STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF DYER	1763 CALUMET AVENUE, DYER, , 46311

(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 IN00373523, IN00373921, IN00373989, and IN00375330. Complaint IN00373523 - Substantiated. State deficiency related to the allegations is cited at R0241. Complaint IN00373921 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00373989 - Substantiated. State deficiencies related to the allegations are cited at R0090, R0052, and R0116. Complaint IN00375330 - Substantiated. State deficiency related to the allegations is cited at R0241. Survey dates: March 21 & 22, 2022 Facility number: 014415	R 0000		

	Residential Census: 74 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/29/22.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, record review and interview, the facility failed to ensure residents were free from neglect, related to not assessing residents timely after falls for 2 of 3 residents reviewed for falls. (Residents E and K) Resident E's fall resulted in a fractured hip and Resident K's fall resulted in an abrasion and bruise of the eye. The facility also failed to intervene during observations of verbal abuse and report to the administrator immediately for 1 of 3 residents reviewed for	R 0052	R052 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Resident E no longer resides at community, no further action taken. Resident K currently resides at community. Resident K was assessed and examined by MD, incident report completed. No further injuries noted. MD gave no new orders or recommendations. Resident D currently resides at community. Allegation was reported to ISDH upon notification, investigation initiated, Ombudsman notified, investigation finalized.	05/23/2022

	abuse. (Resident D) Findings include: 1) Resident E's record was reviewed on 3/22/22 at 10:34 a.m. The diagnoses included, but were not limited to, dementia. An Indiana Department of Health reportable incident, dated 1/6/22, indicated the incident occurred on 1/2/22 at 3:04 p.m. On Tuesday 1/4/22, the day shift CNAs were providing care when increased pain when moving the right leg was observed and reported to the nurse. The CNAs had indicated the resident had fallen on 1/2/22. The fall had not been documented in the record or reported. An x-ray of the right hip was completed on 1/6/22. The x-ray indicted there was a fracture of the right hip. The resident's Responsible Party had chosen to have the resident remain at the facility and Hospice care was to be continued. Nurses' Progress Notes, dated 1/2/22, indicated the following: At 2:10 p.m., the resident continued to attempt to get up and walk. She denied pain upon moving the lower extremity. At 3:34 p.m., she was confused and undressed herself. Her brief was changed, clothing		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected by the deficient practices. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** All staff will be in-serviced on Resident Rights and Identifying & Reporting abuse. All nursing staff will be in-serviced on Fall Policy and Procedures related to timely assessing and reporting incidents.	

	re-applied and she was redirected back to her bed. At 3:38 p.m., her temperature was 97.3, blood pressure was 144/58, pulse was 66, oxygen saturation was 98%, she was in bed resting. There was no documentation of a fall or full nursing assessment. During an interview on 3/22/22 at 10:25 a.m., the Administrator indicated QMA 6 and Agency Nurse 7 were the employees working the day of the fall on 1/2/22. She indicated an Incident Report was to be filled out after each fall and should have been completed. During an interview on 3/22/22 at 12:11 p.m., QMA 6 indicated she received a call from Agency Nurse 7, who was assigned to Memory Care. Agency Nurse 7 requested her help to assist the resident off the floor. QMA 6 indicated she was unaware if the nurse had assessed the resident. The nurse informed her she would document the fall. 2) During an observation on 3/21/22 at 11:21 a.m., Agency Nurse 8 entered Resident K's apartment to assess the resident after a fall. Resident K was sitting on a chair and had an abrasion and bruise along the right eye. She stated she had slipped off the bed last night and got herself up off 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** Continue to re-educate staff on Resident Rights, Abuse Policy & Procedures, and Fall Policy & Procedures at monthly all-staff meetings. Conduct daily stand-up meeting to discuss any incidents or residents at risk for potential abuse. The DOW or Designee to discuss the Accident and Incident Tracking Log during weekly Resident Opportunity & At-Risk Meeting. (ROAR) **By what date the systemic changes will be completed.** May 23, 2022 Addendum: **R052**: Please indicate if the facility will conduct any resident or responsible	

