STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00428961 and IN00428020. Complaint IN00428961- Federal deficiencies related to the allegations are cited at F607. Complaint IN00428020 - Federal deficiencies related to the allegations are cited at F607. Survey dates: March 4, 5, 6, 7, and 8, 2024 Facility number: 000505 Provider number: 155556 AIM number: 100266350 Census Bed Type: SNF/NF: 71 SNF: 22 Total: 93 Census Payor Type: Medicare: 19 Medicaid: 52 Other: 22 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 14, 2024.	F 0000		
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with			

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

Victoria Roe | Administrator | 03/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview, and record review, the facility failed to obtain a physician's order, complete assessments, document care plans, and complete daily function testing for residents wearing personal body alarms. (Residents 20 and 43) Findings include: 1. During an observation on 3/8/24 at 2:12 p.m., Resident 20 was seated in her recliner with a pull	F 0604	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal	04/01/2024

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	tab alarm clipped to her left shoulder. The resident was sleeping. Resident 20's clinical record was reviewed 3/8/24 at 2:15 p.m. Her diagnosis included unspecified dementia, history of falling, and cognitive communication deficits. A 1/4/24 "Fall Risk" care plan indicated interventions included the following: 1/2 side rails to bed to provide assist with mobility and positioning, monitor for changes in gait/positioning, and an "alarm" x 30 days. The clinical record lacked a physician's order for a personal body alarm. The clinical record lacked assessment related to the use of an alarm for fall risk prevention by the Interdisciplinary Team (IDT). The clinical record lacked documentation Resident 20's family or representative was contacted related to the use of a pull tab alarm for fall prevention. 2. During an observation on 3/4/24 at 1:51 p.m., Resident 24 was seated in her recliner with a pull tab alarm clipped to her left shoulder. During an observation and family interview on 3/6/24 at 3:01 p.m., Resident 24 was seated in her wheelchair with the pull tab alarm clipped to her left shoulder. Resident 24's family member indicated they were aware this alarm was being used to assist with fall prevention, but could not remember when it was started. Resident 24's clinical record was reviewed on 3/8/24 at 11:28 a.m. Her diagnosis included unspecified dementia without behavioral		Laws. Facility's date of alleged compliance is: 4/01/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** It is the policy of the facility to ensure that all residents with personal body alarms have the proper assessments completed, physicians' order, care plans, and daily function testing. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 20 and 43 received the proper assessments, physicians order, careplans for personal body alarms. Residents 20 and 43 are receiving daily function testing on their personal body alarms. Facility is reviewing all residents with personal body alarms recent fall history and d/c alarm on residents without falls in the last 30 days. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? An audit was completed by DON/Designee on all personal alarm devices on 3/25/24 to ensure all residents with personal	

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	disturbances, cognitive communication deficit and weakness. A 12/8/23 "Fall Risk" care plan indicated interventions included the following: bed in lowest position, bed wheels must be locked at all times, and call light in reach. The care plan lacked indication of a pull tab alarm. The clinical record lacked a physician's order for a pull tab alarm. The clinical record lacked assessment related to the use of an alarm for fall risk prevention by the Interdisciplinary Team. During an interview, on 3/8/24 at 1:17 p.m., Physical Therapy Assistant (PTA) 7 indicated nursing did request therapy screens for fall interventions and when fall alarms were placed as an immediate intervention, therapy would do an assessment afterwards, as soon as possible. Therapy would assess the resident's cognition and ability to utilize safety protocols to determine if the alarm was appropriate for the resident. She was unaware Resident 43 had a pull tab alarm. During an interview, on 3/8/24 at 1:37 p.m., RN 8 indicated the only assessments she was aware of for a pull tab alarm were the daily function and placement checks and these were documented on the Electronic Medical Record (EMAR). During an interview, on 3/8/24 at 1:46 p.m., RN 8 indicated she had located the policy related to alarms. She pointed out a section at the bottom of the page which stated the following: " The alarms need to be reviewed at least quarterly by the IDT for appropriateness and efficacy for fall prevention."		alarms have the proper assessments completed, physicians' order, care plans, and daily function testing. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** At an in-service held by the DON/Designee on 3/21/2024 for clinical staff the following was reviewed: 1 Safety Alarm Devices Policy and Procedure 2 Careplans Policy and Procedure 3 Assessments Policy and Procedure 4 Physicians Orders Policy and Procedure Additionally, any staff who fail to comply with the points of the in-service will be further educated/disciplined as indicated. **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/Designee will audit all resident with personal alarms for order, monitoring, care plan, function, and assessment 5 times	

