STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/02/2022

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 IN00380442 and IN00380848. Complaint IN00380848- Substantiated. State deficiencies related to the allegations are cited at R240, R270 and R301. Complaint IN00380442 - Unsubstantiated due to lack of evidence. Unrelated deficiency is cited. Survey date: June 1 and 2, 2022 Facility number: 014279 Residential Census: 109 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 6, 2022	R 0000	Complaints (IN00380442, IN00380848) June 1-2, 2022 I would respectively request a desk review.	

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. Based on observation, interview and record review, the facility failed to timely answer a call light for 1 of 3 residents reviewed for call lights (Resident D), and failed to ensure medications were administered as ordered for 3 of 3 residents reviewed for medication administration (Residents C, J, and K). Findings include: 1. The clinical record for Resident D was reviewed on 6/2/22. Resident D's diagnoses included, but not limited to, diabetes type II, obstructive sleep apnea, congestive heart failure, and hypertension.	R 0240	R240 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident D care plan was reviewed on 6/2/22 as well as nurse call light report was reviewed by DON and nursing staff was in serviced on the Emergency Nurse Call System Policy on 6.14.22 by DON/ED. Any future incidents will be reviewed by the DON and corrective action taken as needed. Resident C, J, K will receive injection/medicine as ordered by the MD. -**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	06/19/2022

	Resident D's Level of Care dated, 4/6/22 indicated, she required two or more people for position changes and transfers, can only get around with regular assistance of another person both inside and outside, was not safe to ambulate alone, and did not have required strength or endurance to use mechanical aids alone. An interview with Resident D was conducted on 6/2/22 at 9:55 a.m. Resident D was lying in her bed in her room. Resident D indicted, she was unable to get any assistance from the staff that morning. She stated, she had pressed her call light at 8:50 a.m. and no one had come to answer her call light as of yet. She indicated, "Sometimes my call light stays on for hours and hours" and "I pushed my call light at ten minutes to nine and no one has come to help me. I don't even know why we have them (call lights) and when they do come in, they have very sour attitudes." Resident D then pressed her call light button again at the end of the interview. An observation was made on 6/2/22 which started at 9:55 a.m. and concluded at 10:44 a.m. of the 3rd floor hallway where Resident D resided. During the observation period, no staff had come to Resident D's room to answer her call		this deficient practice. DON/Designee performed a chart and medication audit on 6/4/22 and 6/10/22. Any findings were corrected, and all licensed nursing staff educated on medication administration policy by DON on 6/14/22. -**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 and Emergency Nurse Call System Policy by DON on 6/14/22. DON/Designee will perform medication administration and chart audits and call light report audits weekly 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,	

	light. An interview with DON (Director of Nursing) was conducted on 6/2/22 at 10:44 a.m. DON indicated, how the call light system worked was when a resident pushed the call light box it would then ring the portable phones the Certified Nursing Assistants and Qualified Medication Assistants carry and will continue to ring until answered. DON stated, the expectation was to answer call lights within 3 to 5 minutes. She indicated, the amount of time in which Resident D's call light was left unattended to was an excessive amount of time for a call light to be answered. An Emergency Nurse Call System Policy was received from DON on 6/2/22 at 12:18 p.m. The policy indicated, "Procedure: A. When resident's emergency alert is activated, the following steps will be executed: 1. C.N.A. or on call personnel will immediately go to the located alert. Alarm will be reset as soon as possible after emergency is identified. 2. Ask the resident the nature of the request. 3. Assist resident as needed 4. Call for assistance, if needed. 5. Promptness is essential, the		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** June 19, 2022	