	floor. She washed the blood off her skin. She had laid on the floor for a while before she got up and had not called for assistance. She had gone out to the hallway and reported her fall to one of the staff members. During an interview on 3/21/22 at 1:51 p.m., the Director of Nursing indicated none of the staff on the night shift was aware of the fall and the Administrator informed them of the fall in the morning meeting. During an interview on 3/21/22 at 2:35 p.m., the Administrator indicated CNA 9 had reported the fall to her around 9 a.m. During an interview on 3/21/22, CNA 9 indicated, around 6:30 a.m., Resident K was in the hallway by the elevator and an abrasion and bruise was observed on the right side of her head and eye. The resident indicated she had fallen during the night. CNA 9 assisted her to her room and informed Agency Nurse 8 of the fall around 7-7:30 a.m. Resident K's record was reviewed on 3/22/22 at 12:43 p.m. The diagnoses included, but were not limited to, hypertension. A Nurse's Progress Note, dated 3/21/22 at 11:49 a.m., indicated a fall with injury. The resident had fallen from the bed and		party observations or interviews to ensure allegations of abuse have been reported/ addressed and falls, including follow up, have been documented. Please indicate who is responsible for monitoring and for how long monitoring will occur. Department Managers/designee to conduct resident observations or interviews 2x weekly during routine rounds for 60 days to ensure allegations of abuse have been reported to Executive Director. Department Manager/ Designee is responsible for reporting any/all allegations to ED immediately. ED to monitor routine rounds weekly for 60 days. DOW/Designee to conduct audit of falls utilizing the Accidents and Injury Tracking Tool 3x weekly for 60 days.	

landed on the floor. The fall was unwitnessed. There was a wound noted to the right side of the forehead near the brow area, a laceration with bruise, reddish purple in color. There were two small abrasions on the cheek. The Physician and Power of Attorney were notified.

A Nurse's Progress Note, dated 3/21/22 at 2:52 p.m., indicated a family member was transferring the resident to the Emergency Room.

A Nurse's Progress Note, dated 3/21/22 at 8:30 p.m., indicated the resident returned to the facility. The CT scan results were negative and there were no new Physician's Orders.

An undated fall risk policy, received from the Administrator on 3/22/22 at 2 p.m., indicated, when a resident fell, first aid was to be administered and vital signs checked. The Physician and Family were to be notified. The resident was to be placed on Alert Charting and on the 24-hour report form. An Incident Report and alert Charting was to be initiated.

3) During an interview on 3/21/22 at 9:09 a.m., Housekeeper 1 indicated she had previously overheard a family member talking harshly and raising her voice to Resident D.

	During an interview on 3/21/22 at 9:13 a.m., Housekeeper 2 indicated she felt the family member was verbally abusive to Resident D and had reported it a few weeks ago to the Business Office Manager. During an interview on 3/21/22 at 9:44 a.m., Resident D indicated she had a family member who was disrespectful and made her feel "uncomfortable" and stated no matter what she did, it was not right with the family member. Resident D appeared anxious during the conversation, her hand continually coming to her face and stated, "I am not sure what to do." During an interview on 3/21/22 at 10:12 a.m., the Administrator was notified of the conversation with Resident D. She indicated no one had reported an allegation of abuse against the family member. The Business Office Manager was on vacation and could not be interviewed. She indicated she would report the allegation and the investigation would be initiated. Resident D's record was reviewed on 3/22/22 at 10:12 a.m. The diagnoses included, but were not limited to, hypertension. A Mini-Mental State Exam, dated 8/23/21, indicated mild			

dementia with a score of 23 out of 30.

A signed statement from the Regional Care Manager, dated 3/21/22, indicated Resident D voiced that the family member was "very bossy" towards her. She had not wanted to make things worse or agitate the family member.

A signed statement from CNA 3, dated 3/21/22, indicated the family member had been witnessed being aggressive toward the resident. The resident had been seen crying at times.