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	During an interview, on 3/8/24 at 2:13 p.m., the DON indicated fall risk assessments were completed quarterly, after falls, and at change of conditions. The facility tried to utilize all other fall intervention options before placing an alarm on a resident. The placement of an alarm was utilized as a nursing order, but to have them remain in place a physician's order was needed and a care plan was required. A current facility policy, dated 6/12/23, titled "Guidelines for Safety Alarm Devices", provided by the Administrator, on 3/8/24 at 11:27 a.m., indicated the following: "...Purpose: Safety alarms/devices are utilized when deemed appropriate by the IDT, as an intervention to alert staff of an unassisted transfer to intervene for fall prevention. Personal alarms are to be used only when other interventions have proven unsuccessful. Policy: 1. The use of a personal alarm will be on the order of a physician after which time a resident who is a fall risk has exhausted multiple other interventions and the IDT to include therapy, has a documented discussion and agrees that a personal alarm is appropriate. 2. The resident's family/representative must be informed of and agree to the placement of an alarm. 3. The alarm must be care planned, and appear on the CNA instructions....The alarm needs to be checked daily for function. The alarms need to be reviewed at least quarterly by the IDT for appropriateness and efficacy for fall prevention.... " 3.1-3(w) 3.1-26		a week x 4 weeks, then 3x a week for 4 weeks, then weekly for 4 months to ensure proper assessments completed, physicians' order, careplans, and daily function testing. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **By what date the systemic change for the deficiency will be completed?** Date of Compliance: April 1st, 2024	
F 0607 SS=D	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies			

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Bldg. 00	§483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.			
	Based on interview and record review, the facility failed notify a resident's responsible party of an allegation of abuse, in accordance with facility policy, for 1 of 3 residents reviewed for the implementation of the abuse protocol (Resident B). Findings include:	F 0607	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction	04/01/2024

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	Review of a 2/8/24 facility self reported incident indicated a coworker alleged CNA 100 had spoken to Resident B in an "upset tone." A 2/8/24 "Confidential Witness Statement" indicated CNA 100 pointed her finger at Resident B and spoke to him in an "upset tone" because the resident was in the hallway yelling about the noise from the dining cart. During an interview, on 3/5/24 at 11:51 a.m., with Resident B's representative, she indicated she had not been informed of an employee speaking to the resident in an unkind manner. Resident B's clinical record was reviewed on 3/5/24 at 2:39 p.m. Current diagnoses included Alzheimer's disease, vascular dementia, anxiety, and depression. A 1/18/24, quarterly, Minimum Data Set assessment indicated the resident was severely cognitively impaired, understood others, and did not display any maladaptive behaviors during the assessment period. During an interview on 3/7/24 at 2:45 p.m., the Administrator indicated she had failed to notify Resident B's family in error during the investigation of the 2/8/24 allegation of verbal abuse. She had been inadvertently side tracked with another task and forgot to speak with the resident's family. A current, 10/22/22, facility policy titled, "Abuse Prevention Program", provided by the Administrator on 3/4/24 at 11:18 a.m. indicated the following: "...When an allegation or suspected case of abuse		and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: 4/01/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** It is the policy of the facility to ensure that all residents all residents responsible parties are notified of any allegation of abuse. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Family of resident B was notified of the allegation of abuse on 3/7/2023 by the administrator. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Admin/designee completed a 90 day look back on 3/28/2024 of all reportables for family/responsible party notifications. Any concerns were immediately addressed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**	

