars that do not fall in the parameters of the sliding scale, but unsure if that was the case. The physician should be notified if the medication were not administered. 3. The clinical record for Resident Q was reviewed on 9/27/21 at 2:15 p.m. The diagnosis for Resident Q included, but was not limited to, type 2 diabetes mellitus.			

	A service plan dated 3/23/21 indicated Resident Q was to receive staff assistance with the administration of his medications. A physician order dated 3/23/21 indicated Resident Q was to receive 3 milligrams of trulicity injection once a week. The staff was to administer on Wednesdays. The August 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 8/4/21. The September 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 9/8/21, 9/15/21, and 9/22/21. There was no documentation in the clinical record notifying the physician Resident Q had not received his trulicity injections. An interview was conducted with Resident Q on 9/29/21 at 10:31 a.m. He indicated he was suppose to get his injection of trulicity once a week on Wednesdays. He has not gotten it in awhile.			

	An interview was conducted with Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure why Resident Q had not gotten his trulicity injection on Wednesdays as ordered. The clinical record for Resident F was reviewed on 9/29/21 at 10:24 a.m. The Resident's diagnosis included, but were not limited to, avascular necrosis of bone of left hip and Parkinson's disease. On 9/29/21 at 10:24 a.m., she was observed laying in her bed in her apartment. The apartment had a strong smell of urine. She was laying in bed and an empty indwelling catheter drainage bag attached to the side of the bed. There was a pink wash basin, located under the drainage bag, which contained yellow urine. On 9/29/21 at 10:30 a.m., QMA (Qualified Medication Aide) 23 was observed assisting her with care. She indicated to Resident F that she was going to empty the urine from her catheter. She then emptied the basin under the catheter bag into the toilet. Resident F indicated the drainage bag had been leaking for around 3 days and they did not have the supplies to change it here, so the doctor wanted her to go the clinic or the emergency room to have it changed. She wished they			

	would schedule it or take her so it could get done. She asked QMA 23 to make sure the basin was under the drainage bag so that urine did not get onto the floor. The clinical record did not contain physician's orders addressing care of the indwelling catheter. The clinical record did not contain any documentation of the catheter drainage bag leaking. During an interview on 9/29/21 at 11:15 a.m., the DON (Director of Nursing) indicated the staff had told her about the catheter bag leaking that morning. She was unsure how long it had been leaking and that home health provided the care for her catheter. On 9/29/21 at 12:15 p.m., the DON provided the Catheter Care Policy, revised 2/2021, which read "... Purpose: The purpose of this policy and procedure is to prevent infection of the resident's urinary tract. Policy: It is the policy of this community to provide assistance with catheter care including education, monitoring, hygiene assistances as well as maintenance of urological appliances and system. Catheter care will be provided in such a manner to promote			

	cleanliness, comfort and to minimize risk associated with use of an intermittent or indwelling urological appliance. Responsibility: A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter. C. It is the responsibility of the nursing staff to empty the resident's catheter bas if the resident is unable to complete the task themselves. D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter..." This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200. 4. The clinical record for Resident M was reviewed on 9/28/21 at 2:54 p.m. The diagnoses included, but were not limited to, type 2 diabetes. The 2/26/21 service plan indicated he had the potential for hyper/hypoglycemia and other complications related to altered metabolic state and a diagnosis of diabetes. The services to be provided included to assist/administer medications as ordered.			

The physician's orders indicated Trulicity 0.75 mg/0.5 ml pen, inject 0.5ml subcutaneously every Monday, effective 3/26/21.

The September, 2021 MAR (medication administration record) indicated he received the above medication 9/6/21 and 9/20/21 and did not receive it on 9/13/21 or 9/27/21.

An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated it was agency staff working on 9/13/21 and 9/27/21, and they no longer worked at the facility. It looked to her like the medication was not administered as ordered.

5. The clinical record for Resident E was reviewed on 9/28/21 at 2:40 p.m. The diagnoses included, but were not limited to, polyosteoarthritis.

The 8/10/20 service plan indicated nursing would administer her medications with the objective that her medication regimen would be followed, as ordered by her physician.

The physician's orders indicated for one 50 mg tablet of Tramadol to be administered 4 times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.

