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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WYNDMOOR OF EVANSVILLE LLC	6521 GREENDALE DR EVANSVILLE, IN 47711

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 15 and 16, 2025 Facility number: 010681 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 22, 2024	R 0000		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were signed for 2 of 7 residents who received services in the facility. (Resident 1 and Resident 7) Findings include: 1. On 4/15/25 at 10:24 A.M., Resident 1's clinical record was reviewed. Resident 1 was admitted on 8/23/24. Diagnoses included, but were not limited to, type 2 diabetes mellitus. Resident 1's most recent service plan was revised on 2/28/25 but was not signed by Resident 1. 2. On 4/15/25 at 2:02 P.M., Resident 7's clinical record was reviewed. Resident 7 was admitted on 6/15/23. Diagnoses included, but were not limited to, heart failure.	R 0217	This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 4,2025 and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice;	05/04/2025

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

Lori Lamble 05/04/2025

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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	Resident 7's most recent service plan was revised on 12/26/24 but was not signed by Resident 7 or Resident 7's representative. During an interview on 4/16/25 at 1:30 P.M., Resident 1 and Resident 7's signed service plans were requested; the Marketing Director indicated the most recent service plans had not been signed. On 4/16/25 at 11:48 A.M., the Director of Nursing provided a policy titled Resident Evaluation and Service Plan, revised 2/2020, that indicated "Upon initial review and subsequent changes, members of the community care team and the resident/legally responsible party will sign the service plan."		Service Plans that were identified as having a missing signature will be reviewed with resident and/or family member. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All services plans will be reviewed for missing signatures. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; At the time of the service plan being updated a letter will be issued to resident and/or loved one requesting signature and opportunity for a conference if requested. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Service Plans are created upon admission and updated when there is a change in condition or routinely every 3 months. The Executive Director will audit 100% of service plans for a signature for 30 days. 50% of service plans for	

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R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on interview and record review, the facility failed to ensure as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were preauthorized by a licensed nurse for 3 of 7 resident records reviewed. (Resident 2, Resident 4, and Resident 6) Findings include: 1. On 4/15/25 at 10:30 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, restless legs syndrome. Current physician orders included, but were not limited to: ropinirole hydrochloride (HCl) (a medication used to treat restless legs syndrome) 0.5 milligram (mg) oral tablet - Give one tablet by mouth every 24 hours as needed for leg cramps, dated 4/9/24 Resident 2's Medication Administration Record (MAR) from 4/1/25 through 4/15/25 included, but was not limited to, the following dates that ropinirole HCl 0.5 mg PRN was administered by a QMA without authorization from a licensed nurse: 4/13/25 at 1:00 A.M. (given by QMA 7) 2. On 4/15/25 at 10:53 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder, pain, and end stage renal disease.	R 0246	30 days. 25% of service plans for signatures for 30 days and PRN thereafter. R.0246 This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 4,2025 and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents who were provided care by the QMA cited were reviewed. No negative outcomes were identified based upon the documentation review.¿	05/04/2025

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	Current physician orders included, but were not limited to: Norco (a narcotic pain medication) 5-325 milligrams (mg) oral tablet - Give one tablet by mouth once daily as needed for pain, dated 1/30/25 ondansetron HCL (an antiemetic medication) 4 mg - Give one tablet by mouth every eight hours as needed for nausea and vomiting, dated 10/30/24 TRUEplus Glucose (a medication used to help raise low blood glucose) 4 grams (g) Oral Tablet Chewable - Give one tablet by mouth every 15 minutes as needed for hypoglycemia. Give one table by mouth for blood sugar less than 70. Recheck in 15 minutes and if less than 60 give another, dated 1/7/25 Tylenol (a pain medication) 325 mg oral tablet - Give two tablets by mouth every six hours as needed for pain, dated 1/14/25 hydroxyzine HCl (an antianxiety medication) 25 mg oral tablet - Give one tablet by mouth every six hours as needed for anxiety, dated 1/15/25 Resident 4's Medication Administration Record (MAR) from 4/1/25 through 4/15/25 included, but was not limited to, the following dates that Norco 5-325 mg was administered by a QMA without authorization from a licensed nurse: 4/4/25 at 4:13 A.M. (given by QMA 5) 4/12/25 at 2:04 A.M. (given by QMA 29) Resident 4's MAR from 4/1/25 through 4/15/25 included, but was not limited to, the following dates that ondansetron 4 mg was administered by a QMA without authorization from a licensed		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 100% of residents who received services by the QMA cited were reviewed. No negative outcomes were identified based upon the review of resident documentation and incident reports.¿ What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; The QMA scope of practice was reviewed with nurses and QMAs on staff to educate them on the limitations of the QMA scope, as well as the need for documentation by a nurse for PRN authorization and administration immediately. A binder with PRN documentation sheets for each resident that the nurse will physically sign documenting permission given. How the corrective action will be monitored to ensure the deficient	

