STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FIVE STAR RESIDENCES OF CLEARWATER	4519 EAST 82ND STREET INDIANAPOLIS, IN 46250

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey Dates: October 7 and 8, 2019 Facility Number: 014016 Residential Census: 52 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 15, 2019.	R 0000	This plan of Correction constitutes Five Star Residences of Clearwater's written allegation of compliance for the alleged deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Five Star Residences of Clearwater respectfully requests a desk review for this Plan of Correction. Alleged date of compliance is November 6th, 2019.	
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility			

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

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	must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is			

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	required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with			

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	developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to ensure each resident who was transferred from the facility received, in writing, the reason for the transfer and information regarding the Ombudsman, State agency, and appeal process for 1 of 3 records reviewed. (Resident 64) Findings include: The closed record for Resident 64 was reviewed on 10/8/2019 at 9:46 a.m. Diagnoses included, but were not limited to, hypertension, hypothroidism, thyroid nodule, cerbral vascular accident, Hurthie cell adenoma, and chronic obstructive pulmonary disease. A nursing progress note, dated 7/18/2019 at 2:00 p.m., indicated "Resident discharged to [name of facility, sic] c[sic] all meds et[sic] personal belongings,[sic] transported via PVT[sic, personal vehicle transportation] car[sic]". The resident was transferred to another long term care facility. There was no documentation to indicate the resident was provided with the State Transfer and Discharge form. During an interview with the Executive Director (ED) on 10/8/19 at 12:35 p.m., the ED indicated the State form was not completed and provided to the resident and/or her representative at the time of discharge.	R 0045	**R-0045 Use of Transfer form for Transfer/ Discharge** **1.Corrective action for those residents affected:** **Resident #64 chart was reviewed.** The community implemented the following two forms to be completed at any time a resident shall transfer or discharge from community: State Form 49669 “Notice of Transfer or Discharge” and also in-house form “Transfer Form” which collects the following information: Identification Data Name of resident Name of transferring institution Name of receiving institution Date of transfer Resident’s Personal Property when transferred to an acute care facility Nurse’s notes will accompany these two forms stating the	10/09/2019

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			following: Functional abilities and physical limitations Nursing care Medications Treatment Current diet and condition to transfer A diagnosis and date of chest x-ray and skin test for tuberculosis will also accompany this information. 1.Measures to identify and correct this problem for residents with the potential of being affected: The above listed information contained in the above mentioned forms will be accompanied with a note in the resident chart that states that these forms were completed and that the resident was provided with such forms. 2.Systemic Change: These forms will be provided to each resident upon any transfer or discharge with notation in nursing notes of such forms being given. 3.Monitoring: A quality	

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			improvement review will be conducted by the Director of Nurses or designee to insure that this new method of documenting forms were provided the two discharge/ transfer to any resident discharging or transferring from the community with notation in nursing notes is in compliance and followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI Committee 4.Compliance Date: 10/30/19	
R 0152 Bldg. 00	410 IAC 16.2-5-1.5(i) Sanitation and Safety Standards - Deficiency (i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection. Based on observation and interview, the facility failed to ensure the safe and sanitary storing and processing of clean and soiled linen to prevent the spread of infection for 1 of 2 laundry rooms within the facility. (East Laundry Room) Findings include: During the Environmental Tour with the Maintenance Director on 10/8/19 at 10:30 a.m., the following was observed: a. In the East Laundry room, a closet containing dirty laundry bags, some of which were in black plastic, clear plastic and mesh bags were stored on the floor.	R 0152	**R-01152** **1.Corrective action for the residents affected: The community has ordered four wire spring platform lift bins to store bagged dirty linens in closet located in a separate storage area from clean linens.** **2.Measures to identify and correct this problem for residents with the potential of being affected: Residents with laundry services reviewed. Housekeeping and nursing staff educated on policy of handling dirty linens by 10/28/19.**	10/28/2019

