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	05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MEADOW BROOK SENIOR LIVING	11011 VILLAGE SQUARE LANE FISHERS, IN 46038

(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. This visit included the Investigation of Complaint IN00352545. Complaint IN00352545- Substantiated. State Residential Findings are cited at R0036 and R0090. Survey dates: May 6 and 7, 2021 Facility number: 13163 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 17, 2021	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review the facility failed to timely inform the physician and the legal representative of an injury for 1 of 3 residents reviewed for skin conditions (Resident F) Findings include:	R 0036	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.	06/29/2021

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

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	The clinical record for Resident F was reviewed on 5/6/21 at 1:00 p.m. The Resident's diagnosis included, but were not limited to, Alzheimer's dementia and osteoporosis. A progress noted, 2/18/21 at 4:19 p.m., indicated a bruise was found on her left shoulder. The bruise extended from the shoulder to the inner part of the elbow and was dark purple. The physician and the family were informed on the bruise at that time. A progress note, dated 2/18/21 at 8:34 p.m., indicated the physician had called the facility and given a verbal order for labs to be drawn. The lab was notified. Her family had made an appointment for her to be seen by the physician on 2/19/21. A progress noted, dated 2/19/21 at 5:55 p.m., indicated she had returned for her physician's appointment with new orders for a left shoulder and left humerus (upper arm) x ray and to received 2 Tylenol Extra Strength 500 mg(milligram) every 8 hours for 7 days. A progress noted, dated 2/22/21 at 10:31 a.m., indicated the x ray results had been received and that she had a fractured left clavicle. The responsible party and the physician were notified. During an interview on 5/6/21 at 3:10 p.m., the DW (Director of Wellness) indicated that Resident F did have a large bruise on her left shoulder and upper arm that was found on 2/17/21. The nurse on duty at that time did not document the bruise or inform him of the bruise at the time it was found. The staff had noticed the bruise while getting her dressed on 2/18/21 and informed him of it at that time. When he was notified of the bruise, he had contacted the physician and the		This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. R36 Resident Rights With regards to finding R36 Resident Rights Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** All residents had the potential to be affected. No resident was found to be adversely affected. Resident F has discharged from community. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was found to be adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:***	

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	family had been notified. He had spoken with the staff who worked during the week that the bruise appeared and had been unable to determine a cause for the bruise and fracture. It should have been reported to the physician and family at the time it was found. During an interview on 5/6/21 at 5:29 p.m., FM (Family Member) 6 indicated she had been informed of the bruise on Resident F's left shoulder and upper arm on 2/18/21, the day after it happened. She was concerned that no one seemed to have noticed the bruise earlier, because when she saw the bruise on 2/19/21 it had begun to yellow in places, as if it was healing. During an interview on 5/7/21 at 9:24 a.m., the MDC (Memory Care Director) indicated she had first seen the bruise on 2/18/21 and it extended from her mid shoulder to the middle of her left bicep area. She had seen it again the next day it had spread considerable. It was farther up her shoulder onto the base of her neck and down to the inner part of the elbow. It had started to have a yellow appearance at the edge by her inner elbow. On 5/7/21 at 10:10 a.m., the ED (Executive Director) provided the Daily Log report from 2/10/21 through 4/28/21 for Resident F, which contained an entry, dated 2/17/21 at 9:33 p.m., which read "Resident has bruise on her upper left shoulder and collar bone area. There are smaller bruises on her right arm as well. Resident said those area {sic} are painful to touch." This State Tag relates to complaint IN00352545.		Staff will be in serviced on the Reporting, Investigating and Resident Rights by June 29th, 2021 . The facility also conducts these in-services for all new employees on hire, annually, and as needed for ongoing training. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** The Administrator or Designee will randomly select 5 staff members each week to take a test regarding reporting X 2 months, then 1 X a month X 4 months, the 1 X a quarter. The results will be reviewed at the monthly QA meeting. ***By what date the systemic changes will be completed:*** June 29th, 2021	
R 0090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency			

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Bldg. 00	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be			

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	available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review the facility failed to timely inform the Indiana State Department of Health of an unusual occurrence involving a large bruise and a fracture for 1 of 3 residents reviewed for skin conditions (Resident F) Findings include: The clinical record for Resident F was reviewed on 5/6/21 at 1:00 p.m. The Resident's diagnosis included, but were not limited to, Alzheimer's dementia and osteoporosis. A progress noted, 2/18/21 at 4:19 p.m., indicated a bruise was found on her left shoulder. The bruise extended from the shoulder to the inner part of the elbow and was dark purple. The physician and the family were informed on the bruise at that time. A progress note, dated 2/18/21 at 8:34 p.m., indicated the physician had called the facility and given a verbal order for labs to be drawn. The lab was notified. Her family had made an appointment for her to be seen by the physician on 2/19/21. A progress noted, dated 2/19/21 at 5:55 p.m., indicated she had returned for her physician's appointment with new orders for a left shoulder and left humerus (upper arm) x ray and to received 2 Tylenol Extra Strength 500 mg(milligram) every 8	R 0090	R90 Resident Rights With regards to finding R90 Resident Rights Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** Upon notification Administrator will follow all reporting and investigating policy & procedures. Physician and Family for Resident F were notified of incident. Resident F has since discharged from the community. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was found to be adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure***	06/29/2021