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	or neglect is reported to the Administrator...will notify the following persons or agencies of such incident immediately...1. Resident representative..." This deficiency relates to complaints IN00428020 and IN00428961. 3.1-28(a)		At an in-service held by the Regional Nurse Consultant on 3/26/2024 for the Administrator and Director of Nursing the following was reviewed: 1 Notifying families of allegations of abuse Additionally, any staff who fail to comply with the points of the in-service will be further educated/disciplined as indicated. **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 Admin/designee will review all allegations of abuse/reportables to verify notification of family/responsible party daily x 6 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the	

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			Administrator weekly until resolution. **By what date the systemic change for the deficiency will be completed?** Date of Compliance: April 1st, 2024	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to assess a resident for pain, address her concerns and distress, and notify the physician of resident pain and distress for 1 of 2 resident's reviewed for pain management. (Resident 197) Findings include: During a random observation on 3/4/24 at 10:00 a.m., Resident 197 was observed in her room in bed, positioned on her back. She was moaning loudly and indicated she felt cold. The resident was observed to have a sheet and a blanket over her body. She indicated several times, "Why is it so cold, I just keep shaking." Several staff members were observed walking past the resident's room and not addressing the resident's concerns. At 10:33 a.m., QMA 9 was seated at a small desk in the hallway, entering information into a	F 0697	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.¿ Facility's date of alleged compliance is: 4/01/2024.¿**Facility is respectfully requesting paper compliance for all deficiencies in this POC.¿** It is the policy of this facility to ensure residents are assessed for pain and address any concerns. **What corrective action(s) will be accomplished for those**	04/01/2024

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	computer. The resident continually moaned and indicated she was cold and requesting someone to help her get warm. At 10:58 a.m., a staff member was observed in her room putting clothes away. The resident was heard calling for her Mother and for help. The staff member indicated to the resident to stop yelling and that she was right there putting her clothing away. The resident continued to call out for her Mother. At 11:08 a.m., QMA 9 entered the resident's room and the resident stopped yelling out and asked QMA 9 to help her. The QMA indicated she would get some vital signs for the resident. She left the room and the resident began to moan. At 11:18 a.m., a staff member entered the resident's room and the resident yelled out to her, "Please God, let me go...I can't do it, Help me." The staff member left the room. At 11:25 a.m., vital signs were obtained and the resident was informed all her vital signs were within normal limits and she needed to calm down. At 11:34 a.m., the staff shut the door and no further yelling out was heard. Upon them leaving the room, the resident was calm. The resident had been repositioned to her left side. During an observation on 3/5/24 at 9:33 a.m., the resident was seated in a wheelchair in her room. Her head was back, eyes shut, and she was yelling "help." At 10:32 a.m., the resident was observed in her bed, positioned on her left side with several blankets on, sleeping.		**residents found to have been affected by the deficient practice?** Pain assessment was completed for resident 197 on 3/7/2024 by DON/Designee any concerns were addressed with MD as indicated. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Pain assessment were completed on all residents by 3/31/2024 by DON/Designee any concerns were addressed with the physician. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** At an in-service held by the DON/Designee on 3/21/2024 for all clinical staff the following was reviewed: 1 Policy and Procedure for Pain management 2 Policy and Procedure MD Notifications Additionally, any staff who fail to comply with the points of the in-service will be further educated/disciplined as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	A review of Resident 167's clinical record was completed on 3/6/24 at 10:15 a.m. Diagnoses included fibromyalgia, post surgical fracture of the right femur, depression, and anxiety. An admission Minimum Data Set (MDS) assessment, dated 2/22/24, indicated the resident had moderate cognitive impairment, no delirium, no difficulty focusing attention, and no disorganized thinking. The resident received scheduled pain medication and had received as needed doses of pain medication during the assessment period. She indicated she had occasional moderate pain that rarely affected her sleep or limited her day-to-day activities. A current health care plan, dated 2/20/24, indicated the resident was at risk for pain and discomfort related to a recent fall with injury, arthritis, and fibromyalgia. Interventions included to provide support and reassurance as indicated, offer as needed prescribed analgesic medications as ordered, assess and document the frequency and intensity of the pain symptoms, monitor for verbal and nonverbal expressions of pain, and notify the physician if interventions were not consistently effective. Current physician's orders, included (2/20/24) Tramadol (narcotic pain medication) 50 mg (milligram), one tablet every six hours as needed for mild to moderate pain. (2/20/24) and acetaminophen Extra Strength (to treat pain) 500 mg, take two tablets (1000 mg) three times a day for pain. The resident's electronic medication administration record (eMAR) for March 2024, indicated the resident's as needed Tramadol was		**recur, i.e. what quality assurance program will be put into place?** The DON/Designee will audit will audit 10 random residents a week x 4 weeks for effective pain management, then 5 random residents a week x 4 weeks, then 3 random residents a month x 4 month's. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **By what date the systemic change for the deficiency will be completed?** Date of Compliance: April 1st, 2024	