	Resident may be in an emergency situation such as chest pain, hear attack, difficulty breathing, have fallen, etc." 2. a. The clinical record for Resident C was conducted on 6/2/22. Resident C's diagnoses included, but not limited to, chronic kidney disease, anxiety, and insomnia. A physician's order dated 12/29/21 indicated, to administer one mirtazapine(medication for insomnia and depression) 7.5 mg tablet daily at bedtime. Resident C's April Medication Administration Record (MAR) was received on 6/2/22 at 1:11 p.m. from DON. It indicated, on the following dates, Resident C did not receive the mirtazadine and was coded as "medication not available": 4/1/22 4/3/22 4/5/22 4/7/22 4/8/22 4/11/22 4/16/22 4/17/22			

	4/18/22 4/26/22 4/27/22 4/28/22 It further indicated, on the following dates, the mirtazapine MAR was left blank: 4/2/22 4/4/22 4/6/22 4/10/22 4/12/22 4/13/22 4/14/22 4/15/22 4/20/22 4/21/22 4/22/22 4/25/22 4/29/22 Resident C's nursing notes did not contain any documentation any attempts made to obtain the medication. An interview with DON conducted on 6/2/22 at 3:57			

	p.m. indicated, Resident C's mirtazadine order needed clarification prior to the pharmacy dispensing the medication. DON stated, the clinical record should have contained attempts made to acquire the medication. b. The clinical record for Resident J was reviewed on 6/2/22. Resident J's diagnoses included, but not limited to, hemiparesis, atrial fibrillation, and neuropathic pain. A physician's order dated 2/1/20 indicated, take one gabapentin (neuropathic pain reliever) 600 mg tablet three times daily. Resident J's April MAR was received on 6/2/22 at 1:11 p.m. from DON. It indicated, on the following dates and times, the MAR for gabapentin was left blank: 4/7/22; 12 p.m. dose 4/9/22; 12 p.m. dose 4/10/22; 8 a.m., 12 p.m., and 4 p.m. doses 4/12/22; 12 p.m. dose 4/13/22; 4 p.m. dose 4/14/22; 12 p.m. dose 4/15/22; 8 a.m. and 12 p.m. doses			

	4/24/22; 12 p.m. dose 4/30/22 12 p.m. dose 3. The clinical record for Resident K was reviewed on 6/2/22. Resident K's diagnoses included, but not limited to, diabetes type II. A physician's order dated 4/28/20 indicated, for nursing to complete accuchecks before meals. Resident J's May MAR indicated, on the following dates and times, the blood glucose check was left blank: 5/3/22; 12 p.m. check 5/5/22; 4 p.m. check 5/6/22; 12 p.m. check 5/12/22; 8 a.m. and 12 p.m. checks 5/13/22; 12 p.m. check 5/19/22; 12 p.m. check 5/20/22; 12 p.m. check 5/26/22; 12 p.m. check 5/27/22; 8 a.m., 12 p.m., and 4 p.m. checks			

Resident J's clinical record did not contain any indication as to why the blood glucose checks were not performed for the above dates and times.

An interview with DON conducted on 6/2/22 at 3:57 p.m. indicated, the expectation is for nursing to attempt three times to administer the medication and if unable to administer a medication or check a blood glucose, a note should be placed in the clinical record indicating the reason the medication was not administered. She further indicated, the MAR should not be left blank, instead a coded explanation should be used.

This state tag relates to complaint IN00380848.

Based on observation, interview and record review, the facility failed to timely answer a call light for 1 of 3 residents reviewed for call lights (Resident D), and failed to ensure medications were administered as ordered for 3 of 3 residents reviewed for medication administration (Residents C, J, and K).

Findings include:

1. The clinical record for Resident D was reviewed on 6/2/22. Resident D's diagnoses included, but not limited to, diabetes type II, obstructive

	sleep apnea, congestive heart failure, and hypertension. Resident D's Level of Care dated, 4/6/22 indicated, she required two or more people for position changes and transfers, can only get around with regular assistance of another person both inside and outside, was not safe to ambulate alone, and did not have required strength or endurance to use mechanical aids alone. An interview with Resident D was conducted on 6/2/22 at 9:55 a.m. Resident D was lying in her bed in her room. Resident D indicted, she was unable to get any assistance from the staff that morning. She stated, she had pressed her call light at 8:50 a.m. and no one had come to answer her call light as of yet. She indicated, "Sometimes my call light stays on for hours and hours" and "I pushed my call light at ten minutes to nine and no one has come to help me. I don't even know why we have them (call lights) and when they do come in, they have very sour attitudes." Resident D then pressed her call light button again at the end of the interview. An observation was made on 6/2/22 which started at 9:55 a.m. and concluded at 10:44 a.m. of the 3rd floor hallway where Resident D resided.			