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	hours for 7 days. A progress noted, dated 2/22/21 at 10:31 a.m., indicated the x ray results had been received and that she had a fractured left clavicle. The responsible party and the physician were notified. During an interview on 5/6/21 at 3:10 p.m., the DW (Director of Wellness) indicated the staff had noticed the bruise while getting her dressed on 2/18/21 and informed him of it at that time. When he was notified of the bruise, he had contacted the physician and the family had been notified. He had also informed the Executive Director at the time. On 5/6/21 at 3:33 p.m., the DW provided a copy of the report submitted to the Indiana State Department of Health, which indicated the incident dated was 2/18/21. The brief description of the event was dated 4/1/21 and noted that on 2/18/21 Resident F had bruising to her left shoulder and arm. During an interview on 5/6/21 at 3:33 p.m., the DW indicated that the incident had not been reported to the Indiana State Department of Health by the previous Executive Director. On 5/7/21 at 2:20 p.m., the ED (Executive Director) provided the Incident/ Occurrences Reporting Policy, revised January 2015, which read "The administrator is responsible for the overall management of the facility including informing the division within twenty-four [24] hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a Resident..." This State Tag relates to complaint IN00352545		***that the deficient practice does not recur:*** Staff will be in serviced on the Reporting, Investigating and Resident Rights by June 29th, 2021 by the Executive Director. The facility also conducts these in-services for all new employees on hire, annually, and as needed for ongoing training. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** The Administrator or Designee will randomly select 5 staff members each week to take a test regarding reporting X 2 months, then 1 X a month X 4 months, the 1 X a quarter. The results will be reviewed at the monthly QA meeting. ***By what date the systemic changes will be completed*** June 29th, 2021	

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R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) 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 to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review the facility failed to assure the Director of the dementia unit had 12 hours of dementia training within 3 months of employment for 1 of 5 employee records reviewed (Memory Care Director) Findings include: The employee record for the MCD (Memory Care Director) was reviewed on 5/7/21 at 10:30 a.m. The	R 0095	R95 Administration & Management With regards to finding R95 Administration & Management Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those***	06/29/2021

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	date of hire for the MCD was 2/5/21. The employee record for the MCD did not contain documentation verifying that 12 hours of dementia care training had been completed. A course summary provided by BOM (Business Office Manager) on 5/7/21 at 12:47 p.m. indicated, MCD had completed the following courses in dementia care training: Understanding Alzheimer's Disease and Dementia = 1 credit hour Dementia Care: helping Families and Friends = 1 credit hour Dementia Care: Managing Challenging Behaviors = 0.5 credit hours Dementia Care Preventing Catastrophic Reactions = 1 credit hour Dementia Care: normal Aging vs. Dementia/Alzheimers = 1 credit hour Alzheimer's Disease and Related Disorders: Activities of Daily Living = 1 credit hour A copy of an email provided by BOM on 5/7/21 at 1:33 p.m. indicated MCD had taken a Spectrum Memory Care course but was not accredited by the state. During an interview on 5/7/21 at 12:47 p.m., the BOM indicated she would have to reach out to the corporate office to find out the number of credit hours earned for each dementia training class, but she understood the MCD is required to have 12 hours of dementia care training within 3 months from date of hire. On 5/10/21 at 8:27 a.m., an email from the BOM was received and indicated, the credit hours earned for each course.		***residents found to have been affected by the finding:*** No memory care resident was found to be adversely affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All memory care residents have the potential to be adversely affected. No memory care resident was found to be adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Memory Care Director, Wellness Director, and Executive Director are scheduled to attend Dementia Training on 6/10/2021, 6/17/2021 and 6/24/2021. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Memory Care Director, Wellness Director and Executive Director will all meet the Memory Care	

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			Director qualifications by June 29th, 2021 training will be confirmed/monitored by the Regional Vice President of Operations and Vice President of Cognitive Care. ***By what date the systemic changes will be completed:*** June 29th, 2021	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			

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	Based on record review and interview, the facility failed to ensure at least one staff member with current CPR (cardiopulmonary resuscitation) and first aide certification was on site at all times for 8 of 8 days reviewed for CPR and first aide. (48 residents) Findings include: A record review of the facility schedule, as worked, for the time period of 4/28/21 to 5/5/21 was reviewed on 5/7/21. A record review of the staff's CPR and first aide certifications, provided by the BOM on 5/7/21 at 9:15 a.m., was reviewed on 5/7/21. Based on the comparison of the working schedule for 4/28/21 to 5/5/21 and the staff's CPR/FA (first aide) certifications, the following days and shifts did not have at least one staff member with the following certifications: 4/28/21--No FA on first shift; No CPR or FA on second and third shift 4/29/21--No FA on first shift; No CPR or FA on third shift 4/30/21--No FA on first shift; No CPR or FA on third shift 5/1/21--No CPR or FA on any shift 5/2/21--No CPR or FA on any shift 5/3/21--No FA on first shift; No CPR or FA on third shift 5/4/21--No FA on first shift; No CPR or FA on third shift 5/5/21--No FA on first shift; No CPR or FA for second and third shift An interview with MCD was conducted on 5/7/21 at 2:55 p.m. She indicated, the facility needs to have a CPR and FA class to ensure they have	R 0117	R117 Personnel With regards to finding R117 Personnel Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome identified for those residents affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was adversely affected. An audit was completed to further identify any licensed nursing staff that required first aid & CPR training. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** An audit of existing licensed nursing staff has been completed and CPR & first aid training courses were provided for those identified licensed nursing staff that required training.	06/29/2021

