STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MEADOWS SENIOR ASSISTED LIVING	11570 E 126TH STREET, FISHERS, , 46037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00362610, IN00364423, IN00364918, IN00365563, IN00366077, IN00369009, IN00370101, IN00372371, and IN00373321. Complaint IN00362610 - Substantiated. State Residential Findings are cited at R216, R247, R297, and R301. Complaint IN00364423 - Unsubstantiated due to lack of evidence. Complaint IN00364918 - Substantiated. State Residential Findings are cited at R247 and R297. Complaint IN00365563 - Unsubstantiated due to lack of evidence. Complaint IN00366077 - Substantiated. State Residential	R 0000	Lake Meadows Senior Assisted Living provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law. Craig A. Hestand, HFA Center Executive Director Lake Meadows Senior Assisted Living.	

	Findings are cited at R247 and R297. Complaint IN00369009 - Substantiated. State Residential Findings are cited at R121, R247, and R297. Complaint IN00370101 - Substantiated. State Residential Findings are cited at R121, R247, R297, R301, and R407. Complaint IN00372371 - Substantiated. No state residential findings related to the allegations were cited. Complaint IN00373321 - Substantiated. State Residential Findings are cited at R297. Survey dates: February 14, 15, 16 and 17, 2022 Facility number: 014910 Residential Census: 111 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 21, 2022			
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	R 0041	It is Lake Meadows Assisted Living intention to provide a grievance program, with a dedicated grievance officer. All residents and staff have the potential to be affected by this	04/08/2022

	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 interview and record review, the facility failed to keep records of resident council meetings and follow-up with any potential grievances related to resident council meetings. This had the potential to affect all 111 residents that resided in the facility. Findings include: An interview conducted with Resident H, on 2/14/22 at 3:45 p.m., indicated he was the Resident Council President. Resident Council met on the second Wednesday of the month and the administrative staff was invited to the meetings as well. The meetings have been consistent since he has been a resident here, for approximately a year. The grievance binder was reviewed on 2/16/22 at 4:00 p.m. The binder did not contain any grievances since March of 2021. The grievance from March of 2021 were pertaining		alleged deficient practice. The Regional Operations Director has in-serviced the Executive Director on the regulations pertaining to grievance program. As an initial intervention the community will post the grievance officers name & title, and a dedication location for grievance forms. During the next scheduled resident council meeting the Executive Director will educate all residents at Lake Meadows on the grievance program and process per facility policy. The Executive Director/designee will review grievances daily. Findings will be reviewed at regularly scheduled QAPI meetings. Compliance Date is April 8, 2022	

to resident council.

Resident council minutes for February 2022 was provided by the Director of Nursing (DON) on 2/17/22 at 2:37 p.m. The minutes included, but were not limited to, the following concerns:

The need for extra washers and dryers for more convenience,

Better care for residents,

Medications not on time or late,

Blood pressure medications not coming on time,

Medications are an issue,

Medications being ordered late &

Medications not being given at times.

The DON indicated there was a resident who conducts the record keeping for the minutes and they were unable to find the previous minutes at that time. The DON also indicated the grievance log was maintained by the previous Executive Director. If the residents voiced concerns during resident council, it would have been noted on a grievance form.

A policy titled "Resident Council", undated, was provided by the DON on 2/17/22 at 3:06

p.m. The policy indicated the following, " ...5. The Resident Council will organize and establish by-laws and elect officers ...7. Minutes will be kept of all meetings ...."

Based on interview and record review, the facility failed to keep records of resident council meetings and follow-up with any potential grievances related to resident council meetings. This had the potential to affect all 111 residents that resided in the facility.

Findings include:

An interview conducted with Resident H, on 2/14/22 at 3:45 p.m., indicated he was the Resident Council President. Resident Council met on the second Wednesday of the month and the administrative staff was invited to the meetings as well. The meetings have been consistent since he has been a resident here, for approximately a year.

The grievance binder was reviewed on 2/16/22 at 4:00 p.m. The binder did not contain any grievances since March of 2021. The grievance from March of 2021 were pertaining to resident council.

Resident council minutes for February 2022 was provided by the Director of Nursing (DON) on 2/17/22 at 2:37 p.m. The

	minutes included, but were not limited to, the following concerns: The need for extra washers and dryers for more convenience, Better care for residents, Medications not on time or late, Blood pressure medications not coming on time, Medications are an issue, Medications being ordered late & Medications not being given at times. The DON indicated there was a resident who conducts the record keeping for the minutes and they were unable to find the previous minutes at that time. The DON also indicated the grievance log was maintained by the previous Executive Director. If the residents voiced concerns during resident council, it would have been noted on a grievance form.			

	A policy titled "Resident Council", undated, was provided by the DON on 2/17/22 at 3:06 p.m. The policy indicated the following, " ...5. The Resident Council will organize and establish by-laws and elect officers ...7. Minutes will be kept of all meetings ...."			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall	R 0092	***R092*** It is Lake Meadows Assisted Living intention to conduct scheduled fire and disaster drills per ISDH guidelines. All residents and staff have the potential to be affected by this alleged deficient practice. The Regional Operations Director have in-serviced the Executive Director and Maintenance Director on the regulations pertaining to fire and disaster drills. As an initial intervention the community will conduct a	04/08/2022

	be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure fire drills were conducted from February 2021 to January 2022 for 6 of 12 months reviewed. This had the potential to affect 111 residents that resided in the facility. Findings include: The fire drills were provided by the Executive Director on 2/17/22 at 11:00 a.m. The fire drill reports indicated drills were conducted on the following date(s) and shifts: 2/26/21 on 2nd shift, 3/22/21 on 3rd shift, 4/30/21 on 1st shift, 5/29/21 on 2nd shift, 6/23/21 on 3rd shift, & 12/3/21 in-service conducted. A policy titled "Fire Drill Schedule", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated fire drills will occur monthly. Based on interview and record review, the facility failed to ensure fire drills were conducted		fire drill on each shift to ensure understanding and compliance by all. Drills will then be conducted according to the established quarterly schedule. The Maintenance Director will be responsible for completion of the safety drills, maintaining records of drills and completing a drill report to the Executive Director. The Executive Director will be responsible for confirming that these drills take place per schedule and any concerns are addressed and resolved. The Executive Director/designee will review the fire and disaster drill logs monthly for four months. Findings will be reviewed at regularly scheduled QAPI meetings. The Executive Director may also request increased drills or monitoring as needed at any time. Compliance Date is April 8, 2022	

	from February 2021 to January 2022 for 6 of 12 months reviewed. This had the potential to affect 111 residents that resided in the facility. Findings include: The fire drills were provided by the Executive Director on 2/17/22 at 11:00 a.m. The fire drill reports indicated drills were conducted on the following date(s) and shifts: 2/26/21 on 2nd shift, 3/22/21 on 3rd shift, 4/30/21 on 1st shift, 5/29/21 on 2nd shift, 6/23/21 on 3rd shift, & 12/3/21 in-service conducted. A policy titled "Fire Drill Schedule", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated fire drills will occur monthly.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The	R 0116	***0116*** It is Lake Meadows Assisted Living's intention to provide at	04/08/2022

	facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure screening of newly hired employees by not conducting reference checks for 4 of 5 employee files reviewed. ((Housekeeping Staff 5, Licensed Practical Nurse (LPN) 6, Certified Nursing Assistant (CNA) 8 and CNA 9)) Findings include: The employee files for Housekeeping Staff 5, LPN 6, CNA 8, and CNA 9 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain any references. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented. A policy titled "Personnel Files", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Each employee will have a personnel file which may include the following ...4. Minimum of two		least 2 reference checks for all potential employee prior to employment. An audit of all current employees' records is being reviewed. If an employee is found to not have at least 2 reference checks, they will be completed at that time. These reference checks completed will be placed in their personnel file. No residents were noted to be affected by the alleged noncompliance. Going forth, upon completion of interview, prospective employees will have reference checks and completed prior to first day of employment. Each employee file will be checked for completion and signed by the Executive Director/Designee. Monthly audits of employee files will be completed by Executive Director/Designee. and reported at the QA meeting that will be held monthly to ensure compliance with ISDH. QA will continue monthly x 6 months	

	reference checks ...." Based on interview and record review, the facility failed to ensure screening of newly hired employees by not conducting reference checks for 4 of 5 employee files reviewed. ((Housekeeping Staff 5, Licensed Practical Nurse (LPN) 6, Certified Nursing Assistant (CNA) 8 and CNA 9)) Findings include: The employee files for Housekeeping Staff 5, LPN 6, CNA 8, and CNA 9 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain any references. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented. A policy titled "Personnel Files", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Each employee will have a personnel file which may include the following ...4. Minimum of two reference checks ...."		and then quarterly with no end date. If any discrepancy is noted, it will be addressed at time found. The Executive Director/Designee will then re-evaluate if more frequent monitoring is in need and prior to exiting the QA meeting a new schedule will be put into place. Our community, as always, has the intent to be 100% in compliance. Compliance Date is April 8, 2022	

R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical	R 0119	**0119** It is Lake Meadows Assisted Living's intention to provide all employees with orientation specific to job duties training. An Audit of all current employees' records is being reviewed. Orientation specific to job duties training to all staff in the form of Verbal and written in-servicing is scheduled to be completed no later than 4/8/2022. No residents were noted to be affected by the alleged noncompliance. Upon finding of alleged noncompliance Lake Meadows Assisted Living has started a new procedure to assist with ensuring this deficiency does not reoccur. Going forth, new hires will be required to complete Orientation with job specific training as part of their attendance to the monthly face-to-face general orientation. job specific training will be completed within 2 weeks of the general orientation. Every employee will be required to complete job specific training if no documented completion is found. Maintenance of the completion records will be the responsibility of the Executive Director/Designee. Each employee file will be checked for completion and signed by the Executive	04/08/2022

	considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure a record of orientation was kept in the personnel files for newly hired employees for 5 of 5 employee files reviewed. ((Housekeeping Staff 5, Licensed Practical Nurse (LPN) 6, Certified Nursing Assistant (CNA) 8, CNA 9 and CNA 10)) Findings include: The employee files for Housekeeping Staff 5, LPN 6, CNA 8, CNA 9, and CNA 10 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of orientation. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented.		Director/Designee. Monthly audits of employee files will be completed by Executive Director/Designee and reported at the QA meeting that will be held monthly to ensure compliance with ISDH. QA will continue monthly x 6 months and then quarterly with no end date. If any discrepancy is noted, it will be addressed at time found and the Executive Director/Designee will then re-evaluate if more frequent monitoring is in need and prior to exiting QA meeting a new schedule will be put into place. Our community, as always, has the intent to be 100% in compliance Compliance Date is April 8, 2022	

	A policy titled "Personnel Files", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Each employee will have a personnel file which may include the following ...13. Record of orientation and continuing education ...." Based on interview and record review, the facility failed to ensure a record of orientation was kept in the personnel files for newly hired employees for 5 of 5 employee files reviewed. ((Housekeeping Staff 5, Licensed Practical Nurse (LPN) 6, Certified Nursing Assistant (CNA) 8, CNA 9 and CNA 10)) Findings include: The employee files for Housekeeping Staff 5, LPN 6, CNA 8, CNA 9, and CNA 10 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of orientation. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented. A policy titled "Personnel Files", undated, was provided by the Executive Director on 2/17/22 at			

	2:38 p.m. The policy indicated the following, " ...Each employee will have a personnel file which may include the following ...13. Record of orientation and continuing education ...."			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of	R 0120	**0120** It is Lake Meadows Assisted Living's intention to provide all employees with an organized in-service education and training program specific to state requirements. An Audit of all current employees' records is being reviewed. In-service education schedule is being developed for all staff in the form of written in-servicing is scheduled to be completed no later than 4/8/2022. No residents were noted to be affected by the alleged noncompliance. Upon finding of alleged noncompliance Lake Meadows Assisted Living has started a new procedure to assist with ensuring this deficiency does not reoccur. Going forth, new hires will be required to complete education specific education as part of their	04/08/2022

	cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure resident rights and dementia training was documented as provided upon hire and continued thereafter for annual training for 8 of 8 employee files reviewed. ((Housekeeping Staff 5, Licensed Practical Nurse (LPN) 6, Certified Nursing Assistant (CNA) 8, CNA 9, CNA 10, CNA 12, CNA 15, and Qualified Medication Aide (QMA) 14)) Findings include: The employee files for Housekeeping Staff 5, LPN 6, CNA 8, CNA 9, and CNA 10 were reviewed on 2/16/22 at		attendance to the monthly face-to-face general ins-services. Every employee will be required to participate in in-service education training. Maintenance of the completion records will be the responsibility of the Executive Director/Designee. Each employee file will be checked for completion and signed by the Executive Director/Designee. Monthly audits of in-service records will be completed by Executive Director/Designee and reported at the QA meeting that will be held monthly to ensure compliance with ISDH. QA will continue monthly x 6 months and then quarterly with no end date. If any discrepancy is noted, it will be addressed at time found and the Executive Director/Designee will then re-evaluate if more frequent monitoring is in need and prior to exiting QA meeting a new schedule will be put into place. Our community, as always, has the intent to be 100% in compliance Compliance	

	4:00 p.m. The files did not contain a record of resident rights training or dementia training conducted upon hire. The employee files for CNA 12, CNA 15, and QMA 14 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of continuing resident rights training or dementia training conducted annually. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented. A policy titled "Personnel Files", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Each employee will have a personnel file which may include the following ...13. Record of orientation and continuing education ...." Based on interview and record review, the facility failed to ensure resident rights and dementia training was documented as provided upon hire and continued thereafter for annual training for 8 of 8 employee files reviewed. ((Housekeeping Staff 5,		Date is April 8, 2022	

Licensed Practical Nurse (LPN) 6, Certified Nursing Assistant (CNA) 8, CNA 9, CNA 10, CNA 12, CNA 15, and Qualified Medication Aide (QMA) 14))

Findings include:

The employee files for Housekeeping Staff 5, LPN 6, CNA 8, CNA 9, and CNA 10 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of resident rights training or dementia training conducted upon hire.

The employee files for CNA 12, CNA 15, and QMA 14 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of continuing resident rights training or dementia training conducted annually.

An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented.

A policy titled "Personnel Files", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Each employee will have a personnel file which may include the following ...13. Record of orientation and continuing

	education ...."			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to	R 0121	***R121*** All residents have the potential to be affected by this alleged deficient practice. It is Lake Meadows Assisted Living's policy and intention to provide new employees a health screen prior to resident contact. This screen shall include a Tuberculin skin test, using the Mantoux method, unless a previous positive reaction can be documented. Upon finding of alleged noncompliance the Community has started a new procedure to assist with assuring deficiency does not reoccur. Going forth, upon employment offer, all employees will be scheduled for a Physical Health Screen and a Tuberculosis skin test. Upon completion of skin test, it will be required	04/08/2022

	complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to provide newly hired staff members a first and second step purified protein derivative (PPD) for 4 of 5 newly hired employee files reviewed and failed to provide annual PPD testing for 3 of 3 additional employee files reviewed. ((Housekeeping Staff 5, Licensed Practical Nurse (LPN) 6, Certified Nursing Assistant (CNA) 8, CNA 9, CNA 12, CNA 15, and Qualified Medication Aide (QMA) 14)) Findings include: The employee files for Housekeeping Staff 5, LPN 6, CNA 8, and CNA 9 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of a first and second step PPD conducted after hire. The employee files for CNA 12,		that the results are returned to the Executive Director/Designee. The Executive Director/Designee will then determine if a second step process is to be completed. When both steps are completed, a copy of the form will be placed in the employees' file as well as the Physical Health Screen. Annual TB test will be administered to all staff with the exception of anyone with an allergy or has a history of positive reactor, who will submit a chest x-ray, if necessary, every 5 years or with any signs or symptoms of active TB. All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 4/8/2022. The Director of Clinical Services has in-serviced the Executive Director, and Nursing Managers on the TB requirements. The Executive Director/Designee will audit all current employee health records to ensure compliance. Any concerns were promptly addressed. The Executive Director, as coordinator of employee hiring & training processes, will ensure all new hires and	

	CNA 15, and QMA 14 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of an annual PPD being conducted. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented. A policy titled "Mantoux Testing Policy", undated, was provided by the DON on 2/14/22 at 1:00 p.m. the policy indicated the following, " ...All new employees will have a two-step Mantoux test for tuberculosis ...All staff and residents will be retested per state and county guidelines, annually ...." This State finding relates to Complaints IN00369009 and IN00370101. Based on interview and record review, the facility failed to provide newly hired staff members a first and second step purified protein derivative (PPD) for 4 of 5 newly hired employee files reviewed and failed to provide annual PPD testing for 3 of 3 additional employee files reviewed. ((Housekeeping Staff 5, Licensed Practical Nurse (LPN)		current employees remain compliant with this regulation. Each employee file will be checked for completion and signed by the Executive Director/Designee. Monthly audits of employee files will be completed by Executive Director/Designee and reported at the QA meeting that will be held monthly to ensure compliance with ISDH. QA will continue monthly x 6 months and then quarterly with no end date. If any discrepancy is noted, it will be addressed at time found and the Executive Director/Designee will then re-evaluate if more frequent monitoring is in need and prior to exiting QA meeting a new schedule will be put into place. Our community, as always, has the intent to be 100% in compliance Compliance Date is April 8, 2022	

	6, Certified Nursing Assistant (CNA) 8, CNA 9, CNA 12, CNA 15, and Qualified Medication Aide (QMA) 14)) Findings include: The employee files for Housekeeping Staff 5, LPN 6, CNA 8, and CNA 9 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of a first and second step PPD conducted after hire. The employee files for CNA 12, CNA 15, and QMA 14 were reviewed on 2/16/22 at 4:00 p.m. The files did not contain a record of an annual PPD being conducted. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented. A policy titled "Mantoux Testing Policy", undated, was provided by the DON on 2/14/22 at 1:00 p.m. the policy indicated the following, " ...All new employees will have a two-step Mantoux test for tuberculosis ...All staff and residents will be retested per state and county guidelines, annually ...." This State finding relates to			

	Complaints IN00369009 and IN00370101.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record	R 0123	**0123** It is Lake Meadows Assisted Living's intention to maintain current and accurate personnel records for all employees. Upon finding of alleged nonconformance the facility has started a new procedure to assist with assuring this deficiency does not reoccur. No residents were noted to be affected by the alleged deficiency. The Regional Director of Operations has educated the Executive Director of policy and procedures related to employee files and requirements. The Executive Director will reeducate all Managers no later than 4/8/2022 on employee requirements and ISDH guidelines related to license and certification requirements prior to beginning work. All current employee files will be	04/08/2022

	review, the facility failed to ensure employee files contained a licensure and/or certification for 2 of 41 employees at the facility. ((Qualified Medication Aide (QMA) 16 and QMA 17)) Findings include: The employee certificates and licensures were reviewed on 2/16/22 at 4:30 p.m. The certificates could not be located for QMA 16 and QMA 17. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 4:45 p.m., indicated they were unable to locate QMA 16 and QMA 17's certificate on the Professional Licensing Agency website or their employee files. She was unsure if their names were spelled differently to where the certification would be under a different name. It could not be located at that time. A policy titled "Personnel Files", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Each		audited. All employees that are required to have a certification or license will have those items reverified for compliance. Going forth, upon completion of new hire paperwork, employees will be required to provide a copy of certifications and/or license and they will be verified and reviewed during new hire orientation. Employees will not be permitted to begin employment until verification is completed. Each employee file will be checked for completion and signed by the Executive Director/Designee. Monthly audits of employee files will be completed by Executive Director/Designee and reported at the QA meeting that will be held monthly to ensure compliance with ISDH. QA will continue monthly x 6 months and then quarterly with no end date. If any discrepancy is noted, it will be addressed at time found and the Executive Director/Designee will then re-evaluate if more frequent monitoring is in need and prior to exiting QA meeting a new schedule will be put into place. Our community, as always, has the	

	employee will have a personnel file which may include the following ...6. Copy of license or certificates, if applicable ...." Based on interview and record review, the facility failed to ensure employee files contained a licensure and/or certification for 2 of 41 employees at the facility. ((Qualified Medication Aide (QMA) 16 and QMA 17)) Findings include: The employee certificates and licensures were reviewed on 2/16/22 at 4:30 p.m. The certificates could not be located for QMA 16 and QMA 17. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 12:30 p.m., indicated there was no other information that could be located for the personnel files. The previous Executive Director oversaw making sure these items have taken place and documented.		intent to be 100% in compliance Compliance Date is April 8, 2022	

	An interview conducted with the Director of Nursing (DON), on 2/17/22 at 4:45 p.m., indicated they were unable to locate QMA 16 and QMA 17's certificate on the Professional Licensing Agency website or their employee files. She was unsure if their names were spelled differently to where the certification would be under a different name. It could not be located at that time. A policy titled "Personnel Files", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Each employee will have a personnel file which may include the following ...6. Copy of license or certificates, if applicable ...."			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview and record review, the facility failed to ensure resident rooms were clean and in good repair, failed to provide housekeeping services for 5 of 5 residents reviewed, and had the potential	R 0144	It is Lake Meadows Assisted Living intention to conduct regularlyscheduled weekly unit cleaning. All residents have the potential to be affected by this alleged deficient practice. The Regional Operations Director has in-serviced the Executive Director and Housekeeping director on the regulations pertaining to Housekeeping services. As an initial intervention the community will conduct a routine cleaning off all units,	04/08/2022

	to affect all 111 residents in the facility. (Residents B, C, H, K and M) Findings include: An interview conducted with Resident M, on 2/15/22 at 3:30 p.m., indicated no one has cleaned her room for three months since she has moved into the facility. An interview conducted with Resident H, on 2/14/22 at 3:45 p.m., indicated the apartment was supposed to be cleaned every Monday and it hasn't been done since last Monday. The last Monday the staff only cleaned the bathroom. An interview conducted with Resident C, on 2/15/22 at 10:45 a.m., indicated there was a lack of housekeeping staff. They are supposed to clean the rooms weekly and last week someone just swept and mopped the floor. His mother came in to clean the entire room last week. There was a trash bin full of trash in the bathroom along with a brown substance at the bottom of the toilet. A black substance was noted towards the bottom of the shower and debris noted throughout the floors of the apartment of what appear to be marks from his motorized wheelchair. An interview conducted with Resident K, on 2/15/22 at 1:33		then weekly thereafter per facility policy. Housekeeping Supervisor will maintain a documented sign off log for weekly unit cleanings, with documented refusals. The Executive Director/designee will review the housekeeping and cleaning logs monthly for four months. Findings will be reviewed at regularly scheduled QAPI meetings. The Executive Director may also request increased drills or monitoring as needed at any time. Compliance Date is April 8, 2022	

	p.m., indicated there has been a delay in housekeeping cleaning the apartments due to lack of staff. The apartment was not cleaned on a regular basis. The apartment was last cleaned early last week, and the staff only swept the floor. An observation of a loose panel noted underneath the kitchen countertop that was coming out approximately an arm length. Resident K indicated it's been loose for several weeks. The maintenance person knows about it but they haven't fixed it yet. An interview conducted with Resident B, on 2/15/22 at 3:55 p.m., indicated the staff don't always clean the apartment weekly but "they get to it when they can". Resident B indicated his thermostat doesn't work with operating the unit, but he still is able to control the temperature from the unit itself. He has told the maintenance person about it but since I can still control the temperature from the unit, he didn't seem concerned about it. An interview conducted with the Director of Nursing (DON), on 2/16/22 at 4:30 p.m., indicated there was only 1 housekeeper working at this time and there should be 3. He does the common areas and "flip" apartment for new admissions. He hasn't been able to conduct the weekly room cleans. It			

should be conducted because the residents pay for that service.

A policy titled "Housekeeping", undated, was provided by the DON on 2/16/22 at 1:57 p.m. The policy indicated the following, " ...Assisted living dwelling units will be cleaned weekly, unless otherwise noted in a resident's assistance/service plan ...."

Based on observation, interview and record review, the facility failed to ensure resident rooms were clean and in good repair, failed to provide housekeeping services for 5 of 5 residents reviewed, and had the potential to affect all 111 residents in the facility. (Residents B, C, H, K and M)

Findings include:

An interview conducted with Resident M, on 2/15/22 at 3:30 p.m., indicated no one has cleaned her room for three months since she has moved into the facility.

An interview conducted with Resident H, on 2/14/22 at 3:45 p.m., indicated the apartment was supposed to be cleaned every Monday and it hasn't been done since last Monday. The last Monday the staff only cleaned the bathroom.

An interview conducted with

	Resident C, on 2/15/22 at 10:45 a.m., indicated there was a lack of housekeeping staff. They are supposed to clean the rooms weekly and last week someone just swept and mopped the floor. His mother came in to clean the entire room last week. There was a trash bin full of trash in the bathroom along with a brown substance at the bottom of the toilet. A black substance was noted towards the bottom of the shower and debris noted throughout the floors of the apartment of what appear to be marks from his motorized wheelchair. An interview conducted with Resident K, on 2/15/22 at 1:33 p.m., indicated there has been a delay in housekeeping cleaning the apartments due to lack of staff. The apartment was not cleaned on a regular basis. The apartment was last cleaned early last week, and the staff only swept the floor. An observation of a loose panel noted underneath the kitchen countertop that was coming out approximately an arm length. Resident K indicated it's been loose for several weeks. The maintenance person knows about it but they haven't fixed it yet. An interview conducted with Resident B, on 2/15/22 at 3:55 p.m., indicated the staff don't always clean the apartment			

	weekly but "they get to it when they can". Resident B indicated his thermostat doesn't work with operating the unit, but he still is able to control the temperature from the unit itself. He has told the maintenance person about it but since I can still control the temperature from the unit, he didn't seem concerned about it. An interview conducted with the Director of Nursing (DON), on 2/16/22 at 4:30 p.m., indicated there was only 1 housekeeper working at this time and there should be 3. He does the common areas and "flip" apartment for new admissions. He hasn't been able to conduct the weekly room cleans. It should be conducted because the residents pay for that service. A policy titled "Housekeeping", undated, was provided by the DON on 2/16/22 at 1:57 p.m. The policy indicated the following, " ...Assisted living dwelling units will be cleaned weekly, unless otherwise noted in a resident's assistance/service plan ...."			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment	R 0216	**R216** The Director of Nursing assessed the two identified residents needing a medication self-administration evaluation and updated their plan	04/08/2022

	shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview and record review, the facility failed to ensure residents were evaluated to self-administer their medications for 2 of 5 residents observed with medications in their room. (Resident B and Resident C) Findings include: 1. An observation conducted on 2/15/22 at 3:55 p.m., of Resident B's apartment and he showed writer a bottle of multivitamins labeled Centrum Silver and a bottle containing baby Aspirin. He indicated he doesn't take any medications but a family member of his believes he should take these items to keep up with his health. Resident B indicated he takes them on occasion and "doesn't		of care. The Director of Nursing/designee will audit all resident records to ensure that a self-administration evaluation had been completed and the plan of care updated. Any identified concerns will be corrected if discovered. The Director of Clinical Services has reviewed and educated the nursing leadership and licensed nurses on the Community’s Self Administration of Medication protocols and procedures including use of the designated assessment form, process for determining when a review is necessary and means of monitoring for needed changes. Nurse leaders will also review with the resident during their regularly scheduled ISP reviews. The Director of Nursing/designee will audit resident records for compliance with the self-administration guidelines as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee. Compliance Date is April 8, 2022	

always remember to take them".

The clinical record for Resident B was reviewed on 2/16/22 at 3:15 p.m. The diagnoses included, but was not limited to, alcohol abuse, hypertension, and heart failure.

A "Level of Care" document, dated 12/14/21, indicated Resident B needed caregiver administration of medications around the clock need.

A physician order, dated 6/3/21, noted for Aspirin 81 milligrams daily.

A physician order, dated 6/3/21, noted for multivitamin daily.

2. An observation conducted on 2/15/22 at 10:45 a.m., of Resident C's apartment and noted a bottle containing Debrox ear drops. Resident C indicated the staff administers his medications, but he has attempted to administer ear drops. When he feels like his ears are becoming irritated, due to him having frequent buildup of ear wax, he will start to administer the ear drops to himself.

The clinical record for Resident C was reviewed on 2/16/22 at 11:00 a.m. The diagnoses included, but was not limited to, chronic pain and neurofibromatosis.

	A physician order, dated from 12/17/21, for Debrox drops to both ears. The order was completed on 12/21/21. There was no current order for Debrox drops for Resident C. A service plan regarding medications, dated 6/22/21, indicated medications will be administered by licensed or certified team members. An interview with the Director of Nursing (DON), on 2/16/22 at 12:30 p.m., indicated Resident B and Resident C do not self-administer their medications and should not have medications in their room. A policy titled "Medication Policy", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Self-Administration of Medications ...Residents who elect not to participate in the Medication Management Program are solely responsible for dispensing and administering their own medication, including injectables, and must meet the following requirements ...Have written approval from their physician ...Participate in an Evaluation for Self-Administration to determine whether the resident can safely manage his/her own medications ...."			

This State finding relates to Complaint IN00362610.

Based on observation, interview and record review, the facility failed to ensure residents were evaluated to self-administer their medications for 2 of 5 residents observed with medications in their room. (Resident B and Resident C)

Findings include:

1. An observation conducted on 2/15/22 at 3:55 p.m., of Resident B's apartment and he showed writer a bottle of multivitamins labeled Centrum Silver and a bottle containing baby Aspirin. He indicated he doesn't take any medications but a family member of his believes he should take these items to keep up with his health. Resident B indicated he takes them on occasion and "doesn't always remember to take them".

The clinical record for Resident B was reviewed on 2/16/22 at 3:15 p.m. The diagnoses included, but was not limited to, alcohol abuse, hypertension, and heart failure.

A "Level of Care" document, dated 12/14/21, indicated Resident B needed caregiver administration of medications around the clock need.

A physician order, dated 6/3/21, noted for Aspirin 81 milligrams

daily.

A physician order, dated 6/3/21, noted for multivitamin daily.

2. An observation conducted on 2/15/22 at 10:45 a.m., of Resident C's apartment and noted a bottle containing Debrox ear drops. Resident C indicated the staff administers his medications, but he has attempted to administer ear drops. When he feels like his ears are becoming irritated, due to him having frequent buildup of ear wax, he will start to administer the ear drops to himself.

The clinical record for Resident C was reviewed on 2/16/22 at 11:00 a.m. The diagnoses included, but was not limited to, chronic pain and neurofibromatosis.

A physician order, dated from 12/17/21, for Debrox drops to both ears. The order was completed on 12/21/21. There was no current order for Debrox drops for Resident C.

A service plan regarding medications, dated 6/22/21, indicated medications will be administered by licensed or certified team members.

An interview with the Director of Nursing (DON), on 2/16/22 at 12:30 p.m., indicated Resident B and Resident C do not

	self-administer their medications and should not have medications in their room. A policy titled "Medication Policy", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...Self-Administration of Medications ...Residents who elect not to participate in the Medication Management Program are solely responsible for dispensing and administering their own medication, including injectables, and must meet the following requirements ...Have written approval from their physician ...Participate in an Evaluation for Self-Administration to determine whether the resident can safely manage his/her own medications ...." This State finding relates to Complaint IN00362610.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to	R 0247	**R 247** Upon the discovery of this allegation of deficiency, Lake Meadows Assisted Living immediately began an investigation. Upon investigation it was discovered that all Nursing staff that handle medications should be re-educated on medication policy and procedures,	04/08/2022

	ensure medications administered were consistent with physician orders for 2 of 5 residents reviewed for medication administration. (Resident H and Resident L) Findings include: 1. The clinical record for Resident H was reviewed on 2/16/22 at 12:49 p.m. The diagnoses included, but were not limited to, anxiety disorder and insomnia. A physician order, dated 12/23/21, was noted for Ambien 10 milligrams at bedtime related to insomnia. A "Controlled Drug Use Record" was noted for Ambien 5 milligram tablet to take at bedtime. Resident H did not have a physician order for Ambien 5 milligram in the electronic clinical record to note on the electronic medication administration record. The following administrations were signed off, as given, for Resident H's Ambien 5 milligram tablet: 12/26/21, 12/27/21, 12/28/21,		including order verification, re-order policy and procedures, proper medication administration including timely administration, medication parameters, Insulin administration policy and procedures, which includes infection control for glucose testing/Glucometer sanitation. To ensure deficiency does not reoccur, going forth, all Nursing staff that handle medication will have education to include that proper medication administration, medication policy and procedures, order verification, re-order policy and procedures, proper medication administration including timely administration, medication parameters, Insulin administration policy and procedures, which includes infection control for glucose testing/Glucometer sanitation. Lake Meadows Assisted Living will provide education to all Licensed nurses and Qualified Medication Aides no later than4/8/2022 in the form of Verbal and written in-servicing, including following MD/NP orders that includes guidelines for medication administration timeframes of an hour before and an hour after scheduled administration times, Documentation guidelines and PCA pharmacy's Guidelines on medication administration, ordering medication, insulin	

	12/29/21, 12/30/21, 12/31/21, 1/2/22, 1/3/22, 1/4/22, 1/5/22, 1/7/22, 1/8/22, 1/9/22 & 1/10/22. 2. The clinical record for Resident L was reviewed on 2/16/22 at 2:38 p.m. The diagnoses included, but were not limited to, cerebral infarction, diabetes mellitus and hypertension. A physician order was noted for hydralazine (blood pressure medication) 100 milligrams three times daily. There were special instructions to hold the medication if the systolic blood pressure was less than 120. The electronic medication administration record for January of 2022 was reviewed. The following date(s) and time(s) were noted when Resident L received the		administration and glucometer sanitation. The Director of Clinical Services has reviewed and reeducated the nursing leadership on the Community's Infection control policy and procedures and Medication policy and procedures. Lake Meadows Assisted Living has PCA Pharmacy scheduled for in-services for re-education of all staff that are qualified to administer medication and/or Insulin to be completed no later than 4/8/2022. The Director of Nursing/designee will audit resident records for compliance withmedication administration guidelines as follows: 3 times weekly for one month; 2 times weekly for two months and weekly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee. Compliance Date is April 8, 2022	

	medication even when the systolic blood pressure remained below 120: 1/1/22 at 5:00 p.m., 1/9/22 at 12:00 p.m., 1/19/22 at 8:00 a.m., 1/21/22 at 8:00 a.m., 1/28/22 at 8:00 am., 1/28/22 at 12:00 p.m., & 1/29/22 at 5:00 p.m. A policy titled "Medication Policy", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, "...Medicine is to be taken regularly by the resident, as prescribed by his/her physician...." This State finding relates to Complaints IN00362610, IN00364918, IN00366077, IN00369009, and IN00370101. Based on interview and record review, the facility failed to ensure medications administered were consistent with physician orders for 2 of 5 residents reviewed for medication administration. (Resident H and Resident L) Findings include:			

	1. The clinical record for Resident H was reviewed on 2/16/22 at 12:49 p.m. The diagnoses included, but were not limited to, anxiety disorder and insomnia. A physician order, dated 12/23/21, was noted for Ambien 10 milligrams at bedtime related to insomnia. A "Controlled Drug Use Record" was noted for Ambien 5 milligram tablet to take at bedtime. Resident H did not have a physician order for Ambien 5 milligram in the electronic clinical record to note on the electronic medication administration record. The following administrations were signed off, as given, for Resident H's Ambien 5 milligram tablet: 12/26/21, 12/27/21, 12/28/21, 12/29/21, 12/30/21, 12/31/21, 1/2/22,			

	1/3/22, 1/4/22, 1/5/22, 1/7/22, 1/8/22, 1/9/22 & 1/10/22. 2. The clinical record for Resident L was reviewed on 2/16/22 at 2:38 p.m. The diagnoses included, but were not limited to, cerebral infarction, diabetes mellitus and hypertension. A physician order was noted for hydralazine (blood pressure medication) 100 milligrams three times daily. There were special instructions to hold the medication if the systolic blood pressure was less than 120. The electronic medication administration record for January of 2022 was reviewed. The following date(s) and time(s) were noted when Resident L received the medication even when the systolic blood pressure remained below 120: 1/1/22 at 5:00 p.m., 1/9/22 at 12:00 p.m.,			

	1/19/22 at 8:00 a.m., 1/21/22 at 8:00 a.m., 1/28/22 at 8:00 am., 1/28/22 at 12:00 p.m., & 1/29/22 at 5:00 p.m. A policy titled "Medication Policy", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, "...Medicine is to be taken regularly by the resident, as prescribed by his/her physician...." This State finding relates to Complaints IN00362610, IN00364918, IN00366077, IN00369009, and IN00370101.			
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 proper food storage in the main refrigerator. This had the potential to affect all 111 residents that reside in	R 0273	It is Lake Meadows Assisted Living intention that all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling standards. All residents have the potential to be affected by this alleged deficient practice.	04/08/2022

	the facility. Findings include: An observation was conducted on 2/14/22 at 12:05 p.m. of the kitchen with the Chef. The main refrigerator had two racks that contained food items that were being stored. The first rack had the following items noted in the following order: Cooked bacon on the top rack, Raw bacon on the second rack, Cooked ham below, Cabbage rolls below, & Cooked ham, caramelized onions with no date, and marinated raw meat with no date on the same rack. The second rack had the following items noted in the following order: Three raw loins of pork at the top, Raw beef tips below the loins of pork, & A bag of cooked chicken cubes underneath the raw beef tips.		The Executive Director educated the Director of Food Services on the regulations pertaining to safe food handling and storage. As an initial intervention the community assessed all refrigeration units to ensure all uncooked meat is properly stored. In-service education provided to all Dietary staff on on safe food handling and storage per facility policy on or before 04/08/2022. Audits of all refrigerationunitswill be completed by the Food Service Director or Designee 3 x a week times 4 weeks. Then monthly x 3 months. The Executive Director/designee will review the food storage and handling audit logs monthly for four months. Findings will be reviewed at regularly scheduled QAPI meetings. The Executive Director may also request increased audits or monitoring as needed at any time. Compliance Date is April 8, 2022	

	An interview conducted with the Chef during the observation indicated the raw food should not have been stacked on top of the cooked food. A policy titled "Storage of Refrigerated and Dry Foods", undated, was provided by the Director of Nursing on 2/16/22 at 1:57 p.m. The policy indicated the following, " ...3. Raw meat is never to be stored above cooked foods, fruits, or vegetables ...." Based on observation, interview and record review, the facility failed to ensure proper food storage in the main refrigerator. This had the potential to affect all 111 residents that reside in the facility. Findings include: An observation was conducted on 2/14/22 at 12:05 p.m. of the kitchen with the Chef. The main refrigerator had two racks that contained food items that were being stored. The first rack had the following items noted in the following order: Cooked bacon on the top rack, Raw bacon on the second rack, Cooked ham below, Cabbage rolls below, & Cooked ham, caramelized			

	onions with no date, and marinated raw meat with no date on the same rack. The second rack had the following items noted in the following order: Three raw loins of pork at the top, Raw beef tips below the loins of pork, & A bag of cooked chicken cubes underneath the raw beef tips. An interview conducted with the Chef during the observation indicated the raw food should not have been stacked on top of the cooked food. A policy titled "Storage of Refrigerated and Dry Foods", undated, was provided by the Director of Nursing on 2/16/22 at 1:57 p.m. The policy indicated the following, " ...3. Raw meat is never to be stored above cooked foods, fruits, or vegetables ...."			

R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were obtained and administered per physician orders for 3 of 5 residents reviewed for medication administration. (Resident H, C and K) Findings include: 1. The clinical record for Resident H was reviewed on 2/16/22 at 12:49 p.m. The diagnoses included, but was not limited to, diarrhea, anemia, congestive heart failure, and acute kidney failure. A physician order, dated 3/1/21, noted the following, " ...Lomotil Tablet 2.5-0.025 MG [milligrams] Give 1 tablet by mouth every 8 hours as needed for irritable bowel AND give 1 tablet by mouth three times a day for irritable bowel ...."	R 0297	**R 297** Upon the discovery of this allegation of deficiency, Lake Meadows Assisted Living immediately began an investigation. Upon investigation it was discovered that all Nursing staff that handle medications should be re-educated on medication policy and procedures, including order verification, re-order policy and procedures, proper medication administration including timely administration, medication parameters, Insulin administration policy and procedures, which includes infection control for glucose testing/Glucometer sanitation. To ensure deficiency does not reoccur, going forth, all Nursing staff that handle medication will have education to include that proper medication administration, medication policy and procedures, order verification, re-order policy and procedures, proper medication administration including timely administration, medication parameters, Insulin administration policy and procedures, which includes infection control for glucose testing/Glucometer sanitation. Lake Meadows Assisted Living will provide education to all Licensed nurses and Qualified	04/08/2022

	The "Controlled Drug Use Record" for Resident H's Lomotil noted the following date(s) where the medication wasn't signed off, as administered, for three times daily: 12/28/21- only given twice, 12/31/21- not given at all, 1/1/22- not given at all, 1/2/22- only given twice, 1/5/22- only given twice, 1/10/22- only given twice, 1/11/22- only given twice, 1/13/22- only given twice, 1/15/22- only given twice, 1/17/22- only given twice, 1/18/22- only given twice, 1/19/22- only given twice, 1/29/22- only given twice, 1/30/22- only given twice, 1/31/22- only given twice, 2/1/22- only given once, 2/3/22- only given twice & 2/4/22- only given twice. 2. The clinical record for		Medication Aides no later than 4/8/2022 in the form of Verbal and written in-servicing, including following MD/NP orders that includes guidelines for medication administration timeframes of an hour before and an hour after scheduled administration times, Documentation guidelines and PCA pharmacy's Guidelines on medication administration, ordering medication, insulin administration and glucometer sanitation. The Director of Clinical Services has reviewed and reeducated the nursing leadership on the Community's Infection control policy and procedures and Medication policy and procedures. Lake Meadows Assisted Living has PCA Pharmacy scheduled for in-services for re-education of all staff that are qualified to administer medication and/or Insulin to be completed no later than 4/8/2022. The Director of Nursing/designee will audit resident records for compliance withmedication administration guidelines as follows: 3 times weekly for one month; 2 times weekly for two months and weekly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the	

	Resident C was reviewed on 2/16/22 at 11:00 a.m. The diagnoses included, but was not limited to, chronic pain, neuropathy, and neurofibromatosis. A physician order was noted for Oxycontin 30 milligrams twice daily. A "Controlled Drug Use Record", dated 12/20/21, indicated the last dose of Oxycontin was administered on 1/9/22. The next record, dated 1/11/22, indicated Resident C didn't receive the next dose of scheduled Oxycontin until 1/12/22 at 8:00 a.m. The last dose of Oxycontin in the package was given on 1/26/22 at 8:00 p.m. Another "Controlled Drug Use Record", dated 1/28/22, for Resident C's Oxycontin indicated he didn't receive the next scheduled dose until 1/29/22 at 9:00 a.m. There was a 2 day gap to where Resident C didn't receive his scheduled dose of Oxycontin. An interview conducted with Resident C on 2/15/22 at 10:45 a.m., indicated he will go 2 days without his scheduled Oxycontin when he runs out of the supply and the facility needs to obtain a prescription for additional doses of the medication. 3. The clinical record for		QAPI Committee. Compliance Date is April 8, 2022	

Resident K was reviewed on 2/16/22 at 3:00 p.m. The diagnoses included, but were not limited to, major depression, low back pain and neuropathy.

An interview conducted with Resident K, on 2/15/22 at 1:33 p.m., indicated she takes scheduled pain medication, and she has gone without it at times.

A physician's order was noted for hydrocodone/acetaminophen 10-325 milligrams, 1 tablet four times a day.

A "Controlled Drug Use Record" for Resident K's hydrocodone/acetaminophen tablet noted the following date(s) where the medication wasn't signed off, as administered, for four times daily:

1/18/22- only given three times &

2/2/22- only given three times.

A policy titled "Medication Policy", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, "...Service includes...Delivering medications to resident within acceptable time parameters...Monthly ordering and delivery from our Preferred Pharmacy...Obtaining doctor's orders for refills...Maintaining written records of medication

	orders and supervised assistance or administration...." This State finding relates to Complaints IN00362610, IN00364918, IN00366077, IN00369009, IN00370101, and IN00373321. Based on interview and record review, the facility failed to ensure medications were obtained and administered per physician orders for 3 of 5 residents reviewed for medication administration. (Resident H, C and K) Findings include: 1. The clinical record for Resident H was reviewed on 2/16/22 at 12:49 p.m. The diagnoses included, but was not limited to, diarrhea, anemia, congestive heart failure, and acute kidney failure. A physician order, dated 3/1/21, noted the following, " ...Lomotil Tablet 2.5-0.025 MG [milligrams] Give 1 tablet by mouth every 8 hours as needed for irritable bowel AND give 1 tablet by mouth three times a day for irritable bowel ...."			

	The "Controlled Drug Use Record" for Resident H's Lomotil noted the following date(s) where the medication wasn't signed off, as administered, for three times daily: 12/28/21- only given twice, 12/31/21- not given at all, 1/1/22- not given at all, 1/2/22- only given twice, 1/5/22- only given twice, 1/10/22- only given twice, 1/11/22- only given twice, 1/13/22- only given twice, 1/15/22- only given twice, 1/17/22- only given twice, 1/18/22- only given twice, 1/19/22- only given twice, 1/29/22- only given twice, 1/30/22- only given twice, 1/31/22- only given twice, 2/1/22- only given once, 2/3/22- only given twice & 2/4/22- only given twice. 2. The clinical record for			

	Resident C was reviewed on 2/16/22 at 11:00 a.m. The diagnoses included, but was not limited to, chronic pain, neuropathy, and neurofibromatosis. A physician order was noted for Oxycontin 30 milligrams twice daily. A "Controlled Drug Use Record", dated 12/20/21, indicated the last dose of Oxycontin was administered on 1/9/22. The next record, dated 1/11/22, indicated Resident C didn't receive the next dose of scheduled Oxycontin until 1/12/22 at 8:00 a.m. The last dose of Oxycontin in the package was given on 1/26/22 at 8:00 p.m. Another "Controlled Drug Use Record", dated 1/28/22, for Resident C's Oxycontin indicated he didn't receive the next scheduled dose until 1/29/22 at 9:00 a.m. There was a 2 day gap to where Resident C didn't receive his scheduled dose of Oxycontin. An interview conducted with Resident C on 2/15/22 at 10:45 a.m., indicated he will go 2 days without his scheduled Oxycontin when he runs out of the supply and the facility needs to obtain a prescription for additional doses of the medication. 3. The clinical record for			

Resident K was reviewed on 2/16/22 at 3:00 p.m. The diagnoses included, but were not limited to, major depression, low back pain and neuropathy.

An interview conducted with Resident K, on 2/15/22 at 1:33 p.m., indicated she takes scheduled pain medication, and she has gone without it at times.

A physician's order was noted for hydrocodone/acetaminophen 10-325 milligrams, 1 tablet four times a day.

A "Controlled Drug Use Record" for Resident K's hydrocodone/acetaminophen tablet noted the following date(s) where the medication wasn't signed off, as administered, for four times daily:

1/18/22- only given three times &

2/2/22- only given three times.

A policy titled "Medication Policy", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, "...Service includes...Delivering medications to resident within acceptable time parameters...Monthly ordering and delivery from our Preferred Pharmacy...Obtaining doctor's orders for refills...Maintaining written records of medication

	orders and supervised assistance or administration...." This State finding relates to Complaints IN00362610, IN00364918, IN00366077, IN00369009, IN00370101, and IN00373321.			
R 0301	Pharmaceutical Services - Deficiency 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 medications that were stored in the medication cart were properly labeled for 1	R 0301	**R 301** It is Lake Meadows Assisted Living's intention to store and labeled all medications appropriately. PCA Pharmacy will conduct regular reviews at least monthly on these procedures and that medication is being stored and labeled appropriately. No residents were noted to be affected by the alleged deficiency. Upon finding of alleged deficiency Lake Meadows Assisted Living has reviewed and requested re-education of these procedures from PCA Pharmacy. PCA Pharmacy will provided In-Service training to all staff that handle medication no later than 4/8/2022. Going forth, the Director of Nursing/Designee will monitor that medication	04/08/2022

	of 3 medication carts observed. (Resident N) Findings include: An observation conducted of medication cart 1 with Licensed Practical Nurse (LPN) 2, on 2/15/22 at 12:10 p.m., noted a clear, orange bottle containing white, oval pills. There was no drug name, dosage, or prescription number on the bottle. There was Resident N's name with what LPN 2 described as staff initials. LPN 2 indicated the staff must have put those pills in a separate bottle to make it easier to conduct the narcotic count. Resident N doesn't take this medication very often and she identified the medication as Tramadol. There was another bottle that was labeled appropriately with Resident N's information and contained Tramadol. The clinical record for Resident N was reviewed on 2/17/22 at 1:50 p.m. The diagnoses included but was not limited to dementia and fibromyalgia. A physician order, dated 11/1/21, was noted for Tramadol 50 milligrams every 8 hours as needed for pain. A policy titled "Medication Policy", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy		stored and labeled per ISDH guidelines. The Director of Nursing/designee will audit medication carts for compliance withmedication storage and labeling guidelines as follows: 3 times weekly for one month; 2 times weekly for two months and weekly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee. Compliance Date is April 8, 2022	

	indicated the following, " ...All drug containers/medications shall be labeled and drug labels must be clear, consistent, legible and in compliance with state and federal requirements. Medications must be appropriately and safely labeled ...." This State finding relates to Complaints IN00362610 and IN00370101. Based on observation, interview and record review, the facility failed to ensure medications that were stored in the medication cart were properly labeled for 1 of 3 medication carts observed. (Resident N) Findings include: An observation conducted of medication cart 1 with Licensed Practical Nurse (LPN) 2, on 2/15/22 at 12:10 p.m., noted a clear, orange bottle containing white, oval pills. There was no drug name, dosage, or prescription number on the bottle. There was Resident N's name with what LPN 2 described as staff initials. LPN 2 indicated the staff must have put those pills in a separate bottle to make it easier to conduct the narcotic count. Resident N doesn't take this medication very often and she identified the medication as Tramadol. There was another			

	bottle that was labeled appropriately with Resident N's information and contained Tramadol. The clinical record for Resident N was reviewed on 2/17/22 at 1:50 p.m. The diagnoses included but was not limited to dementia and fibromyalgia. A physician order, dated 11/1/21, was noted for Tramadol 50 milligrams every 8 hours as needed for pain. A policy titled "Medication Policy", undated, was provided by the Executive Director on 2/17/22 at 2:38 p.m. The policy indicated the following, " ...All drug containers/medications shall be labeled and drug labels must be clear, consistent, legible and in compliance with state and federal requirements. Medications must be appropriately and safely labeled ...." This State finding relates to Complaints IN00362610 and IN00370101.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated	R 0349	**R 349** It is the intent of Lake Meadows Assisted Living to recognize and address a resident's change of condition timely and ensure their	04/08/2022

	with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, interview and record review, the facility failed to have documentation of a resident's impaired skin integrity requiring the need for contracted wound care that was being treated for osteomyelitis and failed to have documentation of open areas to a resident's bilateral knees that occurred post fall incident for 2 of 12 residents interviewed for documentation. (Resident C and Resident H) Findings include: 1. The clinical record for Resident H was reviewed on 2/16/22 at 12:49 p.m. The diagnoses included, but were not limited to, osteomyelitis of right ankle and foot, diabetes mellitus, and polyneuropathy. There were no diagnoses related to any skin impairment. A Brief Interview for Mental Status (BIMS) assessment, dated 12/13/21, noted Resident H to be cognitively intact. A physician order, dated		plan of care is followed and appropriate interventions used to meet the resident's needs. All residents have the potential to be affected by this alleged deficiency. The facility's leadership team has reviewed the facility's policies and procedures regarding assessments, creation and updating of plans of care, and general monitoring of residents for changes of condition. Current deficiencies were identified, and current practices updated in consideration of this deficiency and facility protocols. The Director of Nursing will audit and any resident that is identified with a skin issue with have documented skin assessments completed. Staff will be reeducated, and in-servicing will be provided by the Director of Nursing to all nursing staff no later than 4/8/2022. The Director of Nursing will retrain clinical staff on monitoring of residents for skin conditions, per facility policy, and	

	12/20/21, was noted for Vancomycin (antibiotic) 125 milligrams four times daily for osteomyelitis that was a current order. An interview conducted with Resident H, on 2/14/22 at 3:45 p.m., indicated he has a chronic wound to his left heel that started out as a blister. He has scheduled visits with a wound care nurse on Monday, Wednesday, and Fridays. She comes in the afternoon time after his dialysis appointments and has the supplies in hand. He sees a wound doctor as well. He was told the wound is improving but it's slow to heal. There was no documentation in the clinical record about Resident H having a chronic wound or needing assistance of an outside wound care nurse and/or physician. There was nothing reflected on his service plan. There were no physician orders for wound care noted. 2. The clinical record for Resident C was reviewed on 2/16/22 at 11:00 a.m. The diagnoses included, but were not limited to, edema, chronic pain, neuropathy, and neurofibromatosis. A BIMS assessment, dated 12/13/21, noted Resident C to be cognitively intact.		required notifications and/or interventions when such changes are noted. Clinical staff will also be in-serviced on use of plan of care documents to ensure consistent delivery of care including documenting and monitoring skin issues. In addition, the Executive Director/Director of Nursing will review the 24/72 hours reports on a timely basis for noted changes of skin and appropriate follow up by nursing staff. Compliance will be monitored by use of an audit process and tracking form. The Director of Nursing/designee will conduct an audit of 10% of the current resident’s charts as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Audit will note any changes of skin condition, if resolved and outside service follow up. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure compliance. Findings will be reported to the quarterly QAPI Committee for review and	

	An interview conducted with Resident C, on 2/15/22 at 10:45 a.m., indicated he had fallen recently in his room. His knees "gave out" and he had landed on them and now they were sore. He proceeded to pull up the bottom part of his pants and noted a quarter sized open area to each knee. He was unsure of when the areas opened initially. When he told someone about it, they said he would get referred to the wound center, but he hasn't seen anyone nor has anyone applied treatments to the areas. The areas were open and dark red. There was no documentation in Resident C's clinical record about open areas to his bilateral knees. Resident C's service plan, dated 12/13/21, indicated he needed assistance with dressing, grooming, hygiene, and bathing. There were interventions listed to check skin with bath/shower and report any skin concerns to the nurse. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 4:45 p.m., indicated there is a binder that is filled out by the wound care nurse when she comes. The binder was reviewed and didn't appear completed with visits occurring three days a week for Resident H. She was unaware of		recommendations Compliance Date is April 8, 2022	

	Resident C having any skin alterations beside an area to his toe that was noted after he had fallen. If there is a minor injury the nursing staff will treat in-house but if it requires more than first aid, then we will refer to the wound nurse to come and treat. She believes there should have been a reference to Resident H having a chronic wound in the clinical record. Based on observation, interview and record review, the facility failed to have documentation of a resident's impaired skin integrity requiring the need for contracted wound care that was being treated for osteomyelitis and failed to have documentation of open areas to a resident's bilateral knees that occurred post fall incident for 2 of 12 residents interviewed for documentation. (Resident C and Resident H) Findings include: 1. The clinical record for Resident H was reviewed on 2/16/22 at 12:49 p.m. The diagnoses included, but were not limited to, osteomyelitis of right ankle and foot, diabetes mellitus, and polyneuropathy. There were no diagnoses related to any skin impairment. A Brief Interview for Mental Status (BIMS) assessment, dated 12/13/21, noted Resident			

H to be cognitively intact.

A physician order, dated 12/20/21, was noted for Vancomycin (antibiotic) 125 milligrams four times daily for osteomyelitis that was a current order.

An interview conducted with Resident H, on 2/14/22 at 3:45 p.m., indicated he has a chronic wound to his left heel that started out as a blister. He has scheduled visits with a wound care nurse on Monday, Wednesday, and Fridays.

She comes in the afternoon time after his dialysis appointments and has the supplies in hand. He sees a wound doctor as well. He was told the wound is improving but it's slow to heal.

There was no documentation in the clinical record about Resident H having a chronic wound or needing assistance of an outside wound care nurse and/or physician. There was nothing reflected on his service plan. There were no physician orders for wound care noted.

2. The clinical record for Resident C was reviewed on 2/16/22 at 11:00 a.m. The diagnoses included, but were not limited to, edema, chronic pain, neuropathy, and neurofibromatosis.

A BIMS assessment, dated

	12/13/21, noted Resident C to be cognitively intact. An interview conducted with Resident C, on 2/15/22 at 10:45 a.m., indicated he had fallen recently in his room. His knees "gave out" and he had landed on them and now they were sore. He proceeded to pull up the bottom part of his pants and noted a quarter sized open area to each knee. He was unsure of when the areas opened initially. When he told someone about it, they said he would get referred to the wound center, but he hasn't seen anyone nor has anyone applied treatments to the areas. The areas were open and dark red. There was no documentation in Resident C's clinical record about open areas to his bilateral knees. Resident C's service plan, dated 12/13/21, indicated he needed assistance with dressing, grooming, hygiene, and bathing. There were interventions listed to check skin with bath/shower and report any skin concerns to the nurse. An interview conducted with the Director of Nursing (DON), on 2/17/22 at 4:45 p.m., indicated there is a binder that is filled out by the wound care nurse when she comes. The binder was reviewed and didn't appear			

	completed with visits occurring three days a week for Resident H. She was unaware of Resident C having any skin alterations beside an area to his toe that was noted after he had fallen. If there is a minor injury the nursing staff will treat in-house but if it requires more than first aid, then we will refer to the wound nurse to come and treat. She believes there should have been a reference to Resident H having a chronic wound in the clinical record.			
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 ensure to properly	R 0407	**R 0407** It is Lake Meadows Senior Assisted Living's intention to provide every resident with a safe, sanitary and comfortable environment and help prevent the development and transmission of diseases and infection. Upon the discovery of this allegation of noncompliance, Lake Meadows Assisted Living immediately began an investigation. Upon investigation it was discovered that all Nursing staff that handle Insulin should be re-educated on infection control and injectable medication policy and procedures, including cleaning of Glucometers.	04/08/2022

	disinfect glucometers in-between use for 2 of 3 residents reviewed for insulin administration. (Resident P and Resident Q) Findings include: A medication administration observation was conducted with Licensed Practical Nurse (LPN) 2 on 2/15/22 at 11:43 a.m. LPN 2 proceeded to clean the glucometer with an alcohol prep pad. She went into Resident Q's room and obtained a blood glucose and recorded such in the computer. LPN 2 then cleaned the glucometer with an alcohol prep pad before obtaining Resident P's blood glucose and recorded such in the computer. An interview conducted with the Director of Nursing (DON), on 2/16/22 at 12:30 p.m., indicated nursing staff should have utilized a PDI (brand of disinfectant) wipe to clean the glucometer and not an alcohol prep wipe. A policy titled "Cleaning and Disinfecting Blood Glucose Meter", undated, was provided by the DON on 2/16/22 at 1:57 p.m. The policy indicated to clean and disinfect by utilizing a commercially available EPA-registered disinfectant detergent or germicide wipe. This State finding relates to		To ensure deficiency does not reoccur, going forth, all Nursing staff that handle Insulin will have education to include that proper medication administration, medication policy and procedures, including Insulin administration policy and procedures, which includes infection control for glucose testing/Glucometer sanitation. Lake Meadows Assisted Living will provide education to all Licensed nurses and Qualified Medication Aides no later than 4/8/2022 in the form of Verbal and written in-servicing. PCA pharmacy's Guidelines on insulin administration will include proper administration procedures for Insulin pens. All staff will be required to complete re-education will be conducted by the Director of Clinical Services/ Designee in the form of verbal and written in-servicing no later than 4/8/2022. The Director of Clinical Services has reviewed and reeducated the nursing leadership on the Community's Infection control, Medication policy and procedures. Lake Meadows Assisted Living has PCA Pharmacy scheduled for	

Complaint IN00370101.

Based on observation, interview and record review, the facility failed to ensure to properly disinfect glucometers in-between use for 2 of 3 residents reviewed for insulin administration. (Resident P and Resident Q)

Findings include:

A medication administration observation was conducted with Licensed Practical Nurse (LPN) 2 on 2/15/22 at 11:43 a.m. LPN 2 proceeded to clean the glucometer with an alcohol prep pad. She went into Resident Q's room and obtained a blood glucose and recorded such in the computer. LPN 2 then cleaned the glucometer with an alcohol prep pad before obtaining Resident P's blood glucose and recorded such in the computer.

An interview conducted with the Director of Nursing (DON), on 2/16/22 at 12:30 p.m., indicated nursing staff should have utilized a PDI (brand of disinfectant) wipe to clean the glucometer and not an alcohol prep wipe.

A policy titled "Cleaning and Disinfecting Blood Glucose Meter", undated, was provided by the DON on 2/16/22 at 1:57 p.m. The policy indicated to clean and disinfect by utilizing a

in-services for re-education of all staff that are qualified to administer medication and/or Insulin to be completed no later than 4/8/2022.

The Director of Nursing/designee will audit resident records for compliance with Insulin administration, Glucometer cleaning, and Infection control guidelines. Randomly observing staff for compliance as follows: 3 times weekly for one month; 2 times weekly for two months and weekly thereafter times 3 months. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee.

Compliance Date is April 8, 2022

	commercially available EPA-registered disinfectant detergent or germicide wipe. This State finding relates to Complaint IN00370101.			

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