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	administered and was ineffective at relieving her pain on 3/4/24 at 11:01 p.m. and 3/5/24 at 4:11 a.m. A behavior note, dated 3/5/24 at 1:53 a.m., indicated the resident had been yelling out "help" throughout the night shift and staff had been unable to console resident. The resident had been lying in bed and was quiet, but yelling out for help. The resident was provided pain medication per pain management medication orders and readjusted in bed around 3/4/24 at 11:00 p.m. On 3/5/24 at 1:53 a.m., the resident was yelling out in a level that could be heard throughout the hallway. The staff attempted to call the provider, but was told there were no calls taken overnight for residents. The staff left a note in a message book for the physician to make them aware of the resident's continued behaviors. All interventions attempted for the resident were ineffective, and staff continued to try to find relief for the resident. A nursing progress note dated 3/5/24 at 2:13 a.m., indicated the resident had been yelling out "help" and groaning throughout the night shift. The nurse had attempted several times to console and redirect the resident without success. Pain management had been provided per prescribed order without relief. The resident required frequent monitoring and orientation of time. A nursing progress note, dated 3/6/24 at 12:44 p.m., indicated the resident was yelling out "help" and groaning throughout the night shift. The note indicated the nurse attempted several times to console and redirect the resident without success. Pain management had been provided per prescribed order without relief. The resident required frequent monitoring and orientation of time.			

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	155556	A. BUILDING 00 B. WING	03/08/2024

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	A nursing progress note, dated 3/7/24 at 3:40 p.m., indicated the physician had been notified regarding the ineffectiveness of the resident's pain management. A nursing progress note, dated 3/7/24 at 4:28 p.m., indicated the physician had ordered to increase the resident's Tramadol to 100 mg every six hours as needed for pain. During an interview on 3/6/24 at 10:18 a.m., QMA 10 indicated that often times, the resident would be yelling out because she was having pain or just needed repositioned. During an interview on 3/8/24 at 9:58 a.m., QMA 9 indicated they attended to the resident all day on 3/4/24 and informed the nurse regarding her behaviors. The resident had been complaining of being cold and short of breath. The QMA had turned her heat up in her room, but she had continued yelling out. Her vital signs had been fine and she would calm when spoken to. During an interview on 3/8/24 at 1:44 p.m., the DON indicated the facility had a provider available via telehealth that could be reached after hours and on weekends. The nurse should have called the on call provider to report the resident's continued pain and further interventions added to provide relief. A current facility policy, undated, titled, "Management of Pain," provided by the Administrator on 3/8/24 at 12:32 p.m., indicated the following: "...Procedure....2. Physician Communication and Involvement-Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. The physician will be notified of resident's complaint of pain			

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	when not relieved by medication as ordered by the physician. Thorough communication with the physician will ensure an appropriate pain management plan....4. Nursing observation if an important part of the pain assessment, especially in the non verbal resident. Nursing will observe behaviors that may indicate pain in the nonverbal or cognitively impaired resident...." 3.1-48(a)(4)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			