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	nurse: 4/4/25 at 4:15 A.M. (given by QMA 5) 4/4/25 at 8:14 P.M. (given by QMA 11) Resident 4's MAR from 4/1/25 through 4/15/25 included, but was not limited to, the following dates that TRUEplus Glucose 4 g was administered by a QMA without authorization from a licensed nurse: 4/1/25 at 8:17 A.M. (given by QMA 5) Resident 4's MAR from 4/1/25 through 4/15/25 included, but was not limited to, the following dates that Tylenol 325 mg was administered by a QMA without authorization from a licensed nurse: 4/11/25 at 10:04 P.M. (given by QMA 29) Resident 4's MAR from 4/1/25 through 4/15/25 included, but was not limited to, the following dates that hydroxyzine 25 mg was administered by a QMA without authorization from a licensed nurse: 4/11/25 at 10:03 P.M. (given by QMA 29) 3. On 4/15/25 at 11:08 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, spinal stenosis. Physician orders included, but were not limited to: hydrocodone-acetaminophen (a narcotic pain medication) 10-325 milligram (mg) oral tablet - Give one tablet by mouth every four hours as needed for pain, dated 8/12/24 Resident 6's Medication Administration Record (MAR) from 4/1/25 through 4/15/25 included, but was not limited to, the following dates that hydrocodone-acetaminophen 10-325 mg was administered by a QMA without authorization from a licensed nurse:		practice will not recur, i.e., what quality assurance program will be put into place; and The Health and Wellness Director or will review 100% of all PRN medication and treatment administrations by QMA's for 30 days. The Health and Wellness Director will review 50% of all PRN medication and treatment administrations by QMA's for days 31-60. The Health and Wellness Director or will review 25% of all PRN medication and treatment administrations by QMA's for the days 61-90.	

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	12/22/24 at 11:57 P.M. (given by QMA 7) During an interview on 4/16/25 at 9:30 A.M., QMA 9 indicated that for a QMA to give a PRN medication, authorization was needed from a nurse, and the approval was documented with the reason for administration in an order administration progress note. On 4/16/25 at 11:45 A.M., the Director of Nursing (DON) provided a current Scope of Practice for the QMA policy, dated 1/16/20, that indicated "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: ... (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty".			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on observation, record review, and interview, the facility failed to ensure that a medication error was documented in the resident's record. Resident received a medication not ordered in 1 of 5 residents reviewed during medication pass. (Resident 8) Finding includes:	R 0247	R.247 This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of	05/04/2025

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	On 4/16/25 at 6:55 A.M., during a medication pass, Qualified Medicine Aide (QMA) 3 was observed giving Resident 8 the medication Vitactiv Calcium (calcium supplement). On 4/16/25 at 10:00 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis and unspecified osteoporosis. Physician orders included, but were not limited to: Viactiv Calcium Plus D Oral Tablet Chewable 650-12.5-40 Milligrams -Micrograms (MG-MCG) Calcium with Vitamins D and K. Give one tablet by mouth one time a day for supplement, dated 4/11/25 and discontinued on 4/13/25. The current Medication Administration Record for April 2025 was reviewed and the medication was discontinued. During an interview on 4/16/25 at 9:53 A.M., the Director of Nursing (DON) indicated the medication should not have been given because it was discontinued. On 4/16/25 at 12:15 P.M., the Human Resources Director provided a current policy "Physician/Healthcare Provider's Order Summary" revised 3/31/20. The policy indicated "...the community should maintain in the resident record ... Physician/Healthcare Provider's orders in relation to resident's medications...".		May 4, 2025and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents that were affected were reviewed and no negative outcomes were evident after reviewing documentation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents that received medication from QMA during medication pass were reviewed and no negative outcomes were noted in documentation or incident reports. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; The Health and Wellness Director or will do weekly audits of medication and medication orders present in MAR/TAR. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Nursing staff responsible for passing medication will be educated through in-service on medication pass and ensuring medication given matches order prescribed. Medication Pass Training schedule with the pharmacy that facility utilizes. Health and Wellness Director or	