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	enough staff that have their CPR and FA certifications for each shift worked.		***How the corrective action(s) will be monitored to ensure the finding will not recur:*** The Business Office Manager or designee will conduct monthly audit to ensure licensed nursing staff have current CPR & first aid certification. This process will be ongoing. ***By what date the systemic changes will be completed:*** June 29th, 2021	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure residents were evaluated to self administer their medications for 1 of 8 residents' medication administrations observed and 2 of 5 residents reviewed. (Resident	R 0216	R216 Evaluation With regards to finding R216 Evaluation Meadow Brook Senior Living, LLC will;	06/29/2021

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	1, 14, and 43) Findings include: 1. The clinical record for Resident 1 was reviewed on 5/6/21 at 1:22 p.m. The diagnoses for Resident 1 included, but were not limited to, heart failure, hypertension, osteoarthritis of the knee and chronic kidney failure. An interview was conducted with DON (Director of Nursing) on 5/6/21 at 4 p.m. He indicated, Resident 1's medications used to be administered by the facility when he first was admitted to the facility on 10/10/20, but then in December of 2020, the resident's daughter took over his medications. She "sets them up for a few days" and then he administers the medication to himself. "I guess he is considered a self-administration for medications". An interview with Resident 1 was conducted on 5/7/21 at 10:50 a.m. Resident 1 indicated, his daughter sets up his medications in a daily pill planner and he takes them. He further indicated, he does not know the medications that he takes everyday. An observation of Resident 1's room was made at the same time as the interview. It was observed that Resident 1 had his daily pill planner, which contained multiple pills, beside his chair and had bottles of medications in a tub in his closet up on a shelf. There was no evaluation of Resident 1's ability to self administer medications in her clinical record. 2. The clinical record for Resident 14 was reviewed on 5/6/21 at 3:45 p.m. The diagnoses for Resident 14 included, but were not limited to, age related		***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome identified for those residents affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** An audit was completed of all residents any resident that self-administers medications will complete a self- administer evaluation. Evaluations will be completed every 6 months and at the time of any significant change. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Regional Nurse will conduct a monthly audit of residents that self-administer medications to	

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	cognitive decline and chronic pain. A physician order dated 2/25/21 indicated Resident 14 was to receive 650 milligrams of Tylenol three times a day. An observation was made of medication administrations with QMA (Qualified Mediation Aide) 2 on 5/6/21 at 12:43 p.m. During that time, QMA 2 was observed walking into Resident 14's room and sitting down a cup of pills on the counter. Resident 14 was not in her apartment. QMA 2 indicated at that time, Resident 14 was downstairs, but she liked her afternoon medication left on the kitchen counter. The resident would take the mediation after she returned to her apartment. That was the arrangement that was made between her and Resident 14. She leaves the medication for the resident every afternoon. The clinical record did not contain a self medication evaluation for Resident 14. An interview was conducted with QMA 3 and License Practical Nurse (LPN) 1 on 5/6/21 at 4:10 p.m. They indicated Resident 14 does not self medicate. The staff administers her medications. 3. The clinical record for Resident 43 was reviewed on 5/6/21 at 3:05 p.m. The diagnoses for Resident 43 included, but were not limited to, chronic obstructive pulmonary disease, unspecified (COPD), aortic (valve) stenosis. A service plan for Resident 43 dated 2/17/21 indicated "...Resident does not require assistance with medication administration. The clinical record did not contain a self		ensure current evaluations. ***By what date the systemic changes will be completed:*** June 29th, 2021	

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	medication evaluation completed for Resident 43. An interview was conducted with the Memory Care Director on 5/7/21 at 10:30 a.m. She indicated the residents self mediation evaluation should be conducted every 6 months. A Self-Administration of Medication Assessment policy was provided by the Executive Director on 5/7/21 at 2:32 p.m. It indicated "...Policy. Only Residents that are able to successfully pass a self-mediation assessment and have written permission from the Primary Care Provider may self-administer medications in the community...Procedure. 1. The Director of Wellness [DOW] or designee will complete a Self Medication Assessment in the Electronic Health Record [EHR] for any Resident wishing to self-administer medications: a. Upon admission b. Prior to self-administration c. After a significant change of condition d. Reassess every 6 months. 2. The DOW or designee shall obtain written orders from the Primary Care Provider [PCP] prior to the resident self-administrating medications..."			
R 0244 Bldg. 00	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation, interview, and record review, the facility failed to ensure staff were not prepulling medications for other shifts and were able to identify medications that were prepulled through out the day for 6 of 8 medication administrations observed and 2 of 3 medication carts reviewed. (Residents' 10, 14, 15, 24, 25, 33, 48 and 54) Findings include:	R 0244	R244 – Health Services With regards to finding R244 Health Services Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:***	06/29/2021