A signed statement from Resident Aide 4, dated 3/21/22, indicated the family member had been "very nasty" with the the resident, yelled at her and talked very aggressive with the resident.

A signed statement from Resident Aide 5, dated 3/21/22, indicated the family member was very aggressive and had been overheard yelling at the resident.

An undated facility abuse policy, received as current from the Administrator on 3/21/22 at 10:03 a.m., indicated the resident and the person allegedly abusing the resident were to be separated. The alleged abuse was to be reported immediately to the

supervisor or the local Adult Protective Services Agency. A statement was to be written with the assistance of the supervisor of what was seen, heard, or what was suspected.

This state residential finding relates to Complaint IN00373989.

Based on observation, record review and interview, the facility failed to ensure residents were free from neglect, related to not assessing residents timely after falls for 2 of 3 residents reviewed for falls. (Residents E and K) Resident E's fall resulted in a fractured hip and Resident K's fall resulted in an abrasion and bruise of the eye. The facility also failed to intervene during observations of verbal abuse and report to the administrator immediately for 1 of 3 residents reviewed for abuse. (Resident D)

Findings include:

1) Resident E's record was reviewed on 3/22/22 at 10:34 a.m. The diagnoses included, but were not limited to, dementia.

An Indiana Department of Health reportable incident, dated 1/6/22, indicated the incident occurred on 1/2/22 at 3:04 p.m. On Tuesday 1/4/22, the day shift CNAs were providing care when increased

pain when moving the right leg was observed and reported to the nurse. The CNAs had indicated the resident had fallen on 1/2/22. The fall had not been documented in the record or reported. An x-ray of the right hip was completed on 1/6/22. The x-ray indicted there was a fracture of the right hip. The resident's Responsible Party had chosen to have the resident remain at the facility and Hospice care was to be continued.

Nurses' Progress Notes, dated 1/2/22, indicated the following:

At 2:10 p.m., the resident continued to attempt to get up and walk. She denied pain upon moving the lower extremity.

At 3:34 p.m., she was confused and undressed herself. Her brief was changed, clothing re-applied and she was redirected back to her bed.

At 3:38 p.m., her temperature was 97.3, blood pressure was 144/58, pulse was 66, oxygen saturation was 98%, she was in bed resting.

There was no documentation of a fall or full nursing assessment.

During an interview on 3/22/22 at 10:25 a.m., the Administrator indicated QMA 6 and Agency Nurse 7 were the employees working the day of the fall on

	1/2/22. She indicated an Incident Report was to be filled out after each fall and should have been completed. During an interview on 3/22/22 at 12:11 p.m., QMA 6 indicated she received a call from Agency Nurse 7, who was assigned to Memory Care. Agency Nurse 7 requested her help to assist the resident off the floor. QMA 6 indicated she was unaware if the nurse had assessed the resident. The nurse informed her she would document the fall. 2) During an observation on 3/21/22 at 11:21 a.m., Agency Nurse 8 entered Resident K's apartment to assess the resident after a fall. Resident K was sitting on a chair and had an abrasion and bruise along the right eye. She stated she had slipped off the bed last night and got herself up off the floor. She washed the blood off her skin. She had laid on the floor for a while before she got up and had not called for assistance. She had gone out to the hallway and reported her fall to one of the staff members. During an interview on 3/21/22 at 1:51 p.m., the Director of Nursing indicated none of the staff on the night shift was aware of the fall and the Administrator informed them of the fall in the morning meeting.			

During an interview on 3/21/22 at 2:35 p.m., the Administrator indicated CNA 9 had reported the fall to her around 9 a.m.

During an interview on 3/21/22, CNA 9 indicated, around 6:30 a.m., Resident K was in the hallway by the elevator and an abrasion and bruise was observed on the right side of her head and eye. The resident indicated she had fallen during the night. CNA 9 assisted her to her room and informed Agency Nurse 8 of the fall around 7-7:30 a.m.

Resident K's record was reviewed on 3/22/22 at 12:43 p.m. The diagnoses included, but were not limited to, hypertension.