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			will audit 100% medication weekly for 30 days. Health and Wellness Director or will audit 50% of medication weekly for 30 days. Health and Wellness Director or will audit 25% of medication carts weekly for 30 days and PRN thereafter.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions during 2 of 2 kitchen observations. Food past their used by dates was not thrown out, food was not labeled and dated, and the window air conditioning unit was blowing air toward the food preparation area. (Kitchen) Findings include: 1. During a kitchen observation on 4/15/25 at 8:45 A.M., the following was observed: In the walk-in refrigerator: A clear bucket labeled bologna dated 4/9 A clear bucket of hot dogs with no date A container labeled soy sauce prep 2/28 use by 3/21 An open carton with an unsealed bag draped over labeled deli salad dated 4/7 A metal container of prepared sandwiches with no date A bag of mozzarella cheese opened with no date and red sauce smeared on top of bag A stack of sliced white cheese wrapped in plastic wrap with no date	R 0273	R.273 This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 4, and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; No residents were found to be affected by this practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	05/04/2025

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	In the reach-in refrigerator: Two pitchers of dark liquid unlabeled and undated One pitcher labeled tea dated 4/1 2. During an observation on 4/15/25 at 11:54 A.M., an air conditioning window unit was on and blowing cool air, facing the food preparation table (approximately four feet away), where bowls of salad were sitting uncovered. On 4/15/25 at 2:15 P.M., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated "Heating, ventilating, and air conditioning systems shall be designed and installed so that makeup air intake and exhaust vents do not cause contamination of: food; food-contact surfaces; equipment; or utensils." On 4/16/25 at 11:48 A.M., the Director of Nursing provided a policy titled Labeling and Dating for Food Safe Storage of Food, revised 3/20, that indicated "All products should be dated upon receipt. When food is taken out of an original container write the name of the food being stored on the container and the use by date ... Leftover food can be kept for a few days."		will be taken; No residents were identified to be affected by this practice. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; Dietary Manager educated all kitchen staff on proper food storage, labeling, and dating. Device added to AC unit to redirect the flow of air upwards. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Executive Director will perform a kitchen audit twice a week for 30 days, once a week for 30 days, and once every other week for 30 days. Audits will be performed PRN thereafter.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to properly store medication during a random observation of 1 of 4 medication carts. An unopened, unrefrigerated box of Ozempic (antidiabetic medication) was in	R 0298	R.298 This Plan of Correction is neither an agreement with nor an	05/04/2025

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	Medication Cart 4. (Cart 4) Finding includes: On 4/15/25 at 8:50 A.M. during a random observation, an unopened, unrefrigerated box of Ozempic for Resident 9 was observed in the resident's medication drawer located in Cart 4. On 4/16/25 at 1:00 P.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician's order included, but was not limited to: Ozempic (2 Milligrams (Mg)/Dose) Subcutaneous Solution Pen-Injector 8 MG/3 Milliliters (ML) (semaglutide) (Antidiabetic). Inject 2 mg subcutaneously one time a day every Monday with a start date of 9/2/24. The Medication Administration Record for April 2025 was reviewed and indicated that the medication was refused by the resident on 4/14/25. On 4/16/25 at 2:00 P.M., the product insert for "Ozempic Semaglutide" dated February 2025, was retrieved from the Ozempic website at https://www.ozempic.com/ozmepic.pdf#guide.pdf. The insert included: "Prior to first use, Ozempic should be stored in a refrigerator between 36 degrees Fahrenheit (F) to 46 degrees F." During an interview on 4/16/25 at 9:31 A.M., Qualified Medication Aide (QMA) 27 indicated that the Ozempic should be refrigerated before opening. On 4/16/25 at 11:47 A.M., the Director of Nursing (DON) provided a current policy "Medication and		admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 4, and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; that was affected were reviewed and no negative outcomes were noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Residents having the potential to be affected by this practice were reviewed and no negative outcomes noted. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; Nursing staff responsible for	

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	Treatment Storage" revised on 3/29/20. The policy indicated "...medications requiring refrigeration must be stored in a refrigerator located in the drug room...".		storage and administration of Ozempic were educated with the guidelines from Ozempic's website on the proper storage of the medication. Storage guidelines will be placed in refrigerator areas for reference to ensure proper storage in the future. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and and Wellness Director or will audit 100% of Ozempic storage for 30 days. Health and Wellness Director or designee will audit 50% of Ozempic storage for 30 days. Health and Wellness Director or will audit 25% of Ozempic storage for 30 days and PRN thereafter.	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to properly store and label medications in 3 of 3 medication carts and 1 of 1 treatment carts during a random observation for medication storage. The treatment cart had over the counter medications that lacked labeling. There were loose pills and improperly labeled over the counter medications in 3 of 3 medication carts reviewed for medication storage. (Cart 1, Cart 2, Cart 4, Treatment Cart 1)	R 0302	R.302 This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial	05/04/2025