The August, and September, 2021 MARs (medication

	administration records) indicated she was not administered 12 doses of the above medication, with no reason as to why. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. She indicated she missed several doses of Tramadol the previous week, and nursing would try to give her the 9:00 p.m. dose with the 5:00 p.m. dose. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 12:43 p.m. She indicated she was unsure why Resident E's Tramadol was not signed off, so to her it looked like it was not administered. Four of the administrations were by facility staff who needed to be educated, and the other 8 were by agency staff who no longer worked at the facility. 6. The clinical record for Resident C was reviewed on 9/28/21 at 12:48 p.m. The diagnoses included, but were not limited to, hypertension. She no longer resided at the facility. An interview was conducted with Family Member 15 on 9/27/21 at 3:08 p.m. She indicated the facility was supposed to obtain Resident C's blood pressure, beginning in June, 2021, and call the			

	physician if it was over a certain number, but they never did. The 5/18/21 Level of Service Assessment/Evaluation indicated she did not require any treatment procedures and administered her own medications. The 6/1/21 prescription from a prescription pad copied onto an 8 1/2 by 11 inch piece of paper read, "Attn (Attention): Assisted Living Check blood pressure once weekly for 6 weeks," and to call if SBP (systolic blood pressure) was greater than 165 or DBP (diastolic blood pressure) was greater than 105. There was a note at the top of the piece of paper that read, "Please add to EMAR (electronic medication administration record.)" Resident C's clinical record did not include weekly blood pressures in the vitals tab of the electronic health record after the 6/1/21 physician's order, and there was no EMAR at all. An interview was conducted with the DON (Director of Nursing) on 9/29/21 at 10:11 a.m. She indicated she could not find any weekly blood pressures for Resident C resulting from the 6/1/21 order to obtain them, and Resident C had no EMAR, as she administered her own			

	medications. A "Medication, Oversight, Assistance and Administration" policy was provided by the Director of Nursing on 9/29/21 at 9:05 a.m. It indicate "...Purpose: The purpose of this procedure is to ensure that medications are stored in a safe, secure, and orderly manner...Administration. Medication administration shall be provided by a license nurse. Medication administration may include assisting residents in the removal of the medication from the container and assisting the resident in consuming (i.e. placing a dose in a container and placing the container to the mouth of the resident) or applying the medication when requested to do so by the resident, injections. If medication administration is provided, the licensed nurse will document the administration including the medication, dose, route, date, and time of the administration of on the Medication Assistance Record..." Based on interview and record review, the facility failed to administer medications and obtain blood pressures, as ordered, for 6 of 7 residents medications reviewed, and timely care for a leaking indwelling catheter for 1 of 1 resident reviewed for urinary			

catheters (Residents B, C, E, F, L, M and Q)

Findings include:

During a confidential interview on 9/27/21 at 4:54 p.m., she indicated the residents are not getting their medications as ordered. Residents that require insulin administrations are not receiving their insulins. Resident B's inhaler had not been available to administer for several weeks. The Director of Nursing was aware and did not address.

1. The clinical record for Resident B was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident B included, but was not limited to, hypertension.

A service plan dated 9/30/20 for Resident B indicated the resident needed assistance with medication administration and staff will follow medication regimen as physician ordered.

A physician order dated 5/28/21 indicated Resident B would receive 1 puff of 100-250 micrograms of breo ellipta inhaler twice a day.

The July 2021 Medication Administration Record (MAR) indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not

available to administer:

7/5/21, 7/6/21, 7/7/21, 7/8/21, 7/9/21, 7/11/21, 7/12/21, 7/13/21, 7/14/21, 7/15/21, 7/17/21, 7/19/21, 7/20/21, 7/22/21, 7/23/21, 7/24/21, 7/25/21, 7/26/21, 7/27/21, 7/28/21, 7/29/21, 7/30/21, and 7/31/21

The August 2021 MAR indicated in documented notes Resident B did not receive the breo ellipta the following days, because the medication was not available to administer:

8/1/21, 8/3/21, 28/4/21, 8/5/21, 8/7/21, 8/16/21 - "resident away", 8/23/21, 8/29/21, and 8/30/21

There was no documentation the physician was notified the resident did not receive her breo ellipta.

An interview was conducted with Resident B on 9/28/21 at 10:48 a.m. She indicated she had went a couple of months without receiving her breo ellipta inhaler.

An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure the delay in getting the breo ellipta inhaler. The physician should be notified if medication are unable to be administered.

	2. The clinical record for Resident L was reviewed on 9/27/21 at 2:00 p.m. The diagnosis for Resident L included, but was not limited to, type 2 diabetes mellitus. A service plan dated 1/16/21 indicated staff was to assist Resident L with administration of medications. A physician order dated 7/15/20 indicated Resident L was to receive a sliding scale of novolog three times a day. The sliding scale was the following: 10-130 blood sugar reading = 0 units, 131-180 blood sugar readings = 2 units, 181-240 blood sugar readings = 4 units, 241-300 blood sugar reading = 6 units, 301-350 blood sugar reading = 8 units, 351-400 blood sugar reading = 10 units, greater than 400 blood sugar reading = 12 units and notify physician. A physician order dated 7/24/21 indicated Resident L was to receive 40 units of Levemir insulin once a day. The August 2021 MAR indicated the following days and times blood sugar readings were not obtained to administer novolog sliding if needed: 8/1/21 - 12:00 p.m., 8/3/21 - 12:00 p.m.,			