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	b. A linen cart, in the same dirty linen closet, was uncovered and contained clean resident's laundry. c. A black plastic bag and a clear plastic bag containing dirty laundry was butted up against the clean laundry cart in this closet. This exposed the clean residents laundry to possible contaminants. An interview with the Maintenance Director (MD) on 10/8/19 at 10:30 a.m., he indicated the dirty laundry and clean laundry needed to be separated, and contained as to not expose clean laundry to the possible spread of infection.		**3.Systemic Change: Bins with dirty linens will be placed in separate storage area. Dirty linens will be transported to laundry room to be washed per third shift nursing. Bins will be transported covered. Clean laundry will be stored in "Clean Laundry" closet when not returned to the resident's room.** **4.Monitoring: A quality improvement review will be conducted by the Director of Nurses or designee to insure that this new method of keeping clean and dirty linen separate and contained as not to expose clean laundry to the possible spread of infection and compliance is followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI Committee** **5.Compliance Date 10/28/19.**	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to keep the kitchen clean during 2 of 2 observations of the kitchen and to maintain the dining room in good repair for 1 of 1	R 0154	**R-0154** **1.Corrective action for those**	10/28/2019

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	dining rooms. Findings include: 1. A tour of the kitchen was conducted with the DM (Dietary Manager) on 10/7/19 at 12:30 p.m. During the tour, vegetable blend, peas, spinach, and spinach quiche were being served from the steam table. A round heat detector was affixed to the ceiling, directly above the steam table. The heat detector had built up dust hanging off the edges. An interview was conducted with the DM during the above heat detector observation. He looked up at the heat detector and indicated he'd never noticed it before and indicated "Well get it cleaned up. It's kind of gross looking." An observation of the heat detector was made with the DM on 10/8/19 at 11:45 a.m., during the lunch service. The bottom of the heat detector still had built up dust hanging off of it. The DM indicated he reached up to the ceiling to clean it, but would need to do it again. The Sanitation/Food Safety Checklist was provided by the DM on 10/7/19 at 1:27 p.m. It indicated "Physical Plant/Equipment...Ceilings clean and in good repair." 2. On 10/8/2019 at 10:30 a.m., during the Environmental Tour with the Director of Maintenance, the following was observed: The Dining Room had marred, scratched, chipped walls throughout the dining room. There were large gouges in the walls next to dining tables that exposed bare drywall and peeling, chipped paint. An interview, at the time of tour, with the Director		**residents affected: "Sanitation Checklist" to be utilized. This includes the following listed on the checklist:** **Hoods, filters and vents** **Ceiling: clean and free of stains, vents clean, light fixtures clean and working** **Physical plant/ equipment….** **Ceilings clean and in good repair** **Walls: Clean, free of nicks or marks** **Effective 10/14/19. All walls within Dining Room were repaired and freshly painted in Dining Room and elsewhere in community. This was completed 10/28/19.** **1.Measures to identify and correct this problem for residents with the potential of being affected: the Food and Beverage Director will receive education on use of the "Sanitation Checklist". Food and Beverage Director will audit the kitchen daily using the "Sanitation Checklist" will be daily and Executive Director will conduct a weekly audit tool titled, "Weekly Executive Director/ Administrator Sanitation Checklist".** **2.Systemic Change: Daily and weekly Audits of kitchen and dining room to record and monitor findings.**	

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	of Maintenance he indicated the dining room walls were in need of repair.		**3.Monitoring: A quality improvement review will be conducted by the Food and Beverage Director will audit the kitchen daily using the "Sanitation Checklist" and the Executive Director will audit weekly using the "Weekly Executive Director/ Administrator Sanitation Checklist" to insure compliance is followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI Committee.** **4.Compliance Date: 10/31/19**	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure labs were obtained timely and a blood pressure medication was administered as ordered, for 2 of 5 resident records reviewed. (Residents 6 and 22) Findings include: 1. The clinical record for Resident 22 was reviewed on 10/7/19 at 1:30 p.m. The resident's diagnosis included, but was not limited to, stage III chronic kidney disease.	R 0240	**R-240** **1.Corrective action for those residents affected: Ordered labs for resident #22 and orders for blood pressure for resident #6 and were reviewed with the Medical Director to insure the MD was aware of the resident's ordered lab history and blood pressure hold orders.** **2.Measures to identify and correct this problem for residents with the potential of**	10/31/2019