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	Findings include: 1. On 4/15/25 at 8:50 A.M. during a random observation of medication Cart 1, the following was observed: 1 box of Advil (nonsteroidal pain medication) without a label or open date 1 box of Benadryl (antihistamine) with the name (Resident Name) without a label or open date. The following loose pills were observed: 1 large round white pill with TCL and numbers 340 1 small oblong white pill with number 6 2. On 4/15/25 at 9:10 A.M. during a random observation of Medication Cart 2, the following was observed: 1 box of Aleve (nonsteroidal pain medication) for (Room Number) without a label or open date 1 bottle of Miralax (laxative) for (Room Number) without a label or open date 3. On 4/15/25 at 9:20 A.M. during a random observation of the First Floor Treatment Cart, the following was observed: 1 tube of A&D ointment (antibiotic ointment) without a name, label, or open date 1 tube of Ammonium Lactate (medicated moisturizer) without a name, label, or open date 1 tube of Betamethasone (steroid) cream without a name, label or open date 4. On 4/15/25 at 9:31 A.M. during a random observation of Medication Cart 4, the following was observed: 1 container of Vita Calcium for (Room Number)		compliance with this plan of correction as of May 4, and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents that were affected were reviewed and no negative outcomes were noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Residents having the potential to be affected by this practice were reviewed and no negative outcomes noted. All OTC medication will be reviewed by HWD to ensure proper labeling. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; The nursing staff responsible for	

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	without a name, label or open date. 1 box of Pepcid (decrease acid production) for (Room Number) without name, label or open date 1 tube of Diclofenac Sodium (nonsteroidal) cream for (Resident Name) with no name, label, or open date. 1 tube of A and D ointment with (Resident Name) without a label or open date 1 bottle of Vashe Wound Cleaner without a name, label, or open date 1 box of Dulcolax (laxative) pills without a name, label, or open date During an interview on 4/15/25 at 8:50 A.M., Qualified Medication Aide (QMA) 23 indicated that there should be no loose pills and she would notify the nurse and place them in the drug buster pill destroyer. During an interview on 4/16/25 at 8:10 A.M., the Director of Nursing (DON) indicated that medications such as over the counter should have physician name, resident name, label, and date opened. On 4/16/25 at 12:15 P.M., the DON provided a current policy "Medication and Treatment, Disposal of Unused" revised on 8/18/22. The policy indicated "... medication disposal should follow federal and state laws for all unused uncontrolled and controlled medications...".		storing and labeling OTC medications were educated through in-service on facility policy on labeling OTC medications and what must be present. Requirements of labeling OTC medications were placed on each medication cart to ensure proper labeling in the future. Nursing staff on medication carts will do self-audits weekly on carts to ensure proper labeling. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Health and Wellness Director or will audit 100% of OTC labeling for 30 days. Health and Wellness Director or will audit 50% of OTC labeling for 30 days. and Wellness Director or will audit 25% of OTC labeling for 30 days and PRN thereafter.	
R 0379 Bldg. 00	410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency Based on interview and record review, the facility failed to ensure a resident who required a mental health assessment was assessed and offered mental health consultation for 1 of 1 residents reviewed for Medicaid recipients with major	R 0379	R.379	05/04/2025

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	mental illness. (Resident 5) Finding includes: On 4/15/25 at 11:00 A.M., Resident 5's clinical record was reviewed. Resident 5 was admitted on 2/7/25. Diagnoses included, but were not limited to, major depressive disorder and anxiety disorder. An admission application, dated 2/7/25, indicated Resident 5 was a Medicaid waiver and Supplemental Security Income (SSI) recipient payer source. Physician orders included, but were not limited to: citalopram hydrobromide (an antidepressant medication) 20 mg (milligrams) give one tablet by mouth one time a day related to anxiety disorder; Start date 2/8/25. The clinical record lacked a mental health assessment or mental health provider consultation offered. During an interview on 4/16/25 at 8:50 A.M., the Director of Nursing (DON) indicated Resident 5 did not have mental health assessment or was not offered to see mental health services to manage major mental illness diagnoses. During an interview on 4/16/25 at 2:05 P.M., the Marketing Director indicated the facility did not have a mental health service refusal or mental health services provided for Resident 5. On 4/16/25 at 11:48 A.M., a policy related to assessment or treatment of resident recipients of Medicaid with major mental illness was requested. During an interview on 4/16/25 at 2:05 P.M., the		This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 4, and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents found to be affected were reviewed and no negative outcomes noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Other residents were reviewed, and no negative outcomes were identified upon reviewing documentation. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;	