	8/4/21 - 8:00 a.m., 12:00 p.m., 8/5/21 - 8:00 a.m., 12:00 p.m., 8/6/21 - 8:00 a.m., 8/9/21 - 8:00 a.m., 8/10/21 - 8:00 a.m., 12:00 p.m., 8/12/21 - 8:00 a.m., 12:00 p.m., 8/14/21 - 8:00 a.m., 12:00 p.m., 8/17/21 - 12:00 p.m., 8/18/21 - 12:00 p.m., 8/19/21 - 12:00 p.m., 8/24/21 - 12:00 p.m., 8/26/21 - 12:00 p.m., 8/27/21 - 12:00 p.m., 8/28/21 -12:00 p.m., and 8/29/21 - 12:00 p.m., The following days the resident's Levemir insulin was not administered: 8/6/21 and 8/9/21. The September 2021 MAR indicated the following days and times Resident L had not received blood sugar readings to administer novolog sliding scale insulin if needed: 9/3/21 - 12:00 p.m.,			

	9/7/21 - 12:00 p.m., 9/14/21 - 12:00 p.m., 9/16/21 - 12:00 p.m., 9/22/21 - 12:00 p.m.., 9/23/21 - 12:00 p.m., and 9/24/21 - 12:00 p.m., There was no documentation the resident was not available or physician was notified the blood sugar was not obtained nor sliding scale insulin was administered. An interview was conducted with the Director of Nursing on 9/29/21 at 12:00 p.m. She indicated the staff were having trouble with recording blood sugars that do not fall in the parameters of the sliding scale, but unsure if that was the case. The physician should be notified if the medication were not administered. 3. The clinical record for Resident Q was reviewed on 9/27/21 at 2:15 p.m. The diagnosis for Resident Q included, but was not limited to, type 2 diabetes mellitus. A service plan dated 3/23/21 indicated Resident Q was to receive staff assistance with the administration of his medications.			

	A physician order dated 3/23/21 indicated Resident Q was to receive 3 milligrams of trulicity injection once a week. The staff was to administer on Wednesdays. The August 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 8/4/21. The September 2021 MAR indicated Resident Q had not received the 3 milligrams of trulicity on 9/8/21, 9/15/21, and 9/22/21. There was no documentation in the clinical record notifying the physician Resident Q had not received his trulicity injections. An interview was conducted with Resident Q on 9/29/21 at 10:31 a.m. He indicated he was suppose to get his injection of trulicity once a week on Wednesdays. He has not gotten it in awhile. An interview was conducted with Director of Nursing on 9/29/21 at 12:00 p.m. She indicated she was unsure why Resident Q had not gotten his trulicity injection on Wednesdays as ordered.			
R 0272	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(e)	R 0272	R272	10/17/2021

	(e) All food shall be served at a safe and appropriate temperature. Based on observation, interview and record review, the facility failed to monitor food holding temperatures per the facility policy. This had a potential to affect 103 of 103 residents that eat food prepared in the kitchen. (Resident D, E, JJ, LL, MM, and NN) Findings include: During a kitchen tour with the Dietary Manager on 9/27/21 at 11:46 a.m., the food temperature logs were reviewed. The Dietary Manager indicated the food temperatures logs had not been completed in a while. The last food temperature log was completed on 8/22/21. As of that day, the first logged meal was the lunch meal on that day. An interview was conducted with Cook 2 on 9/27/21 at 11:50 a.m. She indicated she had not logged the breakfast food temperatures that morning. An interview was conducted with Resident JJ, LL, MM, and NN on 9/27/21 at 11:46 a.m. They indicated the food was "always" served cold. An interview was conducted with Resident D on 9/28/21 at		-**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Food temperatures will be taken and recorded daily per policy -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents had the potential to be affected by this deficient practice. Food temperatures will be taken and recorded daily per policy -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Dietary Manager/designee in-service kitchen staff on food handling, storage, and food temperatures	

	12:06 p.m. He indicated the hot temperature foods were not hot. The food served was cold. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. The meals served from the kitchen were cold. The Dietary Temperature policy was provided by the Dietary Manager on 9/28/21 at 10:05 a.m. It indicated "...Procedure: The purpose of this policy is to ensure that all food items and cool storage equipment have temperature taken daily. Policy: It is the policy of this community to take temperatures of cooked food products and of cool storage equipment daily. All food temperatures must be taken at all 3 meals, breakfast, lunch, and dinner. The food temperatures will be documented on the proper [name of corporation] Temperature form..." This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200. Based on observation, interview and record review, the facility failed to monitor food holding temperatures per the facility policy. This had a potential to affect 103 of 103 residents that eat food prepared in the kitchen. (Resident D, E, JJ, LL, MM, and NN)		policies on 10/4/2021. DM with audit food temp logs two times a week to ensure food temps are taken per policy. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur,** **i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed**	