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	A physician's order, dated 9/23/19, for Resident 22 indicated staff were to obtained a Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) next routine lab day. The clinical record lacked the CBC and BMP. An interview was conducted with the Director of Nursing (DON) on 10/8/19 at 9:21 a.m. She indicated the lab routinely comes in every Wednesday. The labs ordered for Resident 22 were missed. 2. The clinical record for Resident 6 was reviewed on 10/7/2019 at 2:10 p.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes. The clinical record contained a physician's order, dated 5/20/2019, indicating to hold blood pressure medications if systolic (top number of the blood pressure) was less than 110. The physician's order, dated 4/23/2019, indicated the resident was prescribed "Hydralazine [blood pressure medication] 100 mg [milligrams] tablet give 1 tablet by mouth 3 times a day for HTN [Hypertension]." The resident's Blood Pressure Record for September, 2019 was reviewed on 10/8/2019 at 10:45 a.m. On 9/10/2019 at 2:00 p.m., the recorded blood pressure for Resident 6 was 101/79 and on 9/23/2019 at 8:00 p.m., the recorded blood pressure was 106/56. The September 2019 MAR (Medication Administration Record) for September 2019 was reviewed on 10/8/2019 at 10:45 a.m. The September MAR indicated Resident 6 had received Hydralazine 100 mg on 9/10/2019 at 2:00		**being affected: Residents with orders for medication administration parameters of blood pressure medications and/or routine lab orders were checked for any missed entries in the MAR with any discrepancies were reported to physician. QMA's and LPN's will receive education regarding "call/ hold" parameters.** **3.Systemic Change: Daily log sheets will be placed in front of each daily tab in MAR. Ancillary "flow forms" have been retired to insure documentation is being recorded in one place and to insure accuracy and compliance.** **4.Monitoring: A quality improvement review will be conducted by the Director of Nurses or designee to insure that this new method of documenting physician notification compliance is followed. DON will audit the AHA daily log sheet. This audit will be conducted weekly for 4 weeks, bi-weekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI.** **5.Compliance date: 11/6/19**	

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	p.m. and 9/23/2019 at 8:00 p.m. During an interview on 10/8/2019 at 12:45 p.m., the Director of Nursing indicated that Resident 6 should not have received his blood pressure medication if his systolic blood pressure was below 110 and the doses should have been held.			
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview, and record review, the facility failed to ensure food was served at an appropriate temperature for 1 of 4 hot food temperatures retrieved. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 10/7/19 at 12:30 p.m. During the tour the hot foods from the steam table, served during the 11:00 a.m. to 1:00 p.m. lunch service, were retrieved by the Lead Cook. The Lead Cook retrieved a temperature of 128 degrees Fahrenheit on the spinach quiche. An interview was conducted with the Lead Cook after retrieval of the spinach quiche temperature. He indicated the thermometer read 128 degrees Fahrenheit. The Safe Food Temperatures policy was provided by the DM on 10/7/19 at 1:27 p.m. It read, "This policy provides guidelines for limiting the risk of food borne illness through proper food temperature control...Food temperatures are maintained at acceptable levels during storage, preparation, holding, service, delivery, cooling and reheating....Unless otherwise specified by	R 0272	**R-272** **1.Corrective action for those residents affected: Food and Beverage Director was educated on use of Daily Food Temperature Sheet.** **2.Measures to identify and correct this problem for residents with the potential of being affected: Food and Beverage Director or designee will record daily temperatures at all meals to insure that all appropriate foods are above 135 degrees.** **3.Systemic change: Food and Beverage Director or designee will record temperature of all meals. Food and Beverage Director will audit Daily Food Temperature Sheet and will be given to the Executive Director on Monday mornings for records.** **4.Monitoring: A quality improvement review will be conducted by the Food and**	10/18/2019

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	state specific regulations, during meal service (on the tray line): 1. Hot foods are held at 135 degrees F [Fahrenheit] or higher."		**Beverage Director or designee to insure that this new method of documenting food temperatures is in compliance and followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these review will be reported to the QAPI Committee.** **5.Compliance Date: 11/1/19**	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (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 trash was covered when not in use; food was not exposed to air in the freezer; food was covered when stored on the counter; clean pitchers were stored properly on the counter; scoops were not resting directly on food when stored in bins; and beard covers were worn in the kitchen. This affected 52 of 52 residents in the facility who eat food from the kitchen. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 10/7/19 at 12:30 p.m. There were uncovered trash receptacles located in the following locations in the kitchen: next to the handwashing sink, next to the stove, and across from the bread bins. The receptacle next to the	R 0273	**R-273** **1.Corrective action for those residents affected: "Sanitation Checklist" to be utilized. This includes the following listed on the checklist:** **Garbage/ Trash Cans: Clean, all lids on** **Food items covered, labeled and dated** **Dishes, Trays , Silverware, Pitchers, Plate Covers: Clean and stored dry, free of chips or stains, in good condition** **Food storage bins clean, labeled, no scoops** **Hair restraints used properly** **2.Measures to identify and correct this problem for**	10/18/2019