A Nurse's Progress Note, dated 3/21/22 at 11:49 a.m., indicated a fall with injury. The resident had fallen from the bed and landed on the floor. The fall was unwitnessed. There was a wound noted to the right side of the forehead near the brow area, a laceration with bruise, reddish purple in color. There were two small abrasions on the cheek. The Physician and Power of Attorney were notified.

A Nurse's Progress Note, dated 3/21/22 at 2:52 p.m., indicated a family member was transferring the resident to the Emergency Room.

	A Nurse's Progress Note, dated 3/21/22 at 8:30 p.m., indicated the resident returned to the facility. The CT scan results were negative and there were no new Physician's Orders. An undated fall risk policy, received from the Administrator on 3/22/22 at 2 p.m., indicated, when a resident fell, first aid was to be administered and vital signs checked. The Physician and Family were to be notified. The resident was to be placed on Alert Charting and on the 24-hour report form. An Incident Report and alert Charting was to be initiated. 3) During an interview on 3/21/22 at 9:09 a.m., Housekeeper 1 indicated she had previously overheard a family member talking harshly and raising her voice to Resident D. During an interview on 3/21/22 at 9:13 a.m., Housekeeper 2 indicated she felt the family member was verbally abusive to Resident D and had reported it a few weeks ago to the Business Office Manager. During an interview on 3/21/22 at 9:44 a.m., Resident D indicated she had a family member who was disrespectful and made her feel "uncomfortable" and stated no matter what she did, it was not			

	right with the family member. Resident D appeared anxious during the conversation, her hand continually coming to her face and stated, "I am not sure what to do." During an interview on 3/21/22 at 10:12 a.m., the Administrator was notified of the conversation with Resident D. She indicated no one had reported an allegation of abuse against the family member. The Business Office Manager was on vacation and could not be interviewed. She indicated she would report the allegation and the investigation would be initiated. Resident D's record was reviewed on 3/22/22 at 10:12 a.m. The diagnoses included, but were not limited to, hypertension. A Mini-Mental State Exam, dated 8/23/21, indicated mild dementia with a score of 23 out of 30. A signed statement from the Regional Care Manager, dated 3/21/22, indicated Resident D voiced that the family member was "very bossy" towards her. She had not wanted to make things worse or agitate the family member. A signed statement from CNA 3, dated 3/21/22, indicated the family member had been witnessed being aggressive			

	toward the resident. The resident had been seen crying at times. A signed statement from Resident Aide 4, dated 3/21/22, indicated the family member had been "very nasty" with the the resident, yelled at her and talked very aggressive with the resident. A signed statement from Resident Aide 5, dated 3/21/22, indicated the family member was very aggressive and had been overheard yelling at the resident. An undated facility abuse policy, received as current from the Administrator on 3/21/22 at 10:03 a.m., indicated the resident and the person allegedly abusing the resident were to be separated. The alleged abuse was to be reported immediately to the supervisor or the local Adult Protective Services Agency. A statement was to be written with the assistance of the supervisor of what was seen, heard, or what was suspected. This state residential finding relates to Complaint IN00373989.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6)	R 0090	R090	05/23/2022

	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains,		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Resident D currently resides in community. Allegation was reported to ISDH. Investigation initiated, Ombudsman notified, MD, and family notified. Interventions were put in place to further prevent abuse. Investigation finalized. ED met with daughter/POA to discuss allegations and informed her of Cedarhurst Abuse Policy and Procedure in addition to informing her of Cedarhurst's obligation to report allegations to ISDH. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected by the deficient practice.	

	on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting abuse allegations to the Administrator for 1 of 3 residents reviewed for abuse. (Resident D) Finding includes: During an interview on 3/21/22 at 9:09 a.m., Housekeeper 1 indicated she has overheard a family member talking harshly and raising her voice to Resident D.		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** All staff to be in-serviced on Resident Rights and Identifying & Reporting abuse. ED will report all allegations of abuse/neglect to ISDH within 24 hours of notification. **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** The ED, DOW, or Designee to audit incidents daily utilizing the Accident & Incidents Tracking Tool. The DOW or Designee to discuss during weekly Resident Opportunity & At-Risk Meeting. (ROAR) **By what date the systemic**	