	Findings include: During a kitchen tour with the Dietary Manager on 9/27/21 at 11:46 a.m., the food temperature logs were reviewed. The Dietary Manager indicated the food temperatures logs had not been completed in a while. The last food temperature log was completed on 8/22/21. As of that day, the first logged meal was the lunch meal on that day. An interview was conducted with Cook 2 on 9/27/21 at 11:50 a.m. She indicated she had not logged the breakfast food temperatures that morning. An interview was conducted with Resident JJ, LL, MM, and NN on 9/27/21 at 11:46 a.m. They indicated the food was "always" served cold. An interview was conducted with Resident D on 9/28/21 at 12:06 p.m. He indicated the hot temperature foods were not hot. The food served was cold. An interview was conducted with Resident E on 9/28/21 at 3:15 p.m. The meals served from the kitchen were cold. The Dietary Temperature policy was provided by the Dietary Manager on 9/28/21 at 10:05 a.m. It indicated "...Procedure: The purpose of this policy is to ensure that all food items and		October 17, 2021	

	cool storage equipment have temperature taken daily. Policy: It is the policy of this community to take temperatures of cooked food products and of cool storage equipment daily. All food temperatures must be taken at all 3 meals, breakfast, lunch, and dinner. The food temperatures will be documented on the proper [name of corporation] Temperature form..." This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200.			
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 ensure staff in the kitchen was utilizing hand washing, donning gloves and hairnets, labeling and dating stored food items, and covering of opened food items. This had a potential to affect 103 of 103 residents that eat food prepared in the kitchen. (Resident D)	R 0273	R273 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All staff will wear appropriate dress required while handling food in the kitchen. All staff will maintain infection control practices while handling food in the kitchen. DM labeled and dated all items found to have this deficient practice. All staff will be in	10/17/2021

	Findings include: During a confidential interview on 9/27/21 at 2:54 p.m., she indicated the Certified Nursing Assistants (CNA)s were required to provide care to the residents, and then assist in the kitchen with meals. The staff in the kitchen are not wearing the appropriate dress required or maintaining infection control practices while handling food in the kitchen. An observation was made of the kitchen on 9/27/21 at 10:35 a.m. Certified Nursing Assistant (CNA) 1 was observed standing at the food prep area speaking with Cook 2. During that time, Cook 2 was preparing food. CNA 1 was not observed wearing a hairnet at that time. Cook 2 then went to the back door and asked the Dietary Manager to come from the outside into the kitchen. The Dietary Manager then walked into the kitchen. The Dietary Manager had not used hand hygiene after she returned from outside. An observation was then made of the walk-in refrigerator, walk-in freezer, and the dry storage area with the Dietary Manager. The following food items in the refrigerator were observed not labeled, dated and/or exposed to air and uncovered: 1 bag of shredded cheese - not		serviced on 10/21/2021 on infection control practices, food handling procedures and label and dating per policy by DM. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by this deficient practice. All staff will be in serviced on 10/21/2021 on infection control practices, food handling procedures and label and dating per policy by DM. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

	dated, 2 packages of sliced cheese - not dated, 1 closed container of purple liquid koolaid - not labeled or dated, 1 container of a chicken base with a date of 6/10 that had a top cover with a hole in it that had a piece of aluminum foil crumpled lying on top of the hole, 1 plastic container of pickles - not dated or labeled, 2 foiled trays of lasagna - not labeled or dated, 1 opened jar of banana peppers with a closed top that had a hole and cracked - not dated, 1 opened jar of honey mustard dated 12/14 - no year was written or expiration, 1 opened jar of caesar salad dressing dated 10/5 - no year was written or expiration, 1 opened jar of honey mustard dated 5/13 - no open date, 1 container of shredded lettuce with slight tan tint color - not dated,		All staff will be in serviced on 10/21/2021 on infection control practices, food handling procedures and label and dating per policy by DM. DM will perform an audit 2 times a week to ensure food is labeled and dated, proper hand hygiene is maintained, and proper dress is followed per policy in the kitchen for 6 months. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the	

	1 carton of eggs uncovered with yellow substance dripped over the eggs, and 1 uncovered food cart that contained 4 containers of jello not labeled or dated, 1/4 of a cream pie uncovered and opened to air not labeled or dated, 7 containers of uncovered peaches not labeled or dated, 2 trays full of cooked grilled cheese sandwiches uncovered, opened to air and not labeled or dated. The following food items were observed in the walk-in freezer unlabeled, dated, and/or exposed to air and uncovered: 1 unopened bag of fried vegetable and rice - not dated, 1 bag of sweet corn nuggets - not dated, and 1 opened bag of chicken tenders not sealed and not dated, The following food items were observed in the dry food storage area unlabeled and undated: 1 opened bottle of cherry syrup - not dated, 1 package of fruit punch - not dated, 7 jars of peanut butter with both dates of 1/28 and 7/28 - no year written and all jars had		Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** October 17, 2021	