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	Based on observation and interview, the facility failed to discard an expired insulin pen and to indicate a date opened on another insulin pen, and label over-the-counter medications with resident identifiers for 2 of 3 medication carts observed for medication storage. (Orchard Hall and Garden Hall medication carts) Findings include: 1. During observation of the Orchard Hall medication cart on 3/8/24 at 10:17 a.m., accompanied by QMA 9, the following was observed: A Lantus Solostar insulin pen (to treat diabetes) without an opened date. QMA 9 indicated the pen contained 240 units. A Humalog QuikPen (to treat diabetes) with a "do not use after" date of 12/19/23. QMA 9 indicated the pen should have been discarded. Two unopened bottles of Daily Multivitamin Men's Health (a supplement) without a resident's identifiers. An unopened box of NightTime Cold and Flu (to treat cold or flu) without a resident's identifiers. 2. During an observation of the Garden Hall medication cart on 3/8/24 at 10:31 a.m., accompanied by LPN 11, the following was observed: A Novolog Flexpen (to treat diabetes) with a broken opened seal, undated. LPN 11 indicated the pen appeared to be full. A bottle of Omega-3 (a supplement) 500 mg	F 0761	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: 4/01/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** It is the policy of this facility to discard expired insulin pens and to indicate the date opened on insulin pens. On 3/25/2024 the DON/Designee completed an audit of the medication rooms and medication carts, to ensure all OTC medications are labeled properly and discarded all expired and non-dated insulin pens. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The DON completed an audit on medication carts and discarded any insulin without a date opened and verified all other insulin pens had a date opened 03/25/2024.	04/01/2024

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	without a resident identifier or opened date. LPN 11 indicated the bottle appeared to be 2/3 full. During an interview on 3/8/24 at 1:33 p.m., the DON indicated the over-the-counter medications should have a label indicating the residents name and opened date, along with prescriber information. The insulin pens should be dated with an opened date and discarded when indicated. A current facility policy, dated 8/1023, titled, "Guidelines for Insulin Pens," provided by the DON on 3/8/24 at 1:36 p.m., indicated the following: "Procedure:...3) Upon opening for the first time, the insulin pen will have a date sticker applied. This will be done by the nurse. The date will reflect the date the seal was broken for use....6) Insulin pens will be considered expired after 28 days and up to 45 days depending on the manufacturer's instructions---after they are opened, no matter of the amount of insulin still remaining in the pen...." A current facility policy, dated 3/2023, titled, " Noncontracted Pharmacy Facility Agreement," provided by the DON on 3/8/24 at 1:36 p.m., indicated the following: "...Non prescription medications without a prescription label are in the manufacturer's original container and labeled with the resident's name." 3.1-25(o)		How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Residents who reside in the facility have the potential to be affected by this finding. Therefore, this plan of correction applies to all residents in the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** At an in-service held by the DON/Designee on 3/21/2024 for all staff the following was reviewed: 1 Policy and Procedure for Medication Storage in the Facility Additionally, any staff who fail to comply with the points of the in-service will be further educated/disciplined as indicated. **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/designee will audit the medication rooms and carts for proper medication storage and	

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			dating 5 x a week x 4 weeks, then 3 x a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **By what date the systemic change for the deficiency will be completed?** Date of Compliance: April 1st, 2024	
F 0802 SS=F Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff.			

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	The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). The facility failed to ensure dietary employees had competency and skills in the operation of the dishwasher. This deficient practice had the potential to impact 93 of 93 residents who consumed meals prepared by the facility kitchen. Findings include: During an interview on 3/8/23 at 10:51 a.m., the DON indicated all 93 of the facility's residents consumed foods orally. During an observation of the dishwasher operation on 3/8/24 at 9:17 a.m., Dietary Aide 6 sprayed dishes and placed them on a tray/rack to go into the dishwasher. During an interview on 3/8/24 at 9:17 a.m., Dietary Aide 6 indicated he was a new employee and this was his first time operating the dishwasher. He was being trained, however no one was with him at the moment because staffing was short. He did not know what temperature the dishwasher was supposed to reach during the washing or rinsing process. He did not know anywhere in the kitchen where this information was listed. He would need to ask for assistance. During an observation and interview on 3/8/24 at 9:22 a.m., the Dietary Manager indicated which temperature gauge dial was "rinse" and which was "wash" on the dishwasher. She could not clearly	F 0802	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: 4/01/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** It is the policy of the facility to ensure that all dietary staff are properly trained on dishwater operation and temperature requirements. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents identified in the alleged deficient practice.	04/01/2024