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	1a. The clinical record for Resident 24 was reviewed on 5/6/21 at 1:30 p.m. The diagnoses for Resident 24 included, but were not limited to, Parkinson's Disease and dementia. A physician order dated 6/12/20 indicated Resident 24 was to receive 50 milligrams of bethanechol Chloride three times a day. A physician order dated 12/3/20 indicated Resident 24 was to receive 25 milligrams of carbidopa-leveldopa four times a day. 1b. The clinical record for Resident 25 was reviewed on 5/6/21 at 1:35 p.m. The diagnoses for Resident 25 included, but were not limited to, dementia and hypertension. A physician order dated 3/4/21 indicated Resident 25 was to receive 125 milligrams of divalproex sodium three times a day 1c. The clinical record for Resident 54 was reviewed on 5/6/21 at 1:40 p.m. The diagnoses for Resident 54 included, but were not limited to, dementia and angina pectoris. A physician order dated 1/18/21 indicated Resident 54 was to receive 10 milligrams of bentyl three times a day. An observation was made of medication administrations with Qualified Medication Aide (QMA) 4 on 5/6/21 at 12:00 p.m. She was observed at the medication cart with three residents' medications already pulled and prepped in the medication cups. One of the three cups of medications indicated it was for Resident 24. QMA 4 indicated Resident 24 takes her medication crushed with pudding. QMA 4 at that		No negative outcome identified for those residents involved. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No residents were adversely affected. The Wellness Director conducted a review of all medication carts checking to ensure medications were not pre-set and provided education to nursing staff regarding appropriate medication administration procedure. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Education was provided by Wellness Director to all licensed nurses and QMAs as it relates to medication administration policy and procedure. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** The Wellness Director or designee	

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	time could not identify what medications had been crushed in the cup. She indicated the resident was getting three medications. After pulling the medication cards and reviewing of the medication QMA 4 had clarified the resident did not have three medications in the cup she only had two. Resident 24 was going to receive 50 milligrams bethanechol Chloride and 25 milligrams of carbidopa-leveldopa. After the administration to Resident 24, QMA 4 returned to the medication cart. The 2nd medication cup had a written name of Resident 25. QMA 4 could not identify the medication in the cup with pudding. After pulling the medication card she was able to determine it was 125 milligrams of divalproex. After the administration, QMA 4 then returned to the medication cart for the third medication cup. The cup had a written name of Resident 54. QMA 4 was unable to identify the medication in the cup. QMA 4 then reviewed the resident's medication cards and determined the medication was 10 milligrams of bentyl . An interview was conducted with QMA 4 on 5/6/21 at 12:10 p.m. She indicated prepulling and setting up the residents' medication for the afternoon medication pass was normal practice for her. 2a. The clinical record for Resident 15 was reviewed on 5/6/21 at 3:30 p.m. The diagnoses for Resident 15 included, but were not limited to, congestive heart failure and dementia. A physician order dated 11/9/20 indicated Resident 15 was to receive 500 milligrams of Tylenol three times a day. 2b. The clinical record for Resident 10 was reviewed on 5/6/21 at 3:35 p.m. The diagnoses for		will audit medication cart for preset medications 2x weekly x 1 month, weekly x 3 months and random audits ongoing to monitor for compliance. This practice will be ongoing. ***By what date the systemic changes will be completed:*** 06/29/2021	

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	Resident 10 included, but were not limited to, hypertension and high cholesterol. A physician order dated 4/28/21 at 4/28/21 indicated Resident 10 was to receive 500 milligrams of amoxicillin three times a day. 2c. The clinical record for Resident 14 was reviewed on 5/6/21 at 3:45 p.m. The diagnoses for Resident 14 included, but were not limited to, age related cognitive decline and chronic pain. A physician order dated 2/25/21 indicated Resident 14 was to receive 650 milligrams of Tylenol three times a day. An observation was made of medication administration with QMA 2 on 5/6/21 at 12:43 p.m. She was observed in the medication room with three medication cups with residents' room numbers written on them already pulled and prepared to administer. QMA 2 indicated at that time she was unable to identify the medications in each of the medication cups without pulling the medication cards. After she pulled the medication cards for all three of the residents she was able to identify the medications in the cups. Resident 10 was going to receive 500 milligrams of amoxicillin, Resident 14 was going to receive 650 milligrams of Tylenol, and Resident 15's afternoon medication was 500 milligrams of Tylenol and 2 milligrams of imodium. An interview was conducted with QMA 2 on 5/6/21 at 1:36 p.m. She indicated she always prepulls the residents' afternoon medications after she completes the morning med pass. "I don't have anything to do, so I do that." 3a. The clinical record for Resident 33 was			

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	reviewed on 5/6/21 at 2:30 p.m. The diagnoses for Resident 33 included, but were not limited to, pain and anxiety. 3b. The clinical record for Resident 48 was reviewed on 5/6/21 at 2:35 p.m. The diagnoses for Resident 48 included, but were not limited to, chronic kidney disease and dizziness. An observation was made with QMA 2 of the 2nd floor medication cart on 5/6/21 at 1:00 p.m. The medication cart contained two medication cups with medications in them sitting in the top drawer. There were numbers written on the cups. QMA 2 indicated the medications were prepulled for the evening medication pass for the evening staff member to administer. The numbers on the cups were identified by the residents' room numbers. One of the medication cups was for Resident 48, and the other was for Resident 33. She indicated she could not identify the medications nor had she pulled them. A Medication Assistance/Administration: Routine Medications policy was provided by the Executive Director on 5/7/21 at 2:32 p.m. It indicated "..Assist one Resident at a time following established procedures. 'Pre-pouring' for multiple Residents is not allowed..."			
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 and interview the facility failed to ensure food was properly stored in the dementia kitchen refrigerator for 13 of 13 residents	R 0273	R273 – Food & Nutritional Services -	06/29/2021