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FIVE STAR RESIDENCES OF CLEARWATER	4519 EAST 82ND STREET INDIANAPOLIS, IN 46250

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	handwashing sink had paper towel and other debris easily observed within. The receptacle next to the stove had sliced oranges, bread and other debris easily observed within. The receptacle across from the bread bins had muffins and other debris easily observed within. The freezer, labeled Freezer #1 on the outside, had the following items open and exposed to air: a bag of freezer burnt hush puppies, a bag of fries, and a bag of mini corn dogs that had spilled onto the freezer floor. The freezer, labeled Freezer #2 on the outside, had the following items open and exposed to air: a bag of fries, a bag of freezer burnt okra, a bag of mixed vegetables, a bag of peas, a bag of garden burgers, and a bag of chicken nuggets. An interview was conducted with the DM during the above freezer observations. He indicated the food in the freezer should be tied up, unexposed to air. There were 5 pitchers on the counter next to the refrigerator, right side up, with no lids on them. Two of the pitchers had debris resting inside the bottom of the pitchers. There were 3 black tea pitchers on the counter next to the coffee machine, right side up, with no lids on them. An interview was conducted with the Lead Cook during the above pitcher observations. He indicated the pitchers should be stored upside down or with the lids on them. A flour bin, a sugar bin, and a salt container each had a scoop resting directly on top the substances. The flour bin had a blue sticky note attached to the outside that read, "Do Not Leave Scoops In Bins." The DM picked up the scoops		**residents with the potential of being affected: the Food and Beverage Director will receive education on use of the "Sanitation Checklist". Food and Beverage Director will audit the kitchen daily using the "Sanitation Checklist" will be daily and Executive Director will conduct a weekly audit tool titled, "Weekly Executive Director/ Administrator Sanitation Checklist".** **3.Systemic Change: Daily and weekly Audits of kitchen and dining room to record and monitor findings.** **4.Monitoring: A quality improvement review will be conducted by the Food and Beverage Director will audit the kitchen daily using the "Sanitation Checklist" and the Executive Director will audit weekly using the "Weekly Executive Director/ Administrator Sanitation Checklist" to insure compliance is followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI Committee.** **5.Compliance Date: 10/31/19**	

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		A. BUILDING 00 B. WING	10/08/2019

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	from the flour and sugar bins, hung them on a lever inside of the bins, and stated, "I guess my signs didn't work." During the tour, the Lead Cook with a mustache was not wearing a beard cover, and was serving food from the steam table during lunch service. Cook 6 with a mustache and beard with curly hairs was not wearing a beard cover, and was preparing food next to the steam table during lunch service. An observation of the kitchen was made with the DM on 10/8/19 at 11:45 a.m. The Lead Cook with a mustache was not wearing a beard cover, and was serving food from the steam table during lunch service. Cook 6 with a mustache and beard with curly hairs was not wearing a beard cover, and was preparing food next to the steam table during lunch service. An interview was conducted with the DM during the 10/8/19, 11:45 a.m. kitchen observation. He indicated he was unsure about the appropriate length of facial hair in the kitchen, but was under the impression it just needed to be nicely manicured. During the 10/8/19, 11:45 a.m. kitchen observation, a tray of uncovered cookies was observed on the counter next to the handwashing sink. The tray was located diagonally below the paper towel dispenser. No staff were working with the cookies at this time. An interview was conducted with the DM during the 10/8/19, 11:45 a.m. kitchen observation. He indicated the cookies did not need to be covered yet, because they came out of the oven an hour earlier and were cooling there. There was a multi level tray rack unit 5 feet from where the cookies			