	During an interview on 3/21/22 at 9:13 a.m., Housekeeper 2 indicated she felt the family member was verbally abusive to Resident D and had reported it a few weeks ago to the Business office Manager. During an interview on 3/21/22 at 9:44 a.m., Resident D indicated she had a family member who was disrespectful and made her feel, "uncomfortable" and stated no matter what she did, it was not right with the family member. Resident D appeared anxious during the conversation, her hand continually coming to her face and stated, "I am not sure what to do." During an interview on 3/21/22 at 10:12 a.m., the Administrator was notified of the conversation with Resident D. She indicated no one had reported an allegation of abuse against the family member. The Business Office Manager was on vacation and could not be interviewed. She indicated she would report the allegation and the investigation would be initiated. Resident D's record was reviewed on 3/22/22 at 10:12 a.m. The diagnoses included, but were not limited to, hypertension. A Mini-Mental State Exam, dated 8/23/21, indicated mild		**changes will be completed.** May 23, 2022 Addendum: **R090**: Please indicate if the facility will conduct any resident or responsible party observations or interviews to ensure allegations of abuse have been reported to the administrator, including who is responsible and for how long monitoring will occur. Department Managers/designee to conduct resident observations or interviews 2x weekly during routine rounds for 60 days to ensure allegations of abuse have been reported to Executive Director. Department Manager/ Designee is responsible for reporting any/all allegations to ED immediately. ED to monitor routine rounds weekly for 60 days.	

dementia with a score of 23 out of 30.

A signed statement from the Regional Care Manager, dated 3/21/22, indicated the Resident D voiced the family member was, "very bossy", towards her. She had not wanted to make things worse or agitate the family member.

A signed statement from CNA 3, dated 3/21/22, indicated the family member had been witnessed being aggressive toward the resident. The resident had been seen crying at times.

A signed statement from Resident Aide 4, dated 3/21/22, indicated the family member has been, "very nasty" with the the resident, yelled at her and talked very aggressive with the resident.

A signed statement from Resident Aide 5, dated 3/21/22, indicated the family member was very aggressive and has been overheard yelling at the resident.

An undated facility abuse policy, received as current from the Administrator on 3/21/22 at 10:03 a.m., indicated the resident and the person allegedly abusing the resident were to be separated. The alleged abuse was to be reported immediately to the

supervisor or the local Adult Protective Services Agency. A statement was to be written with the assistance of the supervisor of what was seen, heard, or what was suspected.

This state residential finding relates to Complaint IN00373989.

Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting abuse allegations to the Administrator for 1 of 3 residents reviewed for abuse. (Resident D)

Finding includes:

During an interview on 3/21/22 at 9:09 a.m., Housekeeper 1 indicated she has overheard a family member talking harshly and raising her voice to Resident D.

During an interview on 3/21/22 at 9:13 a.m., Housekeeper 2 indicated she felt the family member was verbally abusive to Resident D and had reported it a few weeks ago to the Business office Manager.

During an interview on 3/21/22 at 9:44 a.m., Resident D indicated she had a family member who was disrespectful and made her feel, "uncomfortable" and stated no matter what she did, it was not

right with the family member. Resident D appeared anxious during the conversation, her hand continually coming to her face and stated, "I am not sure what to do."

During an interview on 3/21/22 at 10:12 a.m., the Administrator was notified of the conversation with Resident D. She indicated no one had reported an allegation of abuse against the family member. The Business Office Manager was on vacation and could not be interviewed. She indicated she would report the allegation and the investigation would be initiated.

Resident D's record was reviewed on 3/22/22 at 10:12 a.m. The diagnoses included, but were not limited to, hypertension.

A Mini-Mental State Exam, dated 8/23/21, indicated mild dementia with a score of 23 out of 30.