During the observation period, no staff had come to Resident D's room to answer her call light.

An interview with DON (Director of Nursing) was conducted on 6/2/22 at 10:44 a.m. DON indicated, how the call light system worked was when a resident pushed the call light box it would then ring the portable phones the Certified Nursing Assistants and Qualified Medication Assistants carry and will continue to ring until answered. DON stated, the expectation was to answer call lights within 3 to 5 minutes. She indicated, the amount of time in which Resident D's call light was left unattended to was an excessive amount of time for a call light to be answered.

An Emergency Nurse Call System Policy was received from DON on 6/2/22 at 12:18 p.m. The policy indicated, "Procedure: A. When resident's emergency alert is activated, the following steps will be executed:

1. C.N.A. or on call personnel will immediately go to the located alert. Alarm will be reset as soon as possible after emergency is identified.

2. Ask the resident the nature of the request.

3. Assist resident as needed

	4. Call for assistance, if needed. 5. Promptness is essential, the Resident may be in an emergency situation such as chest pain, hear attack, difficulty breathing, have fallen, etc." 2. a. The clinical record for Resident C was conducted on 6/2/22. Resident C's diagnoses included, but not limited to, chronic kidney disease, anxiety, and insomnia. A physician's order dated 12/29/21 indicated, to administer one mirtazapine(medication for insomnia and depression) 7.5 mg tablet daily at bedtime. Resident C's April Medication Administration Record (MAR) was received on 6/2/22 at 1:11 p.m. from DON. It indicated, on the following dates, Resident C did not receive the mirtazadine and was coded as "medication not available": 4/1/22 4/3/22 4/5/22 4/7/22 4/8/22 4/11/22			

	4/16/22 4/17/22 4/18/22 4/26/22 4/27/22 4/28/22 It further indicated, on the following dates, the mirtazapine MAR was left blank: 4/2/22 4/4/22 4/6/22 4/10/22 4/12/22 4/13/22 4/14/22 4/15/22 4/20/22 4/21/22 4/22/22 4/25/22 4/29/22 Resident C's nursing notes did not contain any documentation any attempts made to obtain the			

	medication. An interview with DON conducted on 6/2/22 at 3:57 p.m. indicated, Resident C's mirtazadine order needed clarification prior to the pharmacy dispensing the medication. DON stated, the clinical record should have contained attempts made to acquire the medication. b. The clinical record for Resident J was reviewed on 6/2/22. Resident J's diagnoses included, but not limited to, hemiparesis, atrial fibrillation, and neuropathic pain. A physician's order dated 2/1/20 indicated, take one gabapentin (neuropathic pain reliever) 600 mg tablet three times daily. Resident J's April MAR was received on 6/2/22 at 1:11 p.m. from DON. It indicated, on the following dates and times, the MAR for gabapentin was left blank: 4/7/22; 12 p.m. dose 4/9/22; 12 p.m. dose 4/10/22; 8 a.m., 12 p.m., and 4 p.m. doses 4/12/22; 12 p.m. dose 4/13/22; 4 p.m. dose			