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	residing on the memory care unit. Findings include: A tour of the kitchen area on the memory care unit was conducted on 5/6/21 at 11:30 a.m. with DM (Dietary Manager) 10. The memory care refrigerator contained the following items: -An opened Boston creme pie without an opened date or resident label affixed. -An opened, personal sized bottle of milk without an opened date or resident label affixed. -Three opened container of mustard without an opened date. -Two opened boxes of thickened orange juice without an opened date or resident label affixed. -One opened box of thickened lemon water without an opened date or resident label affixed. An interview with DM was conducted on 5/6/21 at 11:42 a.m. She indicated, she was just hired for the position as DM and had not had the time to clean out the memory care refrigerator and ensure items were dated and labeled as needed. She stated that all items should be dated when opened and labeled with the appropriate resident's name as needed. The Indiana Retail Food Manual states, "Sec. 177. (a) Except as specified in subsections (b) and (c), food shall be protected from contamination by storing the food as follows: (1) In a clean, dry location. (2) Where it is not exposed to splash, dust, or other contamination. (3) At least six (6) inches above the floor. (4) In a manner to prevent overcrowding. (5) In packages, covered containers, or wrappings.		With regards to finding R273 Food & Nutritional Services Services Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome identified for those residents affected ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was adversely affected. An audit was completed to further identify any concerns, none noted. Staff will be educated on labeling and dating items in refrigerator. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Culinary Manager or Designee will audit memory care refrigerator daily to ensure compliance with proper food storage and labeling. ***How the corrective action(s) will***	

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	(b) Food in packages and working containers may be stored less than six (6) inches above the floor on case lot handling equipment....Sec. 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day one (1): (1) Forty-one (41) degrees Fahrenheit or less for a maximum of seven (7) days. (2) Forty-five (45) degrees Fahrenheit or between forty-one (41) degrees Fahrenheit and forty-five (45) degrees Fahrenheit for a maximum of four (4) days in existing refrigeration equipment that is not capable of maintaining the food at forty-one (41) degrees Fahrenheit or less if: (A) the equipment is in place and in use in the food establishment, and (B) the equipment is upgraded or replaced to maintain food at a temperature of forty-one (41) degrees Fahrenheit or less as specified in section 187(a)(2)(B)(ii) of this rule. (b) Except as specified in (d) and (e) of this section, refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a retail food establishment and if the food is held for more than twenty-four (24) hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in subsection (a) and:		***be monitored to ensure the finding will not recur:*** Executive Director or Designee will monitor Dietary Managers audit tool weekly X 1 month, monthly x 2 months and random audits ongoing. ***By what date the systemic changes will be completed:*** June 29th, 2021	

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	(1) the day the original container is opened in the retail food establishment shall be counted as day one (1); and (2) the day or date marked by the retail food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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. Based on observation, interview and record review, the facility failed to ensure medications that were stored in the medication carts had open or expired dates for 2 of 3 medication carts reviewed. (Resident 14, 29, 33, 39, 48, and 54) Findings include: 1a. The clinical record for Resident 48 was reviewed on 5/6/21 at 2:35 p.m. The diagnoses for Resident 48 included, but were not limited to, chronic kidney disease and dizziness. A physician order dated 3/17/21 indicated Resident 48 was to receive 4 drops in ears every week once a day. A physician order dated 11/30/20 indicated Resident 48 was to receive 1 drop into each eye every night. 1b. The clinical record for Resident 33 was	R 0300	R300 – Pharmaceutical Services With regards to finding R300 Pharmaceutical Services Services Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** There were no adverse reactions noted regarding residents. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** The Wellness Director and/or	06/29/2021

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	reviewed on 5/6/21 at 2:30 p.m. The diagnoses for Resident 33 included, but were not limited to, pain and anxiety. A physician order dated 1/26/21 indicated Resident 33 was to receive 2 drops in each eye of Refresh eye drops. 1c. The clinical record for Resident 39 was reviewed on 5/6/21 at 3:15 p.m. The diagnoses for Resident 39 included, but were not limited to, high cholesterol and hypertension. A physician order dated 1/20/20 indicated Resident 39 was to receive 1 drop of Latanoprost in each eye nightly. An observation was made with Qualified Medication Aide (QMA) 2 of the 2nd floor medication cart on 5/6/21 at 1:00 p.m. The top drawer of the medication cart was observed with medications stored in it. The following residents' medications were in the top drawer opened, but did not have open or expired dates: Refresh eye drops for Resident 33, douliquid ear drops and latanoprost eye drops for Resident 48, and Latanoprost eye drops for Resident 39 An interview was conducted with QMA 2 on 5/6/21 at 1:10 p.m. She indicated the medications in the cart were opened, but she does not administer those medications to Resident 33, 48 and 39. Another shift does. She was unsure if once a medication was opened an open or expiration date should be placed on the medication. 2a. The clinical record for Resident 14 was		designee conducted a review of all medication carts checking to ensure medications were labeled and that all medications that require a “date open” date were appropriately dated. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Education was provided by Wellness Director to all licensed nurses and QMAs as it relates to labeling and dating medications. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** The Wellness Director or designee will audit medication carts for date open labels and expiration dates weekly X 3 months, monthly x 3 months and random audits ongoing to monitor for compliance. This practice will be ongoing. ***By what date the systemic changes will be completed:*** **June 29th, 2021**	