A signed statement from the Regional Care Manager, dated 3/21/22, indicated the Resident D voiced the family member was, "very bossy", towards her. She had not wanted to make things worse or agitate the family member.

A signed statement from CNA 3, dated 3/21/22, indicated the family member had been witnessed being aggressive

	toward the resident. The resident had been seen crying at times. A signed statement from Resident Aide 4, dated 3/21/22, indicated the family member has been, "very nasty" with the the resident, yelled at her and talked very aggressive with the resident. A signed statement from Resident Aide 5, dated 3/21/22, indicated the family member was very aggressive and has been overheard yelling at the resident. An undated facility abuse policy, received as current from the Administrator on 3/21/22 at 10:03 a.m., indicated the resident and the person allegedly abusing the resident were to be separated. The alleged abuse was to be reported immediately to the supervisor or the local Adult Protective Services Agency. A statement was to be written with the assistance of the supervisor of what was seen, heard, or what was suspected. This state residential finding relates to Complaint IN00373989.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a)	R 0116	R116	05/23/2022

	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to implement the screening of prospective employees, related to criminal back ground checks and references not obtained prior to employees starting employment at the facility for 4 of 5 employee records reviewed. (Concierge 1, CNA 11, CNA 12, Dietary Aide 1) The Employee Records were reviewed on 3/22/22 at 1:15 p.m. The facility had not completed a criminal background check for the State of Indiana or attempted to obtain reference checks on the following employees: Concierge 1, employment start date of 1/31/22 CNA 11, employment start date of 2/21/22 CNA 12, employment start date of 1/25/22 Dietary Aide 1, employment start date of 3/16/22		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All current employee files have been audited and are currently up to date with all IN requirements completed. No residents were experienced any ill effects related to the deficiency. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by the deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**	

	During an interview on 3/22/22 at 3:11 p.m., the Administrator indicated the criminal background checks had not been completed. The undated facility abuse policy, received from the Administrator as current on 3/21/22 at 10:03 a.m., indicated criminal background check would be completed on all staff prior to or upon hire. This state residential finding relates to Complaint IN00373989. Based on record review and interview, the facility failed to implement the screening of prospective employees, related to criminal back ground checks and references not obtained prior to employees starting employment at the facility for 4 of 5 employee records reviewed. (Concierge 1, CNA 11, CNA 12, Dietary Aide 1) The Employee Records were reviewed on 3/22/22 at 1:15 p.m. The facility had not completed a criminal background check for the State of Indiana or attempted to obtain reference checks on the following employees: Concierge 1, employment start date of 1/31/22		Business Office Manager and RCM to be in-serviced on IN New-Hire requirements. **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** Each newly hired employee will have New-Hire Checklist completed and verified ensuring the employee file is complete prior to start date. Checklist to include: IN State Police Criminal Background Check, Reference checks, new-hire orientation, as well as verification of certification or license. **By what date the systemic changes will be completed.** May 23, 2022	

	CNA 11, employment start date of 2/21/22 CNA 12, employment start date of 1/25/22 Dietary Aide 1, employment start date of 3/16/22 During an interview on 3/22/22 at 3:11 p.m., the Administrator indicated the criminal background checks had not been completed. The undated facility abuse policy, received from the Administrator as current on 3/21/22 at 10:03 a.m., indicated criminal background check would be completed on all staff prior to or upon hire. This state residential finding relates to Complaint IN00373989.			

R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and interview, the facility failed to ensure medication was administered by licensed nursing personnel or qualified medication aides (QMA). This had the potential to affect 49 of the 74 residents who reside in the facility. The facility also failed to give antibiotics as ordered by the Physician for 3 of 3 residents reviewed for antibiotic administration (Residents F, G, and H) and failed to administer eye drops in a sanitary manner for 2 of 2 residents observed for eye drop administration. (Residents L and M) Findings include: 1) Employee Files were reviewed on 3/22/22 at 1:15 p.m. Resident Aide (RA) 10 was marked on the Employee Records as a QMA and had a	R 0241	R241 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All employee licenses or certifications have been verified. No unlicensed staff are administering medications. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents receiving antibiotics or eye drops have the potential to be affected by the same deficient practices. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** All nursing staff to be educated and in-serviced on Medication	05/23/2022

start date of 11/22/21.