	4/14/22; 12 p.m. dose 4/15/22; 8 a.m. and 12 p.m. doses 4/24/22; 12 p.m. dose 4/30/22 12 p.m. dose 3. The clinical record for Resident K was reviewed on 6/2/22. Resident K's diagnoses included, but not limited to, diabetes type II. A physician's order dated 4/28/20 indicated, for nursing to complete accuchecks before meals. Resident J's May MAR indicated, on the following dates and times, the blood glucose check was left blank: 5/3/22; 12 p.m. check 5/5/22; 4 p.m. check 5/6/22; 12 p.m. check 5/12/22; 8 a.m. and 12 p.m. checks 5/13/22; 12 p.m. check 5/19/22; 12 p.m. check 5/20/22; 12 p.m. check 5/26/22; 12 p.m. check 5/27/22; 8 a.m., 12 p.m., and 4 p.m. checks			

	Resident J's clinical record did not contain any indication as to why the blood glucose checks were not performed for the above dates and times. An interview with DON conducted on 6/2/22 at 3:57 p.m. indicated, the expectation is for nursing to attempt three times to administer the medication and if unable to administer a medication or check a blood glucose, a note should be placed in the clinical record indicating the reason the medication was not administered. She further indicated, the MAR should not be left blank, instead a coded explanation should be used. This state tag relates to complaint IN00380848.			
R 0270	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(c)(1-3) (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on interview and record	R 0270	R270 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident L was confirmed to be on the room tray list and will continue to receive room trays until no longer necessary	06/19/2022

	review, the facility failed to meet the temporary need for meals to be delivered to a resident's room for 1 of 3 residents reviewed for meal delivery service. (Resident L) Findings include: A Room Tray List was provided by DON (Director of Nursing) on 6/1/22 at 12:37 p.m. The list indicated, Resident L was to receive room trays for each meal related to having a recent surgery. An interview with Resident L conducted on 6/2/22 at 9:36 a.m. indicated, last week, there were two days in which she did not receive a breakfast room tray and one or days she had not received a dinner room tray. Resident L stated, "I was told my nutrition is really important now that I have this ostomy". During the interview, an observation was made of Resident L's room. She had 3 large and 2 small Styrofoam containers from previous meals left in her room. An interview with DM (Dietary Manager) conducted on 6/2/22 at 11:47 p.m. indicated, the room tray list was provided by the DON and changes frequently. DM indicated, on several occasions, he has had residents approach him and tell him their room trays did not get		according to the DON. -**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.** Room tray list was reviewed on 6/2/22 by DON and all residents who where on the list were interviewed and no other residents identified with 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?** All staff was in serviced on 6/14/22 on the Meal Delivery Service policy by ED/DON. DM will review the room tray list weekly with the DON and update the list as needed. -**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**	

	delivered. He stated, the staff that serves the dining room and delivers the room trays are the aides from the floors. A Meal Delivery Service policy was received from DON on 6/2/22 at 1:11 p.m. The policy indicated, "Policy: To provide daily meal delivery service in a safe and timely manner to the residents, such that all meals meet standards for accuracy, temperature, and quality... Procedure:...B. The community will populate the meal ticker with their two menu options, including always available items...C. The meal tickets for the following day will be handed out to each resident when their meals is delivered for lunch. To expedite service the following day, the meal tickets will be collected when their dinner is delivered...D. The dietary staff will deliver the respective meal and drink of choice to non-isolated residents in their respective apartment during published mealtimes of the community...H. At least an hour after each meal is delivered, but prior to an hour before the next meal, dietary staff should collect the garbage from each resident's apartment..." This state tag relates to complaint IN00380848. Based on interview and record review, the facility failed to meet		**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** June 19, 2022	

	the temporary need for meals to be delivered to a resident's room for 1 of 3 residents reviewed for meal delivery service. (Resident L) Findings include: A Room Tray List was provided by DON (Director of Nursing) on 6/1/22 at 12:37 p.m. The list indicated, Resident L was to receive room trays for each meal related to having a recent surgery. An interview with Resident L conducted on 6/2/22 at 9:36 a.m. indicated, last week, there were two days in which she did not receive a breakfast room tray and one or days she had not received a dinner room tray. Resident L stated, "I was told my nutrition is really important now that I have this ostomy". During the interview, an observation was made of Resident L's room. She had 3 large and 2 small Styrofoam containers from previous meals left in her room. An interview with DM (Dietary Manager) conducted on 6/2/22 at 11:47 p.m. indicated, the room tray list was provided by the DON and changes frequently. DM indicated, on several occasions, he has had residents approach him and tell him their room trays did not get delivered. He stated, the staff			