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	were resting on the counter. The DM indicated he did not think the cookies should be on the rack while cooling. The Sanitation and Infection Control Standards policy was provided by the DM on 10/8/19 at 12:12 p.m. It read, "...8. Hair is completely covered and restrained with a hair net or hair booffants while in the food preparation area and/or kitchen. 9. Beard coverings where applicable for facial hair covering." The Food Safety in Receiving and Storage policy was provided by the DM on 10/8/19 at 12:12 p.m. It read, "Scoops are not stored inside bins." The Sanitation/Food Safety Checklist was provided by the DM on 10/7/19 at 1:27 p.m. It read, "Cook's Work Area...Garbage cans clean/covered...Refrigerator/Freezer Storage...Food covered, dated, labeled..."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (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 with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure accurate documentation of a resident's MAR (medication administration record) and to record blood sugar results in the clinical record for 2 of 5 residents whose clinical records were reviewed. (Residents 6 and 51)	R 0349	**R-349** **1.Corrective action for those residents affected: MAR was reviewed with the physicians to insure the physicians were aware of the residents' blood**	10/30/2019

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	Findings include: 1. The clinical record for Resident 51 was reviewed on 10/7/19 at 2:45 p.m. The diagnosis for the resident included, but was not limited to, insomnia. The 9/20/19 physician's order indicated to decrease Doxepine to 10 mg every evening for 14 days, then discontinue. The September and October, 2019 MARs indicated the Doxepine was only administered for 12 days and not administered on 9/30/19 or 10/4/19. An interview was conducted with LPN (Licensed Practical Nurse) 5 on 10/7/19 at 3:38 p.m. She reviewed the resident's September and October, 2019 MARS and indicated she was unsure whether the Doxepine was administered on 9/30/19 and 10/4/19, but to complete the 14 day order, it should have been. An interview was conducted with the DON (Director Of Nursing) on 10/7/19 at 3:40 p.m. She indicated the resident should have received the Doxepine on 9/30/19 and 10/4/19, and was unsure what happened. An interview was conducted with the DON on 10/8/19 at 9:20 a.m. She indicated she contacted the nurse who worked the evenings of 9/30/19 and 10/4/19 and was informed the medication was administered, but not documented on the MAR. She also looked in the medication cart, and the medication was gone, so she knew it was administered.		**sugar history and Doxepine treatment history.** **2.Measures to identify and correct this problem for residents with the potential of being affected: All residents with blood sugars were reviewed and MAR was reviewed and checked for notification of the physician and any discrepancies were reported to the physician.** **3.Systematic Change: NOC nurse will audit MAR daily and turn audit sheet to DON in a.m. Any discrepancies will be noted citing** **Name of resident** **Prescription** **Dosage** **Frequency of administration** **1.Monitoring: A quality improvement review will be conducted by the Director of Nurses or designee to insure that this new method of documenting physician notification compliance is followed. Readings of blood sugars and documentation of Humalog administration will only be documented in the MAR. Current secondary documentation on flow sheets are discontinued to insure that the consolidation of multiple documentations lowers errors.** **2.Compliance Date: 11/6/19**	

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	2. The clinical record for Resident 6 was reviewed on 10/7/2019 at 2:10 p.m. The diagnosis for Resident 6 included, but were not limited to, hypertension and diabetes. The clinical record contained a physician's order, dated 4/24/2019, which indicated Resident 6 was to receive Humalog (a type of insulin) per sliding scale, based on blood sugar reading, 3 times a day. The September 2019 MAR was reviewed on 10/7/2019 at 2:45 p.m. There were no documented blood sugar readings or documented amounts of Humalog administered for the following dates and times: 9/4/2019 at 4 p.m., 9/5/2019 at 4 p.m., 9/19/2019 at 4 p.m., 9/28/2019 at 4 p.m., 9/29/2019 at 4 p.m. and 9/30/2019 at 4 p.m. During an interview on 10/8/2019 at 12:45 p.m., the Director of Nursing indicated that the blood sugar results for those days had been recorded on the 24 hour report sheet, but had not been recorded on the MAR. The Medication Management Program Guidelines policy was provided by the DON on 10/8/19 at 11:27 a.m. It read, "Purpose... To ensure that residents receive appropriate assistance with medication management...To ensure that supervision and /or assistance with medication management is performed according to state regulatory guidelines...Documentation 1. An individual mediation administration record (MAR) will be maintained for each resident receiving			