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	reviewed on 5/6/21 at 3:45 p.m. The diagnoses for Resident 14 included, but were not limited to, age related cognitive decline and chronic pain. 2b. The clinical record for Resident 29 was reviewed on 5/6/21 at 3:05 p.m. The diagnoses for Resident 29 included, but were not limited to, dementia and hypertension. A physician order dated 2/12/21 indicated Resident was to receive 4 drops in each ear for earwax weekly on Sundays and Mondays. 2c. The clinical record for Resident 54 was reviewed on 5/6/21 at 1:40 p.m. The diagnoses for Resident 54 included, but were not limited to, dementia and angina pectoris. A physician order dated 1/18/21 indicated Resident 54 was to receive 1 drop in right eye nightly. An observation was made of the medication cart on the Memory Care Unit with License Practical Nurse (LPN) 1 on 5/6/21 at 4:00 p.m. The medication cart contained in the top drawer a Toujeo insulin flex pen for Resident 14, latanoprost eye drops for Resident 54 and a bottle of ear drops for Resident 29. The medications did not have open or expired dates. Resident 54's ear drops had a manufacture date of 5/12/20. An interview was conducted with LPN 1 at 5/6/21 at 4:05 p.m. She indicated Resident 14's Toujeo insulin flexpen had been opened and used. The medications that did not have open or expired dates were missed. Resident 54's ear drops were "old." A Medication and Treatment Labels policy was			

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MEADOW BROOK SENIOR LIVING	11011 VILLAGE SQUARE LANE FISHERS, IN 46038

(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
	provided by the Executive Director on 5/7/21 at 2:32 p.m. It indicated "...Policy. All medications and treatments, including over-the-counter medications, should be labeled with the necessary information to provide safe assistance or administration procedures. The label should be consistent with a Physician's Order and with regulatory requirements. Procedure. Medication and Treatment Labels 1. The label should be clean, legible and intact. The label should include the following: ...i. Expiration date..."			
R 0354 Bldg. 00	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. Based on interview and record review, the facility failed to ensure a resident's record included a transfer form for 1 of 2 closed records reviewed. (Resident 42) Findings include: The clinical record for Resident 42 was reviewed on 5/6/21 at 11:50 a.m. The diagnoses for	R 0354	R354 – Clinical Records With regards to finding R354 Clinical Records Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been***	06/29/2021

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	Resident 42 included, but were not limited to, dementia. The 4/29/21, 9:14 a.m. nurses note read, "Res [Resident] has moved out this morning to go to [name of new facility], in [town of new facility's] Memory care unit. Was transported by family. All her meds [medications] have been picked by family to the new place." An interview was conducted with the Wellness Director on 5/6/21 at 2:20 p.m. He indicated they used transfer forms when a resident transferred to another facility. There was no transfer form in the clinical record for Resident 42's transfer to her new facility on 4/29/21. An interview was conducted with the Wellness Director on 5/6/21 at 3:43 p.m. He indicated there was no transfer form for Resident 42, and he did not send any information to the new facility afterwards. Resident 42's daughter informed the facility on 4/28/21 that she would be transferring to another facility on 4/29/21. She left the morning of 4/29/21 during breakfast with her medications, and her belongings were collected the following day. An interview was conducted with the Executive Director on 5/7/21 at 2:18 p.m. He indicated the facility had no policy on transfer forms.		***affected by the finding:*** No negative outcome identified for those residents affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Appropriate staff will be trained on transfer/discharge forms necessary. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director or designee will audit all transfer/discharges to ensure appropriate paperwork completed. This audit will remain on going. ***By what date the systemic changes will be completed:***	

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R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed failed to properly prevent and/or contain COVID-19 by not ensuring staff donned on the appropriate Personal Protective Equipment (PPE) prior to entering a resident's room that was in contact isolation due to exposure of COVID-19 for 1 of 8 residents observed during medication administrations. (Resident 48) Findings include: The clinical record for Resident 48 was reviewed on 5/6/21 at 2:35 p.m. The diagnoses for Resident 48 included, but were not limited to, chronic kidney disease and dizziness. An observation was made of medication administrations with the Memory Care Director on 5/6/21 at 12:19 p.m. The Memory Care Director was observed wearing a surgical mask over her nose and mouth. She was pulling and prepping Resident 48's medication in the medication room. She then left the medication room and approached	R 0407	R407 – Infection Control With regards to finding R407 Infection Control Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome identified for those residents affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was	06/29/2021

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	the resident's room. The resident's door had a sign on it that indicated Resident 48 was in contact isolation. The sign indicated prior to entering of the resident's room the PPE equipment to don was a gown, gloves, N95 respirator, and face shield or goggles. At that time, the Memory Care Director was observed donning a gown and a pair of gloves from the PPE cart. Then she entered the resident's room and administered the medication to him. After, doffing the gown and gloves she left the room and returned back to the medication room handing off her keys to Qualified Medication Aide (QMA 2). She then utilized hand sanitizer. The Memory Care Director was not observed utilizing hand sanitizer or donning on N95 respirator or eye protection prior to entering Resident 48's room. An interview was conducted with the Memory Care Director on 5/6/21 at 12:40 p.m. She indicated she was unsure the facility's policies when to utilize hand hygiene and PPE equipment. An interview was conducted with the Director of Nursing on 5/6/21 at 4:30 p.m. He indicated the former company had downgraded the required PPE to be worn by staff in contact isolation rooms. The staff was to wear surgical masks only. They did not have to wear N95s or face shields. The current company has changed the contact isolation signs, and required PPE the staff are to wear in the contact isolation rooms. The isolation signs that are used now with the residents that are quarantined due to being exposed to someone that had tested positive for COVID-19 are the ones that need to be followed. An isolation policy was provided by the Executive Director on 5/7/21 at 2:32 p.m. It indicated "...Isolation Policy & procedure - Assisted Living		adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Staff will be in-serviced on the donning personal protective equipment (PPE). ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director or designee will audit staff 1x week x 3 months, 1 X month x 3 months, then random audits for appropriate donning of PPE. ***By what date the systemic changes will be completed:*** June 29th, 2021	