	that serves the dining room and delivers the room trays are the aides from the floors. A Meal Delivery Service policy was received from DON on 6/2/22 at 1:11 p.m. The policy indicated, "Policy: To provide daily meal delivery service in a safe and timely manner to the residents, such that all meals meet standards for accuracy, temperature, and quality... Procedure:...B. The community will populate the meal ticker with their two menu options, including always available items...C. The meal tickets for the following day will be handed out to each resident when their meals is delivered for lunch. To expedite service the following day, the meal tickets will be collected when their dinner is delivered...D. The dietary staff will deliver the respective meal and drink of choice to non-isolated residents in their respective apartment during published mealtimes of the community...H. At least an hour after each meal is delivered, but prior to an hour before the next meal, dietary staff should collect the garbage from each resident's apartment..." This state tag relates to complaint IN00380848.			
R 0301	Pharmaceutical Services - Deficiency	R 0301	R301	06/19/2022

	410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview, and record review, the facility failed to ensure the proper labeling of medications in 1 of 4 medication carts reviewed for expired and/or discontinued medications. Findings include:		-**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Medication was labeled and stored per policy and procedures. Medication cart audits were performed on 6/6/22 and any deficient findings were corrected. -**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 were in serviced on 6/14/22 by DON, and Admin. Medication cart audits were performed on 6/6/22 and any deficient findings were corrected. -**What measures will be put into place or what**	

	An observation of the first and third floor's medication cart conducted on 6/2/22 at 3:26 p.m. with Qualified Medication Assistant (QMA) 4 indicated the following was found inside the locked narcotic box: 1. One oblong, white tablet with G 035 etched on it inside a clear, plastic sleeve which is used for crushing medication in. The plastic sleeve with the tablet was found inside an empty glove box. The tablet was later identified as hydrocodone (narcotic pain medication). 2. A taped closed, cycle pack for Resident 3 labeled as containing acetazolamide ER 500 mg tablet, atorvastatin 20 mg tablet, and trazadone 50 mg tablet and written on the back of the packet was "hydro" in black marker. The contents of the packet was one oblong tablet with G 035 etched on it. 3. A plastic bag contained 4 different, unlabeled eye medication bottles without resident labels. The bottles were: brimonidine 0.2% with "326" handwritten on it, timolol 0.5%, prednisolone 1%, and dorzolamide 2%. 4. A plastic bag with 3 bottles of eye medication without resident labels. The bottles consisted of two bottles of brimonidine 0.2% and one bottle of timolol 0.5%.		**systemic changes will be made to ensure that the deficient practice does not recur?** All staff were in serviced on 6/14/22 by DON, and Admin. DON/designee will conduct a medication cart audit weekly to ensure this deficient practice does not occur. -**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	

	5. A bottle of dorzolamide 2% without a resident label by itself on the bottom of the lock box. An interview with DON (Director of Nursing) conducted on 6/2/22 at 3:51 p.m. indicated, resident's medications come in cycle packets and if a resident were to refuse a medication out of the cycle packet, it should be documented as refused and disposed of per protocol. She indicated, all medications should be labeled with the appropriate information for identification and resident safety. A Pharmacy Services policy was received on 6/2/22 at 3:57 from DON. The policy indicated, "B. Our Community controls, handles, and administers medication for a resident if medication management is needed. Medication management includes, but is not limited to:... * Be responsible for the duties as specified in 856 IAC 1-7 of the regulations; * Review the drug handling and storage practices in the Community... C. Labeling of prescription drugs shall include the following: * Resident's full name * Physician's name		Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** June 19, 2022	