	expiration date of 11/23/21, 13 unopened jars of relish - all dates written with no year written nor expiration date could be located on jars. 3 unopened jars of ginger dressing dated 11/27 - no year written nor expiration date could be located on jars, 1 container of shredded wheat - not labeled or dated, and 1 container of frosted flakes - not labeled, or dated and a styrofoam cup was observed lying in the cereal During the tour, an observation was made of the kitchen area. Cook 2 was observed with cooked eggs peeling them with her bare hands at the trash cans. Cook 2 had not used hand hygiene nor donned gloves prior to peeling the cooked eggs. CNA 3 and CNA 8 were at the food prep area standing side by side talking while food was uncovered sitting on the counter. CNA 3 was not wearing a hairnet and her mask was below her nose and mouth during that time. CNA 4 was standing at the ice machine scooping ice with a scoop in one hand and using his other hand pushing ice into the scoop. He then was observed placing the ice with the scoop in individual cups. CNA 4 was not observed donning gloves prior to placing			

	hands in the ice machine. An interview was conducted with the Dietary Manager on 9/27/21 at 10:51 a.m. She indicated all staff should wear hairnets, use hand hygiene, don gloves while touching food items and wear face masks covering their noses and their mouths while they are in the kitchen. The staff were not storing, dating or labeling food items correctly. The food that did have a month and day written on them was the day the item was brought into the kitchen not the open date. Since, the staff were not placing the year on the food items, she was unable to determine how long the food had been stored in the facility. All food that was opened should have open dates and labels. The date should include month, day, and year. All opened food should be covered and contained in a closed wrapping or container. The styrofoam cup should not be lying in the cereal container. Cook 2 and CNA 4 should not be touching food or ice with their bare hands. The CNAs are coming into the kitchen to assist with meals during meal times. The CNAs are needing training. An interview was conducted with Resident D on 9/28/21 at 12:06 p.m. He indicated the food served from the kitchen was not good quality. He had			

	received black-brown colored lettuce on his sandwich the other day. A "When to Wash Hands policy was provided by the Dietary Manager on 9/27/21 at 2:30 p.m. It indicated "Procedure: The purpose of this policy is to ensure that all dietary employees know when to wash their hands. Policy: It is the policy of this community to wash hands before engaging in food preparations. Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food...a) After touching bare human body parts other than clean hands and clean exposed portion of arms;..f) During food preparation, as often as is necessary to remove soil and contamination and to prevent cross-contamination when changing tasks; g) when switching between working with raw food and working with ready-to-eat food; h) before donning gloves for working with food and i) after engaging in other activities that contaminate the hands." "Dietary Uniform and Dress Code Practices" policy was provided by the Dietary Manager on 9/27/21 at 2:30 p.m. It indicated "Purpose: The purpose of this policy is to			

ensure that federal, state, local, and management policies are followed. Policy: It is the policy of this community to ensure uniformity with all staff and comply with all regulations...e) Long hair must be restrained or tied back. Caps/hats or hairnets must be worn in the kitchen."

"Receiving" policy was provided by the Dietary Manager on 9/27/21 at 2:30 p.m. It indicated "All communities will receive deliveries from purveyors...All items taken out of the original box must be dated with day, month, and year..."

This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200.

Based on observation, interview, and record review, the facility failed to ensure staff in the kitchen was utilizing hand washing, donning gloves and hairnets, labeling and dating stored food items, and covering of opened food items. This had a potential to affect 103 of 103 residents that eat food prepared in the kitchen. (Resident D)

Findings include:

During a confidential interview on 9/27/21 at 2:54 p.m., she indicated the Certified Nursing Assistants (CNA)s were required to provide care to the residents, and then assist in the

kitchen with meals. The staff in the kitchen are not wearing the appropriate dress required or maintaining infection control practices while handling food in the kitchen.

An observation was made of the kitchen on 9/27/21 at 10:35 a.m. Certified Nursing Assistant (CNA) 1 was observed standing at the food prep area speaking with Cook 2. During that time, Cook 2 was preparing food. CNA 1 was not observed wearing a hairnet at that time. Cook 2 then went to the back door and asked the Dietary Manager to come from the outside into the kitchen. The Dietary Manager then walked into the kitchen. The Dietary Manager had not used hand hygiene after she returned from outside. An observation was then made of the walk-in refrigerator, walk-in freezer, and the dry storage area with the Dietary Manager. The following food items in the refrigerator were observed not labeled, dated and/or exposed to air and uncovered:

1 bag of shredded cheese - not dated,

2 packages of sliced cheese - not dated,

1 closed container of purple liquid koolaid - not labeled or dated,

	1 container of a chicken base with a date of 6/10 that had a top cover with a hole in it that had a piece of aluminum foil crumpled lying on top of the hole, 1 plastic container of pickles - not dated or labeled, 2 foiled trays of lasagna - not labeled or dated, 1 opened jar of banana peppers with a closed top that had a hole and cracked - not dated, 1 opened jar of honey mustard dated 12/14 - no year was written or expiration, 1 opened jar of caesar salad dressing dated 10/5 - no year was written or expiration, 1 opened jar of honey mustard dated 5/13 - no open date, 1 container of shredded lettuce with slight tan tint color - not dated, 1 carton of eggs uncovered with yellow substance dripped over the eggs, and 1 uncovered food cart that contained 4 containers of jello not labeled or dated, 1/4 of a cream pie uncovered and opened to air not labeled or dated, 7 containers of uncovered peaches not labeled or dated, 2 trays full of cooked			

	grilled cheese sandwiches uncovered, opened to air and not labeled or dated. The following food items were observed in the walk-in freezer unlabeled, dated, and/or exposed to air and uncovered: 1 unopened bag of fried vegetable and rice - not dated, 1 bag of sweet corn nuggets - not dated, and 1 opened bag of chicken tenders not sealed and not dated, The following food items were observed in the dry food storage area unlabeled and undated: 1 opened bottle of cherry syrup - not dated, 1 package of fruit punch - not dated, 7 jars of peanut butter with both dates of 1/28 and 7/28 - no year written and all jars had expiration date of 11/23/21, 13 unopened jars of relish - all dates written with no year written nor expiration date could be located on jars. 3 unopened jars of ginger dressing dated 11/27 - no year written nor expiration date could be located on jars,			

	1 container of shredded wheat - not labeled or dated, and 1 container of frosted flakes - not labeled, or dated and a styrofoam cup was observed lying in the cereal During the tour, an observation was made of the kitchen area. Cook 2 was observed with cooked eggs peeling them with her bare hands at the trash cans. Cook 2 had not used hand hygiene nor donned gloves prior to peeling the cooked eggs. CNA 3 and CNA 8 were at the food prep area standing side by side talking while food was uncovered sitting on the counter. CNA 3 was not wearing a hairnet and her mask was below her nose and mouth during that time. CNA 4 was standing at the ice machine scooping ice with a scoop in one hand and using his other hand pushing ice into the scoop. He then was observed placing the ice with the scoop in individual cups. CNA 4 was not observed donning gloves prior to placing hands in the ice machine. An interview was conducted with the Dietary Manager on 9/27/21 at 10:51 a.m. She indicated all staff should wear hairnets, use hand hygiene, don gloves while touching food items and wear face masks covering their noses and their mouths while they are in the kitchen.			

	The staff were not storing, dating or labeling food items correctly. The food that did have a month and day written on them was the day the item was brought into the kitchen not the open date. Since, the staff were not placing the year on the food items, she was unable to determine how long the food had been stored in the facility. All food that was opened should have open dates and labels. The date should include month, day, and year. All opened food should be covered and contained in a closed wrapping or container. The styrofoam cup should not be lying in the cereal container. Cook 2 and CNA 4 should not be touching food or ice with their bare hands. The CNAs are coming into the kitchen to assist with meals during meal times. The CNAs are needing training. An interview was conducted with Resident D on 9/28/21 at 12:06 p.m. He indicated the food served from the kitchen was not good quality. He had received black-brown colored lettuce on his sandwich the other day. A "When to Wash Hands policy was provided by the Dietary Manager on 9/27/21 at 2:30 p.m. It indicated "Procedure: The purpose of this policy is to ensure that all dietary employees know when to wash			

	their hands. Policy: It is the policy of this community to wash hands before engaging in food preparations. Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food...a) After touching bare human body parts other than clean hands and clean exposed portion of arms;..f) During food preparation, as often as is necessary to remove soil and contamination and to prevent cross-contamination when changing tasks; g) when switching between working with raw food and working with ready-to-eat food; h) before donning gloves for working with food and i) after engaging in other activities that contaminate the hands." "Dietary Uniform and Dress Code Practices" policy was provided by the Dietary Manager on 9/27/21 at 2:30 p.m. It indicated "Purpose: The purpose of this policy is to ensure that federal, state, local, and management policies are followed. Policy: It is the policy of this community to ensure uniformity with all staff and comply with all regulations...e) Long hair must be restrained or tied back. Caps/hats or hairnets must be worn in the kitchen." "Receiving" policy was provided			

	by the Dietary Manager on 9/27/21 at 2:30 p.m. It indicated "All communities will receive deliveries from purveyors...All items taken out of the original box must be dated with day, month, and year..." This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to prevent and limit exposure of staff and residents to COVID-19 by not wearing face masks above their nose	R 0407	R407 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All staff will wear mask per policy in the community. All nursing staff will follow the cleaning and disinfecting procedure for glucometers as stated in the policy. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	10/17/2021

and mouth while less than 6 feet from one another in the kitchen. This had a potential to affect 103 of 103 that eat food prepared in the kitchen. The facility also failed to maintained infection control practices with disinfection of a glucometer between resident usage for 4 of 4 residents blood sugar observed. (Resident RR, TT, VV, and ZZ)

Findings include:

1.During a confidential interview on 9/27/21 at 2:54 p.m., they indicated staff were in the kitchen not wearing the appropriate Personal Protective Equipment (PPE) required while handing food.