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	(COVID-19)..3. Isolation of Resident a. Isolation occurs when a Resident has signs or symptoms consistent with infectious disease, including COVID-19 illness, and may or may not been tested for COVID-19 or exposure to a confirmed case of COVID-19...5. Providing Direct Care to a Resident on Isolation..i...In the event the care team member must provide care for residents who are on both isolation and not on isolation, the following rules apply to PPE: 1. Hand hygiene must be performed prior to donning gown and gloves....2. Gown and gloves must be discarded after each Resident contact and placed in an appropriate receptacle inside the Resident's apartment prior to leaving the apartment. Hand hygiene must be performed after removal of gown and gloves...c. All Team Members caring for Residents on isolation will use the full PPE - gloves, gowns, N95 mask and eye protection..."			
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to ensure annual tuberculin skin tests or risk assessments were conducted for 2 of 5 residents reviewed. (Resident 39 and 43) Findings include:	R 0412	R412 – Infection Control With regards to finding R412 Infection Control Meadow Brook Senior Living, LLC will;	06/29/2021

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	1. The clinical record for Resident 39 was reviewed on 5/6/21 at 3:15 p.m. The diagnoses for Resident 39 included, but were not limited to, high cholesterol and hypertension. The clincal record indicated Resident 39 had an allergy to tuberculin. A chest x-ray for Resident 39 dated 7/26/19 indicated no signs of Tuberculosis. The clinical record for Resident 39 did not include annual Tuberculosis risk assessments conducted on the resident in 2020 or 2021. 2. The clinical record for Resident 43 was reviewed on 5/6/21 at 3:05 p.m. The diagnoses for Resident 43 included, but were not limited to, chronic obstructive pulmonary disease, unspecified (COPD), aortic (valve) stenosis. An Immunization Record for Resident 43 indicated a turberculin skin test was conducted on 10/24/16. The clinical record for Resident 39 did not include annual turberculin skin tests or Tuberculosis risk assessments were conducted on the resident in 2020 or 2021. An interview was conducted with Executive Director on 5/7/21 at 4:08 p.m. He was unable to provided any additional skin tests or annual risk assessments for Resident 43 or 39. A Tuberculosis Testing policy was provided by the Executive Director on 5/7/21 at 4:00 p.m. It indicated "..Policy..Tuberculosis (TB) is a disease that is spread through the air from one person to another. There are two types of test that are used		***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome identified for those residents affected ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Resident medical records will be audited for annual tuberculin skin test or risk assessments. Any medical record found out of compliance will be corrected immediately. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director or designee will monitor annual tuberculin skin tests or risk assessments 2 x month for 3 months and monthly	

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	to determine if a person has been infected with TB: the tuberculin skin test (example: Mantoux sin test] and TB blood tests. A chest x-ray can also be used to look for TB in the chest and is required if the Resident has a positive TB skin or blood test to rule out active TB...Annual Tuberculosis [TB] Screening 1. Annually the Resident will be screened for symptoms of TB. 2. Using the annual Tuberculosis screening Questionnaire the Director of Wellness or designee will screen the Resident for symptoms of active TB..."		after. ***By what date the systemic changes will be completed:*** June 29th, 2021	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure hand hygiene was utilized during medication administrations and donning and doffing Personal Protective Equipment (PPE) during a COVID-19 pandemic for 8 of 8 residents' medication administrations observed. (Resident 10, 14, 15, 24, 25, 33, 48 and 54) Findings include: 1a. The clinical record for Resident 24 was reviewed on 5/6/21 at 1:30 p.m. The diagnoses for Resident 24 included, but were not limited to, Parkinson's Disease and dementia. 1b. The clinical record for Resident 25 was reviewed on 5/6/21 at 1:35 p.m. The diagnoses for Resident 25 included, but were not limited to, dementia and hypertension. 1c. The clinical record for Resident 54 was	R 0414	R414 – Infection Control With regards to finding R414 Infection Control Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No resident was adversely affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents have the potential to be affected by the deficient	06/29/2021

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	reviewed on 5/6/21 at 1:40 p.m. The diagnoses for Resident 54 included, but were not limited to, dementia and angina pectoris. An observation was made of medication administrations with Qualified Medication Aide (QMA) 4 on 5/6/21 at 12:00 p.m. She was observed at the medication cart with three residents' medications already pulled and prepped in the medication cups. QMA 4 grabbed one of the three medication cups with a written name of Resident 24. She then left the medication room and went to Resident 24 in the dining room. QMA 4 was observed touching Resident 24's spoon the resident was using to eat with and had brushed hands with the resident during administration of her medications. She then returned back to the medication room and picked up Resident 25's medication cup. After, she returned back to the dining room and administered the medication to Resident 25. During that time, QMA 4 had brushed hands with the resident handing off a cup of water to him. QMA 4 then returned back to the medication room and picked up Resident 54's medication cup. She went to the dining room and was observed administering his medication to him. She had brushed hands with the resident after handing him a cup of water. There was no hand hygiene observed before or after the medication administrations observed with QMA 4 for Resident 24, 25, and 54. An interview was conducted with QMA 4 on 5/6/21 at 12:10 p.m. She indicated she washes her hands before the start of her medication administrations and then after completing the administrations. 2a. The clinical record for Resident 33 was reviewed on 5/6/21 at 2:30 p.m. The diagnoses for		practice. No resident was adversely affected. The corrective action will be to educate and in-service staff on the Handwashing policy as it relates to medication administration, donning and doffing PPE. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Staff will be educated/in-serviced on the Hand washing policy, particularly as it relates to medication administration, donning and doffing PPE. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** The Wellness Director or designee will be responsible for maintaining compliance with the Hand washing policy. The Wellness Director or designee will audit one medication administration, donning and doffing PPE daily X 4 weeks, one medication administration, donning and doffing PPE weekly X 4 weeks. If no issues are identified then monthly audits thereafter. ***By what date the systemic changes will be completed:***	