	* Prescription number * Name and strength of drug * Directions for use * Date of issue and expiration date (when applicable)... F. Medication administered by the community shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned or destroyed medication shall be documented in the resident's clinical record and shall include the following information: * Name of the resident * The name and strength of the drug * The prescription number * The reason for disposal * The amount disposed of * The method of disposition * The date of the disposition * The signature of the person conducting the disposal of the drug * The signature of a witness, if any, to the disposal of the drug" This state tag relates to complaint IN00380848			

Based on observation, interview, and record review, the facility failed to ensure the proper labeling of medications in 1 of 4 medication carts reviewed for expired and/or discontinued medications.

Findings include:

An observation of the first and third floor's medication cart conducted on 6/2/22 at 3:26 p.m. with Qualified Medication Assistant (QMA) 4 indicated the following was found inside the locked narcotic box:

1. One oblong, white tablet with G 035 etched on it inside a clear, plastic sleeve which is used for crushing medication in. The plastic sleeve with the tablet was found inside an empty glove box. The tablet was later identified as hydrocodone (narcotic pain medication).

2. A taped closed, cycle pack for Resident 3 labeled as containing acetazolamide ER 500 mg tablet, atorvastatin 20 mg tablet, and trazadone 50 mg tablet and written on the back of the packet was "hydro" in black marker. The contents of the packet was one oblong tablet with G 035 etched on it.

3. A plastic bag contained 4 different, unlabeled eye medication bottles without resident labels. The bottles were: brimonidine 0.2% with

	"326" handwritten on it, timolol 0.5%, prednisolone 1%, and dorzolamide 2%. 4. A plastic bag with 3 bottles of eye medication without resident labels. The bottles consisted of two bottles of brimonidine 0.2% and one bottle of timolol 0.5%. 5. A bottle of dorzolamide 2% without a resident label by itself on the bottom of the lock box. An interview with DON (Director of Nursing) conducted on 6/2/22 at 3:51 p.m. indicated, resident's medications come in cycle packets and if a resident were to refuse a medication out of the cycle packet, it should be documented as refused and disposed of per protocol. She indicated, all medications should be labeled with the appropriate information for identification and resident safety. A Pharmacy Services policy was received on 6/2/22 at 3:57 from DON. The policy indicated, "B. Our Community controls, handles, and administers medication for a resident if medication management is needed. Medication management includes, but is not limited to:... * Be responsible for the duties as specified in 856 IAC 1-7 of the regulations; * Review the drug handling and			

	storage practices in the Community... C. Labeling of prescription drugs shall include the following: * Resident's full name * Physician's name * Prescription number * Name and strength of drug * Directions for use * Date of issue and expiration date (when applicable)... F. Medication administered by the community shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned or destroyed medication shall be documented in the resident's clinical record and shall include the following information: * Name of the resident * The name and strength of the drug * The prescription number * The reason for disposal * The amount disposed of * The method of disposition * The date of the disposition			

	* The signature of the person conducting the disposal of the drug * The signature of a witness, if any, to the disposal of the drug" This state tag relates to complaint IN00380848			
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 observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 for 1 of 1 residents during a random observation. (Resident 2).	R 0407	R407 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The contracted staff member put on correct PPE while giving the COVID-19 to residents and was informed of our 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. The contracted staff member put on correct PPE	06/19/2022

Findings include:

An observation was made on 6/1/22 at 12 p.m. in the common area in front of the dining room. Many residents were gathered in the common area waiting for their to-go lunch orders. Resident 2 was sitting in a chair in the common area and was less than 6 feet from other residents. Also in the common area was Contracted Staff member (CSM) 3. CSM 3 approached Resident 2 and swabbed Resident 2 for COVID-19 in front of the other residents. CSM 3 was not wearing an isolation gown, eye protection, nor a N 95 mask when she performed the COVID-19 swab test.