RA 10 had a CNA registry verification from Illinois and a certificate which indicated 48 contact hours of training for medication distillation for unlicensed personnel from a college in Minnesota, dated 4/14/11.

RA 10 was not a CNA in the State of Indiana. RA 10 was not a QMA in the State of Indiana.

RA 10's schedule indicated she administered medications on February 1, 4, 5, 7, 8, 9, 10, 14, 18, 21, 23, 24, 25, 26, and 28, 2022 and March 11 and 14, 2022.

During an interview on 3/22/22 at 1:32 p.m., the Administrator indicated RA 10 administered medications and was scheduled for her CNA test on 3/23/22.

2) Resident F's record was reviewed on 3/21/22 at 1:55 p.m. The diagnoses included, but were not limited to, hypertension.

A Physician's Order, dated 2/25/22, indicated doxycycline 100 mg was to be given twice a day for 30 days.

The Medication Administration Record (MAR), dated 3/2022, indicated the doxycycline had not been given on 2/25/22 at 8 p.m., 2/26/22 and 2/27/22 at 8

Administration Policy & Procedure in addition to the Medication and Delivery Standards Policy & Procedure.

All nursing staff to be in-serviced on Hand Hygiene during medication administration.

Each newly hired employee will have New-Hire Checklist completed and verified ensuring the employee file is complete including verification of certification or license.

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

All new orders to be tracked on the Medication Communication Log.

By what date the systemic changes will be completed.

a.m. and 8 p.m. and March 6, 7, and 8, 2022 at 8 a.m. and 8 p.m.

During an interview with the Director of Nursing (DON) on 3/22/22 at 8:39 a.m., she indicated she had found some sign out forms from the Emergency Drug Kit (EDK), She indicated the first doxycycline removed from the EDK was on 2/28/22. She was unable to determine if the doxycycline had been given March 6, 7, and 8, 2022. She indicated they use hand written MAR's until the pharmacy puts the order in the computer and was able to find the hand written MARs for March 1-5, 2022.

3) Resident G's record was reviewed on 3/22/22 at 11:28 a.m. The diagnoses included, but were not limited to, dementia.

A Physician's Order, dated 2/10/22, indicated cephalexin (antibiotic) 500 mg, two capsules twice a day, start 2/10/22 and stop 2/15/22 for an urinary tract infection.

A Physician's Order, dated 3/14/22, indicated Bactrim DS (antibiotic), start 3/14/22 and stop 3/21/22 for an urinary tract infection.

The MAR, dated 2/2022, indicated the cephalexin was not administered on February

May 23, 2022

Addendum:

R241: Please indicate how the facility will monitor medication administration completion only by appropriately licensed personnel ongoing. Please indicate if the facility will conduct observations, interviews, and resident record reviews to ensure medications are being administered as ordered, including upon admission/ re-admission, including who is responsible, how often and for how long monitoring will occur.

DOW/Designee to conduct medication review for each admission/re-admission for 60 days to ensure medications are being administered as ordered.

DOW/Designee to conduct competency assessment of all licensed personnel currently employed and upon hire.

12 & 13, 2022 at 8 a.m. and 4 p.m. and only 5 doses had been administered.

The MAR, dated 3/2022, indicated the Bactrim DS had not been administered on March 15 at 8 a.m. and 8 p.m. and at 8 p.m. on March 17, 2022.

During an interview with the DON on 3/22/22 at 8:39 a.m., she indicated the nurses were to fax the orders to the Pharmacy, then the Pharmacy placed the order in the computer. A paper/hand-written MAR was used until this was done.

4) Resident H's record was reviewed on 3/22/22 at 12:22 p.m. The diagnoses included, but were not limited to, dementia.

A Physician's Order, dated 12/29/21, indicated nitrofurantoin (antibiotic) 50 mg once a day for an urinary tract infection.