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	see the reading on either gage due to condensation/steam build up. The required temperatures for the dishwasher were not posted in the dish room. The required temperatures were not listed on the dish temperature log. She indicated she believed wash temperatures should be 180 and rinse temperatures should be 178, but she needed to find a source to double check the correct amounts. During an observation on 3/8/24 at 9:22 a.m., the temperature gages on the dishwasher were covered with heavy condensation and the gauges could not be read. The dishwasher log, contained on a clip board in the dish room, did not have any listed temperature range. The form had columns to record wash and rinse temperatures and offered no instructions or directions. During an observation and interview on 3/3/24 at 10:07 a.m., Dietary Aide 5, who was working on the clean side of the dishwasher, indicated he had been employed 4 to 5 months. There was not a location to check for correct wash and rinse temperatures for the dishwasher. He believed the wash temperature might need to be 180 and the rinse temperature might be 160, but he was unsure. During an observation on 3/8/24 at 10:09 a.m., plates, silverware, glasses, cooking utensils, and pans were being washed in a Hobart brand dishwasher. The gauges on the dishwasher could not be observed. A current, 4/2017, facility policy titled, "Food Safety & Sanitation," provided by the Administrator on 3/8/24 at 11:28 a.m., indicated the following: "...Food services employees are able to operate the machine according to manufacture's		How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Residents who reside in the facility have the potential to be affected by this finding. Therefore, this plan of correction applies to all residents in the facility. All facility dietary staff will be properly trained on how to use the dishwasher and the required temperatures for operations. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** At an in-service held by the Administrator/Designee on 3/21/2024 for all dietary staff the following was reviewed: 1 Dishwashing Policy and Procedure 2 Dishwater Operation Manual Additionally, any staff who fail to comply with the points of the in-service will be further educated/disciplined as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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	specifications and instructions .... High Temperature dish machine has a final rinse if at least 180 [degrees] F [Fahrenheit]...." Page 4 of a Hobart dishwashing manual, provided by the Administrator on 3/8/24 at 12:31 p.m., indicated the following: "...Minimum water temperature "Wash Cycle" 150 degrees F, "Rinse Cycle" 180 degrees F...." 1.3-20(h)		**assurance program will be put into place?** The Admin/designee will review all new dietary employees files upon completion of orientation to ensure they have a completed dishwasher competency check off weekly x8 weeks, then monthly x4 months. The Dietary Manager will interview 10 random dietary staff weekly x 4 weeks, then 5 random staff members weekly x 4 weeks, then 3 random staff members monthly x 4 months for procedure on temperature for dishwashing machine and how to operate the dishwashing machine. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **By what date the systemic change for the deficiency will be completed?** Date of Compliance: April 1st,	

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F 9999 Bldg. 00	3.1-13(w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to submit a "Alzheimer's/Dementia Special Care Unit" state form as required. Findings include: Review of a facility completed, 3/4/24, "Bed Inventory" document, provided by the Administrator following the entrance conference on 3/4/24, indicated there were 9 rooms with a total of 18 beds on the dementia unit.	F 9999	2024 Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: 4/01/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** It is the policy of this facility to submit a Alzheimer/Dementia Special Care Unit form as required by the state. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Admin submitted the Alzheimer/Dementia Special Care Unit form to the Division of Aging on 3/8/2024.	04/01/2024

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	Review of a "Alzheimer's Dementia Special Care Unit" document, provided by the Administrator in 3/8/24 at 12:31 p.m., indicated the form had been submitted to the Division of Aging on 3/8/24 at 12:09 p.m. During an interview on 3/8/24 at 12:35 p.m., the Administrator indicated the facility did not have a record of the disclosure form being submitted in December 2023 as required. Therefore, the facility submitted the form in 3/8/24 to correct the error.		How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Residents who reside in the facility special care unit have the potential to be affected by this finding. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** At an in-service held by the Regional Director of Operations on 3/20/2024 for the administrator and director of nursing the following was reviewed: 1 State Regulation F999 on Special Care Unit Disclosure Form Additionally, failure to comply with the points of the in-service will be further educated/disciplined as indicated. **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?** Admin/designee will monitor completion of the disclosure form monthly for 6 months and then annually thereafter.	

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			If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **By what date the systemic change for the deficiency will be completed?** Date of Compliance: April 1st, 2024	