An interview with CSM 3 was conducted on 6/1/22 at 1:06 p.m. CSM 3 indicated, she had been contracted to come to the facility and perform COVID-19 testing on the residents related to a recent resident outbreak of COVID-19. She indicated, this was the third time at the facility performing the task. She stated, "I don't know how effective it would be for me to do the whole garbing up thing in every room and get the facility done."

An interview with DON (Director of Nursing) conducted on 6/1/22 at 1:12 p.m. indicated, the facility is in outbreak testing for COVID-19. The facility's

while giving the COVID-19 to residents and was informed of our policy.

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

Any contracted staff who comes to perform such test on residents will be instructed by the DON/Designee of our infection control policy and monitored for compliance with such 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

	outbreak started 5/16/22 and subsequent resident testing on 5/16/22 and 5/23/22 indicated additional COVID-19 positive residents. The facility had the lab come out to perform the resident COVID-19 testing. DON indicated, CSM 3 had been instructed to use the necessary PPE (personal protective equipment) which included, an isolation gown, gloves, eye protection, and a N 95 mask when performing the COVID-19 swabbing. She further indicated, she had gathered the necessary PPE for CSM 3 and placed it on the cart along with testing supplies. DON stated, during meal times when residents gathered in the common area, CSM 3 was to use a separate, private area to perform the COVID-19 testing. The CDC's (Centers for Diseases and Control) Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings last updated Apr. 4, 2022 indicated, "Personnel collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2 should maintain proper infection control and use recommended personal protective equipment (PPE), which could include an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a lab coat or		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** June 19, 2022	

gown... Disinfect surfaces within 6 feet of the specimen collection and handling area at these times:

Before testing begins each day

Between each specimen collection

At least hourly during testing

When visibly soiled

In the event of a specimen spill or splash

At the end of every testing day"

Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 for 1 of 1 residents during a random observation. (Resident 2).

Findings include:

An observation was made on 6/1/22 at 12 p.m. in the common area in front of the dining room. Many residents were gathered in the common area waiting for their to-go lunch orders. Resident 2 was sitting in a chair in the common area and was less than 6 feet from other residents. Also in the common area was Contracted Staff member (CSM) 3. CSM 3 approached Resident 2 and swabbed Resident 2 for COVID-19 in front of the other

residents. CSM 3 was not wearing an isolation gown, eye protection, nor a N 95 mask when she performed the COVID-19 swab test.

An interview with CSM 3 was conducted on 6/1/22 at 1:06 p.m. CSM 3 indicated, she had been contracted to come to the facility and perform COVID-19 testing on the residents related to a recent resident outbreak of COVID-19. She indicated, this was the third time at the facility performing the task. She stated, "I don't know how effective it would be for me to do the whole garbing up thing in every room and get the facility done."

An interview with DON (Director of Nursing) conducted on 6/1/22 at 1:12 p.m. indicated, the facility is in outbreak testing for COVID-19. The facility's outbreak started 5/16/22 and subsequent resident testing on 5/16/22 and 5/23/22 indicated additional COVID-19 positive residents. The facility had the lab come out to perform the resident COVID-19 testing. DON indicated, CSM 3 had been instructed to use the necessary PPE (personal protective equipment) which included, an isolation gown, gloves, eye protection, and a N 95 mask when performing the COVID-19 swabbing. She further indicated, she had gathered the necessary PPE for

CSM 3 and placed it on the cart along with testing supplies. DON stated, during meal times when residents gathered in the common area, CSM 3 was to use a separate, private area to perform the COVID-19 testing.

The CDC's (Centers for Diseases and Control) Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings last updated Apr. 4, 2022 indicated, "Personnel collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2 should maintain proper infection control and use recommended personal protective equipment (PPE), which could include an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a lab coat or gown... Disinfect surfaces within 6 feet of the specimen collection and handling area at these times:

Before testing begins each day

Between each specimen collection

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	At the end of every testing day"			

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