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	medication supervision, assistance and/or administration which lists the medication or treatment dosage. 2. All medications will be recorded at the time of supervision, assistance and/or administration." 410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.			
R 0354 Bldg. 00	Based on interview and record review, the facility failed to have a transfer form that included the identification data, name of the transferring institution, name of the receiving institution, date of transfer, resident's personal property, resident's functional abilities and physical limitations; nursing care; medications; treatment; and current diet and condition on transfer, diagnosis, date of chest x-ray and skin test for tuberculosis for 2 of 2 residents whose closed records were reviewed. (Residents 63 and 64) Findings include: 1. The record for Resident 63 was reviewed on	R 0354	**R-0354 Use of Transfer form for Transfer/ Discharge** **1)Corrective action for those residents affected:** **Resident #63 and #64 chart was reviewed.** **The community implemented the following two forms to be completed at any time a resident shall transfer or discharge from community: State Form 49669 “Notice of Transfer or Discharge” and also in-house form “Transfer Form” which collects the**	10/09/2019

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	10/7/2019 at 3:00 p.m. The resident's diagnoses included, but were not limited to, retention of urine and hyperlipidemia. The clinical record contained a nursing note which indicated Resident 63 had been transferred to an acute care hospital on 10/4/2019. The clinical record did not contain a transfer form. On 10/8/2019 at 9:36 a.m., the Director of Nursing provided a copy of the documents that were sent with Resident 63 to the acute care hospital, which included a face sheet, a copy of the Indian Physicians Order for Scope of Treatment form, the September 2019 physician orders sheet, and recent orders written for Resident 63. During an interview on 10/8/2019 at 11:21 a.m., the Director of Nursing indicated the facility does not have a transfer for that they routinely utilize, and that transfer form was used when Resident 63 was sent to the acute care hospital. 2. The clinical record for Resident 64 was reviewed on 10/8/2019 at 9:30 a.m. The diagnosis for Resident 64 included, but were not limited to, hypertension and dementia. The clinical record contained a nursing note dated 7/18/2019 at 2:00 p.m., indicating Resident 64 had been transferred to a memory care unit at another long term care facility. The clinical record did not contain a transfer form from the sending facility pertaining to Resident 64's needed transfer information. A nursing note dated 7/18/2019 at 2:00 p.m., stated "Resident discharged to [name of facility, sic] c[sic] all meds et[sic] personal belongings,[sic]		**following information:** **Identification Data** **Name of resident** **Name of transferring institution** **Name of receiving institution** **Date of transfer** **Resident's Personal Property when transferred to an acute care facility** **Nurse's notes will accompany these two forms stating the following:** **Functional abilities and physical limitations** **Nursing care** **Medications** **Treatment** **Current diet and condition to transfer** **A diagnosis and date of chest x-ray and skin test for tuberculosis will also accompany this information.** **1.Measures to identify and correct this problem for residents with the potential of being affected: The above listed information contained in the above mentioned forms will be accompanied with a note in the resident chart that states that these forms were completed and that the resident was provided with such forms.** **2.Systemic Change: These forms will be provided to each resident upon any transfer or**	

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	transported via PVT[personal vehicle transportation, sic] car". During an interview on 10/8/2019 at 11:21 a.m., the Director of Nursing (DON) indicated that transfer forms were not utilized when a resident was transferred or discharged. The facility would normally send a copy of the MAR (Medication Administration Record), facesheet, POST form, insurance cards, and nursing notes, if requested. The Move-Out (Discharge/Transfer Policy) Criteria policy received from the Executive Director on 10/8/2019 at 1:17 p.m., stated, "....E. The resident and/or responsible part is issued a written discharge notice (the"Notice") within the time frame required by applicable stare law or regulation (and as set forth in he resident's Residency Agreement). The Notice includes, without limitation, the following: 1. Reason for transfer/discharge including the events that were the bases for the action; 2. Effective date of the transfer; 3. Notice of the resident's right to appeal the decision (in accordance with state regulations); and 4. Address/phone number of the Ombudsman and any other agency as required by state regulations...".		**discharge with notation in nursing notes of such forms being given.** **3.Monitoring: A quality improvement review will be conducted by the Director of Nurses or designee to insure that this new method of documenting forms were provided the two discharge/ transfer to any resident discharging or transferring from the community with notation in nursing notes is in compliance and followed. This review will be conducted weekly for 4 weeks, biweekly for 4 weeks, monthly for 2 months. The results of these reviews will be reported to the QAPI Committee** **4.Compliance Date: 10/30/19**	