An observation was made of the kitchen on 9/27/21 at 10:50 a.m. Certified Nursing Assistant (CNA) 3 and CNA 8 were observed at the food prep area standing side by side talking. CNA 3 was wearing her mask below her nose and mouth during that time.

An interview was conducted with the Dietary Manager on 9/27/21 at 10:51 a.m. She indicated all staff should wear their masks above their noses and their mouths.

2a. The clinical record for Resident TT was reviewed on 9/28/21 at 2:00 p.m. The diagnosis for Resident TT

action(s) will be taken.

All residents have
the potential to be affected by this deficient practice.

All staff were in
serviced on 9/28/2021 by DON, DM, and Admin, on infection control relating to
the proper way to wear a mask, and cleaning and disinfecting glucometers.

-**What measures will
be put into place or what systemic changes will be made to ensure that the deficient
practice does not recur?**

All staff were in
serviced on 9/28/2021 by DON, DM, and Admin, on infection control relating to
the proper way to wear a mask, and cleaning and disinfecting glucometers.

DON/designee will
audit the cleaning and disinfecting procedure for glucometer 2 times a week ton ensure policy and procedure are followed

included, but was not limited to, type 2 diabetes mellitus.

A physician order dated 6/24/21 indicated Resident TT was to receive a sliding scale of novolog three times. The sliding scale was the following: 0-149 blood sugar reading = 0 units, 150 - 190 blood sugar reading = 2 units, 191-230 blood sugar reading = 4 units, 231 -270 blood sugar reading = 6 units, 271- 310 blood sugar reading = 8 units, 311 - 350 blood sugar reading = 10 units.

2b. The clinical record for Resident ZZ was reviewed on 9/28/21 at 2:10 p.m. The diagnosis for Resident ZZ included, but was not limited to, type 1 diabetes mellitus.

A physician order dated 12/24/20 indicated the staff was to obtain Resident ZZ's blood sugars four times a day.

2c. The clinical record for Resident VV was reviewed on 9/28/21 at 2:20 p.m. The diagnosis for Resident VV included, but was not limited to, type 2 diabetes mellitus.

A physician order dated 12/17/20 indicated staff was to obtain blood sugar readings for Resident VV four times a day.

2d. The clinical record for Resident RR was reviewed on 9/28/21 at 2:45 p.m. The

-**How the corrective action(s) will be monitored to ensure the deficient practice will not recur,**
i.e., what quality assurance program will be put into place.

This process will be reviewed by DON/designee,
IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then
as needed.

At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator
until resolved. Any concerns will be addressed as discovered.

-**By what date the systematic changes will be completed**

October 17, 2021

diagnosis for Resident RR included, but was not limited to, type 2 diabetes mellitus.

A physcian order dated 3/5/21 indicated staff was to obtain blood sugar readings before meals and at bedtime for Resident RR.

An observation was made of medication administrations with License Practical Nurse (LPN) 7 on 9/28/21 at 12:24 p.m. LPN 7 indicated she had to obtain the residents' blood sugars using a glucometer prior to administrating the insulins. An observation was made of Resident TT's blood sugar check. LPN 7 had gathered her supplies and went to Resident TT's room. She pricked the resident's finger and placed the blood on a strip that had been placed in the glucometer. The glucometer then provided a blood sugar reading. After, LPN 7 returned back to the cart from administering the resident's insulin. She then was observed preparing for Resident ZZ blood sugar check. She gathered her supplies and entered Resident ZZ's room. She had not disinfected the glucometer prior to obtaining Resident ZZ's blood sugar reading using the same glucometer. LPN 7 then was observed returning to her cart after the administration of the resident's insulin. She gathered her supplies and entered

Resident VV's room and obtained his blood sugar reading. There was no observation of disinfecting the glucometer prior to obtaining Resident VV's blood sugar reading. She then entered Resident RR's room with the same glucometer and obtain her blood sugar reading. There was no observation of disinfecting of the glucometer prior to obtaining Resident RR's blood sugar readings.

An interview was conducted with LPN 7 on 9/28/21 1:00 p.m. She indicated she disinfects the glucometer after she completes the residents' blood sugar checks. The glucometer was cleaned with an alcohol swab. If there was another product she should be using she was unaware.