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	Resident 33 included, but were not limited to, pain and anxiety. 2b. The clinical record for Resident 48 was reviewed on 5/6/21 at 2:35 p.m. The diagnoses for Resident 48 included, but were not limited to, chronic kidney disease and dizziness. An observation was made of medication administrations with the Memory Care Director on 5/6/21 at 12:19 p.m. She was observed using hand hygiene prior to starting the medication preparations to Resident 33. She had pulled all the medications and placed them in a medication cup. She then left the medication room and knocked on the resident's door. Using the knob on the door, she opened the resident's door and realized she was not in her room. After, she went downstairs and found resident going into the dining room. During that time, the Memory Care Director was observed touching the walkie talkie, the resident's walker and brushing hands with the resident during the medication administration. She then returned to the medication room after the administration was completed. The Memory Care Director at that time used hand sanitizer. There was no observation of hand hygiene prior to the administration once the resident was located. The Memory Care Director was then observed pulling and prepping Resident 48's medication. After, she went to the resident's room. There was a sign on the door Resident 48 was in contact isolation. At that time, she was observed donning a gown and a pair of gloves from the PPE cart. Then entered the resident's room and administered the medication to him. During the administration, she handed the cup to the resident touching hands. She then was observed doffing the gown and gloves and left the room. At that time, she indicated hand sanitizer should be on the PPE		June 29th, 2021	

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	supply cart outside the resident's door. She was observed walking down to the end of the hallway to the medication room. The Memory Care Director entered the medication room and handed the keys to QMA 2. After, she then used hand sanitizer. The Memory Care Director was not observed using hand hygiene before or after the resident's medication administration nor donning or doffing PPE. An interview was conducted with the Memory Care Director on 5/6/21 at 12:40 p.m. She indicated she was unsure the facility's policies when to utilize hand hygiene, but she reported after every resident encounter she should use hand sanitizer. 3a. The clinical record for Resident 15 was reviewed on 5/6/21 at 3:30 p.m. The diagnoses for Resident 15 included, but were not limited to, congestive heart failure and dementia. 3b. The clinical record for Resident 10 was reviewed on 5/6/21 at 3:35 p.m. The diagnoses for Resident 10 included, but were not limited to, hypertension and high cholesterol. 3c. The clinical record for Resident 14 was reviewed on 5/6/21 at 3:45 p.m. The diagnoses for Resident 14 included, but were not limited to, age related cognitive decline and chronic pain. An observation was made of medication administration with QMA 2 on 5/6/21 at 12:43 p.m. She was observed in the medication room with three medication cups with residents' room numbers written on them already pulled and prepared to administer. QMA 2 was observed stacking all three of the medication cups on top of each other and leaving the medication room. QMA 2 then stopped at Resident 15's room. She			

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	knocked and entered the resident's room. She was observed administrating the medication while the resident was in the bathroom still holding the other two medication cups. QMA 2 then left the resident's room and entered Resident 14's room. She left one of the medication cups sitting on the counter. QMA 2 indicated she leaves the afternoon medications for Resident 14 in her room. When she returns she will take. QMA 2 then left Resident 14's room and went to Resident 10's room. Resident 10 was standing with his walker. QMA 2 was observed handing the medication cup to the resident. During the exchange their hands did touch one another. She then left the resident room. There was no hand hygiene observed during the medication administrations with QMA 2 for Resident 10, 14 or 15. An interview was conducted with QMA 2 on 5/6/21 at 1:36 p.m. She indicated hand hygiene should be utilized after every resident. At that time, she pulled out of her pocket hand sanitizer. She had forgotten to use. A hand hygiene policy was provided by the Executive Director on 5/7/21 at 2:32 p.m. It indicated "...Policy: Hand hygiene is the single most important measure for preventing the spread of infection and disease. All team members will be responsible for carrying out the hand hygiene guideline. Procedure. 1. Team member will perform hand hygiene after: ...b. after glove removal. d. Before handling medication. e. Before and after helping Residents with personal care tasks of daily living..." An isolation policy was provided by the Executive Director on 5/7/21 at 2:32 p.m. It indicated "...Isolation Policy & procedure - Assisted Living (COVID-19)..3. Isolation of Resident a. Isolation			

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	occurs when a Resident has signs or symptoms consistent with infectious disease, including COVID-19 illness, and may or may not been tested for COVID-19 or exposure to a confirmed case of COVID-19...5. Providing Direct Care to a Resident on Isolation..i...In the event the care team member must provide care for residents who are on both isolation and not on isolation, the following rules apply to PPE: 1. Hand hygiene must be performed prior to donning gown and gloves....2. Gown and gloves must be discarded after each Resident contact and placed in an appropriate receptacle inside the Resident's apartment prior to leaving the apartment. Hand hygiene must be performed after removal of gown and gloves...c. All Team Members caring for Residents on isolation will use the full PPE - gloves, gowns, N95 mask and eye protection..."			