The MAR, dated 2/2022, indicated the nitrofurantoin was not administered as ordered on February 23 and 25, 2022.

During an interview on 3/22/22 at 8:39 a.m., the DON indicated there was nothing documented in the Nurses' Progress Notes or on the MAR related to why the nitrofurantoin was not administered.

5) During an observation of an evening medication pass on 3/21/22 with QMA 6, the following was observed:

At 3:05 p.m., QMA 6 entered Resident L's room after her medications were prepared, which included olopatadine (itchy eye relief) eye drops 0.1%. QMA 6 had not completed hand hygiene and had not donned gloves. She touched the eye dropper to the right and left eye lids as she administered one drop of the medication into each eye. She then placed the cap back on the bottle and exited the room. Hand hygiene was not performed.

QMA 6 then began to prepare Resident M's medications and was stopped. She then completed hand hygiene. She then prepared Resident M's medications, which included dorzolamide (glaucoma) 2%, and entered the apartment. Hand hygiene was completed. No gloves were donned. She then touched the right and left eye lid with the dropper as she administered the dorzolamide one drop into each eye. She placed the cap on the bottle, exited the room and placed the bottle back into the medication drawer.

This state residential finding relates to Complaints

IN00373523 and IN00375330.

Based on observation, record review, and interview, the facility failed to ensure medication was administered by licensed nursing personnel or qualified medication aides (QMA). This had the potential to affect 49 of the 74 residents who reside in the facility.

The facility also failed to give antibiotics as ordered by the Physician for 3 of 3 residents reviewed for antibiotic administration (Residents F, G, and H) and failed to administer eye drops in a sanitary manner for 2 of 2 residents observed for eye drop administration. (Residents L and M)

Findings include:

1) Employee Files were reviewed on 3/22/22 at 1:15 p.m. Resident Aide (RA) 10 was marked on the Employee Records as a QMA and had a start date of 11/22/21.

RA 10 had a CNA registry verification from Illinois and a certificate which indicated 48 contact hours of training for medication distillation for unlicensed personnel from a college in Minnesota, dated 4/14/11.

RA 10 was not a CNA in the State of Indiana. RA 10 was not a QMA in the State of Indiana.

RA 10's schedule indicated she administered medications on February 1, 4, 5, 7, 8, 9, 10, 14, 18, 21, 23, 24, 25, 26, and 28, 2022 and March 11 and 14, 2022.

During an interview on 3/22/22 at 1:32 p.m., the Administrator indicated RA 10 administered medications and was scheduled for her CNA test on 3/23/22.

2) Resident F's record was reviewed on 3/21/22 at 1:55 p.m. The diagnoses included, but were not limited to, hypertension.

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The Medication Administration Record (MAR), dated 3/2022, indicated the doxycycline had not been given on 2/25/22 at 8 p.m., 2/26/22 and 2/27/22 at 8 a.m. and 8 p.m. and March 6, 7, and 8, 2022 at 8 a.m. and 8 p.m.

During an interview with the Director of Nursing (DON) on 3/22/22 at 8:39 a.m., she indicated she had found some sign out forms from the Emergency Drug Kit (EDK), She indicated the first doxycycline

removed from the EDK was on 2/28/22. She was unable to determine if the doxycycline had been given March 6, 7, and 8, 2022. She indicated they use hand written MAR's until the pharmacy puts the order in the computer and was able to find the hand written MARs for March 1-5, 2022.

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A Physician's Order, dated 3/14/22, indicated Bactrim DS (antibiotic), start 3/14/22 and stop 3/21/22 for an urinary tract infection.

The MAR, dated 2/2022, indicated the cephalexin was not administered on February 12 & 13, 2022 at 8 a.m. and 4 p.m. and only 5 doses had been administered.

The MAR, dated 3/2022, indicated the Bactrim DS had not been administered on March 15 at 8 a.m. and 8 p.m. and at 8 p.m. on March 17, 2022.

During an interview with the

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE