STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNITY	5202 ST JOE ROAD, FORT WAYNE, , 46835

(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 an Initial State Residential Licensure Survey. This visit included the Investigation of Complaint IN00378141. Complaint IN00378141 - Unsubstantiated due to lack of evidence. Survey dates: April 21, 2022 Facility number: 015503 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 22, 2022	R 0000	The following Plan of Correction is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne as mandated by the Indiana State Department of Health. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Arbor Glen Independent & Assisted Living Community, Fort Wayne maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations. We respectfully request a paper compliance for the following citations.	
R 0117	Personnel - Deficiency	R 0117	**What Corrective action(s) will**	04/29/2022

	410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review the facility failed to have a certified first aid staff member on site at all times. 72 residents resided in the facility. Findings included: During a review of the facility's		**be accomplished for those residents found to have been affected by the deficient practice:** It is the policy of Arbor Glen Independent & Assisted Living Community to establish general guidelines to manage and maintain state specific requirements for CPR and First Aid Training meeting at least the minimum requirement of one staff member per shift at all times. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential of being affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: QA process will be as follows:** Verification that CPR and First	

	nursing staff as worked schedules on 4-21-2022 at 11:00 a.m., indicated there was not a certified first aid staff member who had worked on 4-18-2022 on the third shift. A review of the facility's nursing staff as worked schedule dated 4-19-2022, indicated there was not a certified first aid staff member who had worked on the third shift. During an interview on 4-21-22 at 5:36 p.m. with Director of Nursing, indicated, there were only two shifts that were not covered by a staff with first-aid. The staff member who had worked on those nights was from a staffing agency. The DON indicated, she was told the agency did not require them to be first-aid certified. The DON also indicated they were going to get all of the facility staff certified in first-aid. The DON further indicated they did not have a facility policy, and followed the state guidelines. Based on interview and record review the facility failed to have a certified first aid staff member on site at all times. 72 residents resided in the facility. Findings included: During a review of the facility's nursing staff as worked schedules on 4-21-2022 at 11:00 a.m., indicated there was		aid training for all employees to be received prior to or by completion of their first 90 days of hire for Licensed Nurses, Qualified Medication Assistants & Certified Nurse Aids. Verification to be received by the Business Office Director and is then to be communicated to the Director of Nursing. Employees who do not have verification of completing CPR and First Aide Training will not be scheduled unless there is a scheduled employee working the same shift with verification of completing CPR and First aid training. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: -** An audit of the schedule will be completed by the Director of Nursing, Executive Director or Designee once a week for 4 weeks, then Bi-weekly for 6 weeks, followed by Monthly for 2 months and then monitored monthly in QA moving forward.	

	not a certified first aid staff member who had worked on 4-18-2022 on the third shift. A review of the facility's nursing staff as worked schedule dated 4-19-2022, indicated there was not a certified first aid staff member who had worked on the third shift. During an interview on 4-21-22 at 5:36 p.m. with Director of Nursing, indicated, there were only two shifts that were not covered by a staff with first-aid. The staff member who had worked on those nights was from a staffing agency. The DON indicated, she was told the agency did not require them to be first-aid certified. The DON also indicated they were going to get all of the facility staff certified in first-aid. The DON further indicated they did not have a facility policy, and followed the state guidelines.		**Date systemic system changes in place/completed: 4/29/2022**	
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on interview and record review, the facility failed to ensure 9 of 12 pets living with	R 0151	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** There were missing records for 9/12 Residents. The above referenced pets found without updated vaccinations were immediately given a letter to	04/29/2022

	resident's in the facility had their required veterinary examination and required immunizations. This deficiency had the potential to affect all residents and pets residing in the facility. (Resident 3, Resident 8, Resident 9, Resident 10, Reident 11, Resident 12, Resident 13, Residetn 14, and Resident 16) Findings include: During the entrance conference on 4-21-2022 at 10:10 a.m., the Executive Director indicated the facility had residents who had pets residing in the facility and would provided the facility's pet policy and pet records. A review of the Facility's Pet Binder began on 4-21-2022 at 3:00 p.m. The Pet Binder contained 4 Resident Pet Health Statements. Resident 3 had records for 3 pets, one dog and 2 cats and Resident 15 had a record for 1 cat. During an interview with the Business Director on 4-21-2022 at 3:05 p.m., she indicated more than 2 residents had pets. During an interview, the Business Director on 4-21-2022 at 3:35 p.m., indicated all pet records were in the pet binder. The Business Director also indicated they had talked to the residents and they were requesting records to be faxed to the facility from their		provide records or remove pet from the community. Also provided education to the resident/family as to the state specific regulation until such a time they could arrange for the pet to receive updated vaccinations by an appropriately licensed individual. Ie. Families or Residents are to provide documentation of updated pet vaccination records and this to be placed within the resident's administrative file prior to the pets return to the community. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Business office Director, Executive Director and/or Designee will review current administrative files with no other findings pertaining to outdated pet vaccinations. No other residents were found to be affected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice**	

	Veterinarians. On 4-21-20222 at 3:40 p.m., a review the list of identified Residents who had pets and pet records in the Pet Binder indicated the Resident Pet Health Statements were lacking for the following residents' pets: Resident 3 was identified to 1 dog and 2 cats residing in the facility. One of Resident 3's cats did not have record if the cat had been vaccinated. Resident 8 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 8's cat. Resident 9 was identified to have a dog, who resided in the facility. A health record was not on file or available for Resident 9's dog. Resident 10 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 10's cat. Resident 11 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 11's cat. Resident 12 was identified to have a dog, who resided in the facility. A health record was not on file or available for Resident		**does not reocure:** The Business office Director and/or Designee will conduct a monthly audit of the resident's administrative file to ensure pets entering the community have up to date vaccinations for a period of twelve months through the communities QA process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: -** The monthly audits will be reviewed after twelve months in order to determine the need for the ongoing frequency of the monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. These actions are to ensure continued compliance with Indiana state regulation R 151. **Compliance Date: 4/29/2022**	

12's dog.

Resident 13 was identified to have a dog, who resided in the facility. A health record was not on file or available for Resident 13's dog.

Resident 14 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 14's cat.

Resident 16 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 16's cat.

During an interview on 4-21-2022 at 5:40 p.m., the Business Director indicated the facility had not received any additional pet records from the residents nor the Veterinarians' offices.

A review of the current facility policy, titled, Permitting & Maintaining Pets, dated October 1, 2021, was provided by the Business Manager on 4-21-2022 at 4:40 p.m., indicated, "...All pets brought on the Community's premises must be registered and the registration must be updated annually. To qualify for registration, the pet must meet the Selection Criteria, the pet owner must agree to comply with the provisions of this Pet Policy including...Addendum A:

	Pet Agreement and Addendum B: Pet Registration...Selection Criteria...Type of Pet...1 Dog...Maximum adult weight 25 pounds or less, must be housebroken and spayed or neutered...1 Cat...Must be spayed or neutered and trained to the litter box...Registration All pet owners must register their pets with the Provider before the pet is brought into the Community...Registration must include:...A certificate signed by a licensed veterinarian, or a State or local authority empowered to inoculate animals (or designated agent of such authority) stating the pet has received all inoculations required by applicable State and local law...Proof of licensing for dogs...Inoculations...Dogs must be vaccinated in accordance with the appropriate Stat and local laws. This includes, but is not limited to, canine distemper, infectious hepatitis-lepto series, parvo virus and rabies, with booster shots as needed. Dogs must be licensed by the appropriate local government jurisdiction...Cats must be vaccinated in accordance with the appropriate State and local laws. This includes, but is not limited to, feline enteritis and rabies, with booster shots as needed...." A review of the facility's non-dated Pet Policy Agreement, provided by the			

	Business Manager on 4-21-2022 at 4:40 p.m., indicated, "...Because You wish to keep a pet in Your unit the Company grants you permission to keep the pet subject to the following terms and conditions:...All cats and dogs must have current vaccinations as recommended by Your veterinarian and any other requirements required by applicable law or regulation Your are required to show proof of current vaccinations and annually submit the Resident Pet Health Statement and will provided, upon request, any additional information about Your pet's health status...." Based on interview and record review, the facility failed to ensure 9 of 12 pets living with resident's in the facility had their required veterinary examination and required immunizations. This deficiency had the potential to affect all residents and pets residing in the facility. (Resident 3, Resident 8, Resident 9, Resident 10, Reident 11, Resident 12, Resident 13, Residetn 14, and Resident 16) Findings include: During the entrance conference on 4-21-2022 at 10:10 a.m., the Executive Director indicated the facility had residents who had pets residing in the facility and would provided the facility's pet			

policy and pet records.

A review of the Facility's Pet Binder began on 4-21-2022 at 3:00 p.m. The Pet Binder contained 4 Resident Pet Health Statements. Resident 3 had records for 3 pets, one dog and 2 cats and Resident 15 had a record for 1 cat.

During an interview with the Business Director on 4-21-2022 at 3:05 p.m., she indicated more than 2 residents had pets.

During an interview, the Business Director on 4-21-2022 at 3:35 p.m., indicated all pet records were in the pet binder. The Business Director also indicated they had talked to the residents and they were requesting records to be faxed to the facility from their Veterinarians.

On 4-21-20222 at 3:40 p.m., a review the list of identified Residents who had pets and pet records in the Pet Binder indicated the Resident Pet Health Statements were lacking for the following residents' pets:

Resident 3 was identified to 1 dog and 2 cats residing in the facility. One of Resident 3's cats did not have record if the cat had been vaccinated.

Resident 8 was identified to have a cat, who resided in the facility. A health record was not

	on file or available for Resident 8's cat. Resident 9 was identified to have a dog, who resided in the facility. A health record was not on file or available for Resident 9's dog. Resident 10 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 10's cat. Resident 11 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 11's cat. Resident 12 was identified to have a dog, who resided in the facility. A health record was not on file or available for Resident 12's dog. Resident 13 was identified to have a dog, who resided in the facility. A health record was not on file or available for Resident 13's dog. Resident 14 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 14's cat.			

	Resident 16 was identified to have a cat, who resided in the facility. A health record was not on file or available for Resident 16's cat. During an interview on 4-21-2022 at 5:40 p.m., the Business Director indicated the facility had not received any additional pet records from the residents nor the Veterinarians' offices. A review of the current facility policy, titled, Permitting & Maintaining Pets, dated October 1, 2021, was provided by the Business Manager on 4-21-2022 at 4:40 p.m., indicated, "...All pets brought on the Community's premises must be registered and the registration must be updated annually. To qualify for registration, the pet must meet the Selection Criteria, the pet owner must agree to comply with the provisions of this Pet Policy including...Addendum A: Pet Agreement and Addendum B: Pet Registration...Selection Criteria...Type of Pet...1 Dog...Maximum adult weight 25 pounds or less, must be housebroken and spayed or neutered...1 Cat...Must be spayed or neutered and trained to the litter box...Registration All pet owners must register their pets with the Provider before the pet is brought into the Community...Registration must			

	include:...A certificate signed by a licensed veterinarian, or a State or local authority empowered to inoculate animals (or designated agent of such authority) stating the pet has received all inoculations required by applicable State and local law...Proof of licensing for dogs...Inoculations...Dogs must be vaccinated in accordance with the appropriate Stat and local laws. This includes, but is not limited to, canine distemper, infectious hepatitis-lepto series, parvo virus and rabies, with booster shots as needed. Dogs must be licensed by the appropriate local government jurisdiction...Cats must be vaccinated in accordance with the appropriate State and local laws. This includes, but is not limited to, feline enteritis and rabies, with booster shots as needed...." A review of the facility's non-dated Pet Policy Agreement, provided by the Business Manager on 4-21-2022 at 4:40 p.m., indicated, "...Because You wish to keep a pet in Your unit the Company grants you permission to keep the pet subject to the following terms and conditions:...All cats and dogs must have current vaccinations as recommended by Your veterinarian and any other requirements required by applicable law or regulation			

	Your are required to show proof of current vaccinations and annually submit the Resident Pet Health Statement and will provided, upon request, any additional information about Your pet's health status...."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.	R 0217	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Resident #1 was missing the Hospice care information in Service plan and it wasn't signed. Resident #1 now has a current signed Service Plan on the chart. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All current resident files, IL & AL, have been audited – All residents, IL & AL, service plans have been completed, signed placed in the medical record. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** The facility DON & clinical team	04/29/2022

	(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were reviewed and/or signed for 6 of 6 residents reviewed. (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6) Findings include: 1. A review of Resident 1's record on 4/21/22 at 11:00 a.m. indicated there was no signed service plan. Hospice services were not included on the plan.		was educated on the Service plans and responsibility to oversee the file. Inservice training was on or before 4/29/2022. The DON has established a monitoring system to ensure that all Service Plans are completed - updated, signed and placed on the medical record in a timely manner. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: -** The DON, ED, designee will audit the records bi-weekly for the first 2 months, monthly for 2 months and then quarterly to ensure ongoing compliance. The DON, ED &/or designee will evaluate the audits and develop an action plan if necessary. **Compliance date:** 4/29/2022	

	In an interview on 4/21/22 at 3:17 p.m. with the Business Manager, AIT and Director of Nursing, (DON) the DON indicated hospice services should have been added to the service plan. She further indicated that service plans should be signed and reviewed with the residents and/or their families. 2. A review of Resident 2's record on 4/21/22 at 11:45 a.m. indicated Resident 2 did not have a service plan. A residency agreement dated 2/10/22 included general services. In an interview on 4/21/22 at 2:30 p.m. the Administrator in Training, (AIT) indicated Resident 2 was an independent resident and service plans are not completed for independent living residents. 3. A review of Resident 3's record on 4/21/22 at 3:05 p. m. indicated there was no signed service plan. A "Standard Interview and Initial Assessment" was incomplete as the assessment (page 7) was blank. The assessment was without a date. A residency agreement dated 2/2/22 included general services and basic care rate. In an interview on 4/21/22 at 3:50 p.m., the Assistant Director			

	of Nursing, (ADON) indicated nursing provides an assessment upon admission. 4. A review of Resident 4's record on 4/21/22 at 12:35 p.m. indicated there was no signed service plan. In an interview on 4/21/22 at 2:30 p.m., the Administrator in Training, (AIT) indicated service plans are not completed for independent living residents. 5. A review of Resident 5's record on 4/21/22 at 11:45 a.m. indicated Resident 5 did not have a service plan. A residency agreement dated 2/10/22 included general services. In an interview on 4/21/22 at 2:30 p.m., the Administrator in Training, (AIT) indicated service plans are not completed for independent living residents. A review of Resident 6's record on 4/21/22 at 11:45 a.m. indicated Resident 6 did not have a service plan. A residency agreement dated 10/22/21 included general services In an interview on 4/21/22 at 2:30 p.m. the Administrator in Training, (AIT) indicated t service plans are not completed for independent living residents. A policy dated 10/1/21 "Coordination/Individualization of Service Plan" indicated that			

each resident will receive an individualized, comprehensive service plan upon admission.

Based on interview and record review, the facility failed to ensure service plans were reviewed and/or signed for 6 of 6 residents reviewed. (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6)

Findings include:

1. A review of Resident 1's record on 4/21/22 at 11:00 a.m. indicated there was no signed service plan. Hospice services were not included on the plan.

In an interview on 4/21/22 at 3:17 p.m. with the Business Manager, AIT and Director of Nursing, (DON) the DON indicated hospice services should have been added to the service plan. She further indicated that service plans should be signed and reviewed with the residents and/or their families.

2. A review of Resident 2's record on 4/21/22 at 11:45 a.m. indicated Resident 2 did not have a service plan. A residency agreement dated 2/10/22 included general services.

In an interview on 4/21/22 at 2:30 p.m. the Administrator in Training, (AIT) indicated Resident 2 was an independent

	resident and service plans are not completed for independent living residents. 3. A review of Resident 3's record on 4/21/22 at 3:05 p. m. indicated there was no signed service plan. A "Standard Interview and Initial Assessment" was incomplete as the assessment (page 7) was blank. The assessment was without a date. A residency agreement dated 2/2/22 included general services and basic care rate. In an interview on 4/21/22 at 3:50 p.m., the Assistant Director of Nursing, (ADON) indicated nursing provides an assessment upon admission. 4. A review of Resident 4's record on 4/21/22 at 12:35 p.m. indicated there was no signed service plan. In an interview on 4/21/22 at 2:30 p.m., the Administrator in Training, (AIT) indicated service plans are not completed for independent living residents. 5. A review of Resident 5's record on 4/21/22 at 11:45 a.m. indicated Resident 5 did not have a service plan. A residency agreement dated 2/10/22 included general services. In an interview on 4/21/22 at			

	2:30 p.m., the Administrator in Training, (AIT) indicated service plans are not completed for independent living residents. A review of Resident 6's record on 4/21/22 at 11:45 a.m. indicated Resident 6 did not have a service plan. A residency agreement dated 10/22/21 included general services In an interview on 4/21/22 at 2:30 p.m. the Administrator in Training, (AIT) indicated t service plans are not completed for independent living residents. A policy dated 10/1/21 "Coordination/Individualization of Service Plan" indicated that each resident will receive an individualized, comprehensive service plan upon admission.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview and record review the facility failed to ensure medications were administered as ordered for 1 of 6 resident reviewed. (Resident 7) Findings include:	R 0240	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #7 used an inhaler that wasn't dated. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	04/29/2022

	An observation and interview, on 4-21-22 at 11:48 a.m., indicated Resident 7 was short of breath. QMA 2 (Qualified Medical Assistant) alerted LPN 1 (Licensed Practical Nurse) she needed assistance. LPN 1 indicated Resident 7 was short of breath and it was appropriate to give her the PRN (as needed) Proventil inhaler (inhaled medication for breathing.) Resident 7 indicated they did not get their Advair inhaler (a inhaled mediation for breathing) 2 times a day (routine) as ordered. Resident 7 was attempting to show LPN 1 and QMA 2 their papers from a physician showing them their current medication list. Resident 7's Advair inhaler was observed to not be labeled with an open date on it. The Advair inhaler had a piece of tape attached to it which had Resident 7's full name and ordering physician's name written on the tape. The Advair inhaler's dose counter had 29 doses remaining to be administered out of 60 doses the inhaler had contained. Neither LPN 1 nor QMA 2 could say when the Advair inhaler had been opened. QMA 2 indicated Resident 7 was admitted to the facility with one Advair inhaler and it was not labeled nor in a box with a prescription label on it. QMA 2 indicated the Advair inhaler was marked off as given on 4-21-22, the 8:00 a.m. dose on the MAR (Medication		The facility reviewed each resident's record to determine which, if any residents, could be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** An audit of the med carts will be conducted on a weekly basis by the Unit Managers. In addition, nursing staff were given a training on or before 4/29/2022 & will attend quarterly in-services on the facility policy for medication administration/disposal of medication and the ISDH regulations on med administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: -** A med cart audit form was created for use during the Unit Manager weekly cart inspection. Once the med cart audit is	

	Administration Record). Resident 7 immediately indicated they had not received the inhaler that morning. A record review for Resident 7 began on 4-21-22 at 12:02 PM. Diagnoses included but were not limited to, dyspnea, kidney disease, and heart disease. Resident 7's physician orders indicated an order for Advair 1 puff twice daily, originally started on 2-1-22. The order was rewritten on 4-8-22 after a pharmacy review and advised to add the instructions to rinse mouth after use. The order was then written for the Advair, 1 puff twice daily and rinse mouth after use. A review of Resident 7's April 2022 MAR (Medication Administration Record) indicated Advair inhaler was administered twice a day as ordered with refusals on 4-2-22. The Advair was to be administered at 8:00 a.m. and 8:00 p.m. daily. The MAR documentation indicated from 4-1-22 to 4-21-22 with 2 refusals, Resident 7 had received 38 doses of the Advair inhaler. The Advair inhaler's counter indicated only 29 puffs had been given. A review of the delivery forms from the facility's Pharmacy indicated Resident 7 had not		complete, the form will be signed by the Unit Manager and filed by DON. Nursing staff will attend quarterly training on the facility policy for med administration/disposal of medication and the ISDH regulations on med administration. **Compliance date: 4/29/2022**	

	received any replacement inhalers from the Pharmacy. The Pharmacy's account of deliveries for Resident 7 indicated the pharmacy (with a signed consent on 4-1-2021 to started Pharmacy Services) had filled 4 oral medications on 4-20-22. During an interview, Resident 7 on 4-21-22 at 2:26 PM, indicated they were administered the inhaler from one QMA as ordered, but the rest of them had not given them the inhaler twice a day. The resident also indicated they had been on the inhaler for several months. Resident 7 indicated they had not refused the inhaler. Resident 7 further indicated they tended to get up later than usual and was not generally up prior to 10:00 a.m. Resident 7 wondered if nurses were indicating they had refused the inhaler due to not answering their door in early morning. Resident 7 indicated the nurses had not informed their POA (Power of Attorney) of any refusals of medication. A review of a current facility policy, titled, "Medication & Treatment Administration Assistance", was provided by the Administrator on 4-21-22 at 11:45 a.m., and indicated, "...3. Medication assistance and administration should be in accordance with the prescriber's			

	orders...." Based on observation, interview and record review the facility failed to ensure medications were administered as ordered for 1 of 6 resident reviewed. (Resident 7) Findings include: An observation and interview, on 4-21-22 at 11:48 a.m., indicated Resident 7 was short of breath. QMA 2 (Qualified Medical Assistant) alerted LPN 1 (Licensed Practical Nurse) she needed assistance. LPN 1 indicated Resident 7 was short of breath and it was appropriate to give her the PRN (as needed) Proventil inhaler (inhaled medication for breathing.) Resident 7 indicated they did not get their Advair inhaler (a inhaled mediation for breathing) 2 times a day (routine) as ordered. Resident 7 was attempting to show LPN 1 and QMA 2 their papers from a physician showing them their current medication list. Resident 7's Advair inhaler was observed to not be labeled with an open date on it. The Advair inhaler had a piece of tape attached to it which had Resident 7's full name and ordering physician's name written on the tape. The Advair inhaler's dose counter had 29 doses remaining to be administered out of 60 doses the inhaler had contained.			

	Neither LPN 1 nor QMA 2 could say when the Advair inhaler had been opened. QMA 2 indicated Resident 7 was admitted to the facility with one Advair inhaler and it was not labeled nor in a box with a prescription label on it. QMA 2 indicated the Advair inhaler was marked off as given on 4-21-22, the 8:00 a.m. dose on the MAR (Medication Administration Record). Resident 7 immediately indicated they had not received the inhaler that morning. A record review for Resident 7 began on 4-21-22 at 12:02 PM. Diagnoses included but were not limited to, dyspnea, kidney disease, and heart disease. Resident 7's physician orders indicated an order for Advair 1 puff twice daily, originally started on 2-1-22. The order was rewritten on 4-8-22 after a pharmacy review and advised to add the instructions to rinse mouth after use. The order was then written for the Advair, 1 puff twice daily and rinse mouth after use. A review of Resident 7's April 2022 MAR (Medication Administration Record) indicated Advair inhaler was administered twice a day as ordered with refusals on 4-2-22. The Advair was to be administered at 8:00 a.m. and 8:00 p.m. daily. The MAR			

	documentation indicated from 4-1-22 to 4-21-22 with 2 refusals, Resident 7 had received 38 doses of the Advair inhaler. The Advair inhaler's counter indicated only 29 puffs had been given. A review of the delivery forms from the facility's Pharmacy indicated Resident 7 had not received any replacement inhalers from the Pharmacy. The Pharmacy's account of deliveries for Resident 7 indicated the pharmacy (with a signed consent on 4-1-2021 to started Pharmacy Services) had filled 4 oral medications on 4-20-22. During an interview, Resident 7 on 4-21-22 at 2:26 PM, indicated they were administered the inhaler from one QMA as ordered, but the rest of them had not given them the inhaler twice a day. The resident also indicated they had been on the inhaler for several months. Resident 7 indicated they had not refused the inhaler. Resident 7 further indicated they tended to get up later than usual and was not generally up prior to 10:00 a.m. Resident 7 wondered if nurses were indicating they had refused the inhaler due to not answering their door in early morning. Resident 7 indicated the nurses had not informed their POA (Power of Attorney) of any			

	refusals of medication. A review of a current facility policy, titled, "Medication & Treatment Administration Assistance", was provided by the Administrator on 4-21-22 at 11:45 a.m., and indicated, "...3. Medication assistance and administration should be in accordance with the prescriber's orders...."			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known	R 0356	R356 Clinical Records-It is the practice of this facility to maintain a current emergency information file that is immediately accessible for each resident (IL & AL). **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** -Resident #1 had missing information on emergency file -The missing information was corrected immediately. The facility DON & clinical team was educated on the emergency information file; and responsibility to oversee the file, on or before 4/29/2022. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	04/29/2022

	allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to maintain current and updated information in the emergency preparedness book for 7 of 7 Residents. (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7) Findings include: During a review of the emergency file book on 4-22-22 at 4:00 p.m., indicated 7 residents lacked correct documentation on their emergency file. Review of Resident 1's emergency file, dated 2-12-22, there was not a code status, and no hospital preference noted. Resident 1's move in date was on 12-24-21. Review of Resident 2's emergency file, dated 1-24-22, there was not a hospital preference noted. Resident 2's move in date was on 12-23-21. Review of Resident 3's emergency file, dated 1-24-22, there was not a code status, and no hospital preference		**corrective action will be taken:** -All residents have the potential of being affected by the alleged deficient practice. Our team will keep be updating the Emergency/Face Sheet book, which is located at the front desk where it is available for access 24 hours a day. The Emergency/Face Sheet book will be updated upon resident move-ins, discharges & as needed when changes occur. DON/Designee will review the emergency information file (For both AL and IL Residents) bi -weekly to ensure it is current with all required information/photos. -The facility completed in-service with the DON and Assistant DON on the regulation of the emergency information file and it's requirements. The in-service took place on or before 4/29/2022. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** -DON, Executive Director or Designee will review the emergency information file bi-weekly to ensure it is current with all required information/photos.	

noted. Resident 3's move in date was 12-23-21.

Review of Resident 4's emergency file, dated 1-11-22, there was not a code status, and no hospital preference noted. Resident 4's move in date was 12-23-21.

Review of Resident 5's emergency file, dated 1-24-22, there was not a code status, and no hospital preference noted. Resident 5's move in date was 10-1-21.

Review of Resident 6's emergency file, dated 1-11-22, there was not a code status, and no hospital preference noted. Resident 6's move in date was 12-22-21.

Review of Resident 7's emergency file, dated 1-24-22, there was not a code status, and no hospital preference noted. Resident 7's move in date was 12-23-22.

During an interview on 4-21-22 at 4:24 p.m., the Administrator in Training (AIT) indicated, they did not have a facility policy for resident's emergency files and further indicated they would follow the state guidelines.

Based on interview and record review, the facility failed to maintain current and updated information in the emergency preparedness book for 7 of 7

-The facility
will in-service the DON & Assistant DON on the regulation of the emergency information file and it's requirements on or before April 29, 2022. -The DON/Designee will
be responsible for ensuring the photos of new residents are in the emergency
information file within the first 48 hours of moving into the facility.

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

QA monitoring tool, Emergency Information File will be completed bi-weekly for 2 months, then monthly x 2 months, and quarterly for at least 6 months -Data will collected by the ED or Designee, if
the threshold of 100% is not met, an action plan will be developed.

Compliance date: 4/29/2022

Residents. (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7)

Findings include:

During a review of the emergency file book on 4-22-22 at 4:00 p.m., indicated 7 residents lacked correct documentation on their emergency file.

Review of Resident 1's emergency file, dated 2-12-22, there was not a code status, and no hospital preference noted. Resident 1's move in date was on 12-24-21.

Review of Resident 2's emergency file, dated 1-24-22, there was not a hospital preference noted. Resident 2's move in date was on 12-23-21.

Review of Resident 3's emergency file, dated 1-24-22, there was not a code status, and no hospital preference noted. Resident 3's move in date was 12-23-21.

Review of Resident 4's emergency file, dated 1-11-22, there was not a code status, and no hospital preference noted. Resident 4's move in date was 12-23-21.

Review of Resident 5's emergency file, dated 1-24-22, there was not a code status,

	and no hospital preference noted. Resident 5's move in date was 10-1-21. Review of Resident 6's emergency file, dated 1-11-22, there was not a code status, and no hospital preference noted. Resident 6's move in date was 12-22-21. Review of Resident 7's emergency file, dated 1-24-22, there was not a code status, and no hospital preference noted. Resident 7's move in date was 12-23-22. During an interview on 4-21-22 at 4:24 p.m., the Administrator in Training (AIT) indicated, they did not have a facility policy for resident's emergency files and further indicated they would follow the state guidelines.			

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