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	Regional Consultant indicated the facility did not have a written policy, but the policy was to follow State regulations.		A consent/decline form will be initiated at the time of admission offering mental health services to residents. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Mental Health Services will be reviewed on admission by and Wellness Director or to ensure residents are receiving requested treatment.	
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance Based on interview and record review, the facility failed to ensure a service plan of care related to major mental illness diagnoses was developed for 1 of 1 residents reviewed for Medicaid recipients with major mental illness. (Resident 5) Finding includes: On 4/15/25 at 11:00 A.M., Resident 5's clinical record was reviewed. Resident 5 was admitted on 2/7/25. Diagnoses included, but were not limited to, major depressive disorder and anxiety disorder. An admission application, dated 2/7/25, indicated Resident 5 was a Medicaid waiver and Supplemental Security Income (SSI) recipient payer source.	R 0382	R.382 This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 4, and requests paper compliance for this survey.	05/04/2025

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	Physician orders included, but were not limited to: citalopram hydrobromide (an antidepressant medication) 20 MG (milligrams) give one tablet by mouth one time a day related to anxiety disorder; Start date 2/8/25. The clinical record lacked a service plan of care related to Resident 5's major mental illnesses. During an interview on 4/16/25 at 8:50 A.M., the Director of Nursing (DON) indicated Resident 5's service plan of care did not include mental illness care. On 4/16/25 at 11:48 A.M., the DON provided a policy titled Resident Evaluation and Service Plan, revised 2/2020, that indicated "An evaluation and service plan will be developed, implemented and maintained for each resident..(and) will include specific and individualized needs of the resident (and) approaches for the care of the resident based on their needs." During an interview on 4/16/25 at 2:05 P.M., the Regional Consultant indicated the facility's policy was to follow State regulations.		What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents found to be affected were reviewed and no negative outcomes noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Other resident service plans were reviewed, and no negative outcomes were identified upon reviewing documentation. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; Comprehensive Behavior Care Plan Addendum added to current resident service plan to be completed at time of admission, change of condition, and routinely every three months. How the corrective action will be monitored to ensure the deficient	

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			practice will not recur, i.e., what quality assurance program will be put into place; and The Executive Director will audit 100% of service plans to review the addendum for 30 days. 50% of service plans for 30 days. 25% of service plans for 30 days and PRN thereafter.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were performed during 5 of 5 random observations. Staff were observed not performing hand hygiene during a medication pass on the second floor. (Resident 11, Resident 8, Resident 10, Resident 9, Resident 12) Findings include: 1. On 4/16/25 at 6:45 A.M., Qualified Medication Aide (QMA) 3 was observed not performing hand hygiene prior to the administration and after giving medication to Resident 11. 2. On 4/16/25 at 6:55 A.M., QMA 3 was observed not performing hand hygiene prior to the administration and after giving medications to Resident 8. 3. On 4/16/25 at 7:15 A.M., QMA 3 was observed not performing hand hygiene prior to the	R 0414	R.414 This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 4, and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice;	05/04/2025

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	administration and after giving medications to Resident 10. 4. On 4/16/25 at 7:55 A.M., QMA 3 was observed not performing hand hygiene prior to the administration and after giving medications to Resident 9. 5. On 4/16/25 at 8:05 A.M., QMA 3 was observed not performing hand hygiene prior to the administration and after giving medications to Resident 12. During an interview on 4/16/25 at 8:10 A.M., the Director of Nursing (DON) indicated that staff should sanitize their hands in between residents. On 4/16/25 at 11:47 A.M., the DON provided a current policy "Handwashing" revised on 3/26/20. The policy indicated "...this policy is to enforce handwashing procedures as part of infection prevention...handwashing will be performed...before and after performing resident care...".		Residents found to be affected were reviewed and no negative outcomes noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Other residents that received care from QMA cited were reviewed and no negative outcomes were noted. measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; All nursing staff by facility IP on the importance of handwashing and the proper way to wash hands to prevent the spread of infection. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Monthly in-services on handwashing will be conducted by the Health and Wellness Director. The Health and Wellness director will do random audits of	

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			handwashing 8 times a month for 30 days, 6 times a month for 30 days, and 4 times a month for 30 days. Audits will occur PRN thereafter.	