An interview was conducted with the Director of Nursing on 9/28/21 at 3:30 p.m. She indicated the nursing staff should be disinfecting the glucometer per the manufacture instructions.

A "Cleaning and Disinfecting Procedures for the Meter" was provided by the Director of Nursing on 9/29/21 at 10:15 a.m. It indicated "...The EvenCare G3 Meter should be cleaned and disinfected between each patient. The meter is validated to withstand a

cleaning and disinfection cycle of ten times per day for an average period of three years. The following products have been approved for cleaning and disinfecting the EvenCare G3 Meter:...Hospital Cleaner Disinfectant Towels with Bleach, Medline Micro-Kill Disinfecting Deodorizing Cleaning Wipes with Alcohol, Clorox Healthcare Bleach Germicidal and Disinfectant Wipe..."

This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200.

Based on observation, interview, and record review, the facility failed to prevent and limit exposure of staff and residents to COVID-19 by not wearing face masks above their nose and mouth while less than 6 feet from one another in the kitchen. This had a potential to affect 103 of 103 that eat food prepared in the kitchen. The facility also failed to maintained infection control practices with disinfection of a glucometer between resident usage for 4 of 4 residents blood sugar observed. (Resident RR, TT, VV, and ZZ)

Findings include:

1.During a confidential interview on 9/27/21 at 2:54 p.m., they indicated staff were in the

kitchen not wearing the appropriate Personal Protective Equipment (PPE) required while handing food.

An observation was made of the kitchen on 9/27/21 at 10:50 a.m. Certified Nursing Assistant (CNA) 3 and CNA 8 were observed at the food prep area standing side by side talking. CNA 3 was wearing her mask below her nose and mouth during that time.

An interview was conducted with the Dietary Manager on 9/27/21 at 10:51 a.m. She indicated all staff should wear their masks above their noses and their mouths.

2a. The clinical record for Resident TT was reviewed on 9/28/21 at 2:00 p.m. The diagnosis for Resident TT included, but was not limited to, type 2 diabetes mellitus.

A physician order dated 6/24/21 indicated Resident TT was to receive a sliding scale of novolog three times. The sliding scale was the following: 0-149 blood sugar reading = 0 units, 150 - 190 blood sugar reading = 2 units, 191-230 blood sugar reading = 4 units, 231 -270 blood sugar reading = 6 units, 271- 310 blood sugar reading = 8 units, 311 - 350 blood sugar reading = 10 units.

2b. The clinical record for

Resident ZZ was reviewed on 9/28/21 at 2:10 p.m. The diagnosis for Resident ZZ included, but was not limited to, type 1 diabetes mellitus.

A physician order dated 12/24/20 indicated the staff was to obtain Resident ZZ's blood sugars four times a day.

2c. The clinical record for Resident VV was reviewed on 9/28/21 at 2:20 p.m. The diagnosis for Resident VV included, but was not limited to, type 2 diabetes mellitus.

A physician order dated 12/17/20 indicated staff was to obtain blood sugar readings for Resident VV four times a day.

2d. The clinical record for Resident RR was reviewed on 9/28/21 at 2:45 p.m. The diagnosis for Resident RR included, but was not limited to, type 2 diabetes mellitus.

A physcian order dated 3/5/21 indicated staff was to obtain blood sugar readings before meals and at bedtime for Resident RR.

An observation was made of medication administrations with License Practical Nurse (LPN) 7 on 9/28/21 at 12:24 p.m. LPN 7 indicated she had to obtain the residents' blood sugars using a glucometer prior to administrating the insulins. An

observation was made of Resident TT's blood sugar check. LPN 7 had gathered her supplies and went to Resident TT's room. She pricked the resident's finger and placed the blood on a strip that had been placed in the glucometer. The glucometer then provided a blood sugar reading. After, LPN 7 returned back to the cart from administering the resident's insulin. She then was observed preparing for Resident ZZ blood sugar check. She gathered her supplies and entered Resident ZZ's room. She had not disinfected the glucometer prior to obtaining Resident ZZ's blood sugar reading using the same glucometer. LPN 7 then was observed returning to her cart after the administration of the resident's insulin. She gathered her supplies and entered Resident VV's room and obtained his blood sugar reading. There was no observation of disinfecting the glucometer prior to obtaining Resident VV's blood sugar reading. She then entered Resident RR's room with the same glucometer and obtain her blood sugar reading. There was no observation of disinfecting of the glucometer prior to obtaining Resident RR's blood sugar readings.

An interview was conducted with LPN 7 on 9/28/21 1:00 p.m. She indicated she disinfects the

glucometer after she completes the residents' blood sugar checks. The glucometer was cleaned with an alcohol swab. If there was another product she should be using she was unaware.

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	This state finding relates to complaints IN00362686, IN00363247, IN00362246, IN00362985 and IN00363200.			

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