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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK AT LUTHERWOODS	1301 N RITTER AVE INDIANAPOLIS, IN 46219

(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 Complaints IN00419589, IN00428111, and IN00434670. Complaint IN00419589 - No deficiencies related to the allegations are cited. Complaint IN00428111 - No deficiencies related to the allegations are cited. Complaint IN00434670 - No deficiencies related to the allegations are cited. Survey dates: July 23, 24, and 25, 2024 Facility number: 011587 Residential Census: 88 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 1, 2024.	R 0000		
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.			

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

Tyler Brammer | Executive Director | 08/18/2024

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

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	(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 a residents' ability to self-administer medications by completing a self-administration evaluation for 2 of 2 residents observed with medications in their rooms. (Residents 20 and 87) Findings include: 1. The clinical record for Resident 87 was reviewed on 7/24/24 at 1:00 p.m. The diagnoses included, but was not limited to, somatization disorder (a generation of physical symptoms of a psychiatric condition such as anxiety), diabetes type II, and Sjogren's syndrome (an immune system illness that mainly causes dry eyes, dry mouth and difficulty swallowing). A medication administration observation with Licensed Practical Nurse (LPN) 2 was conducted on 7/24/24 at 8:50 a.m. During the medication administration with Resident 87, it was observed that she had over the counter (OTC) medications in her room. The OTC medications were a bottle of nasal decongestant, Theraworx foam, a bottle of artificial tears, and a bottle of a store brand allergy nasal spray. None of the OTC medications had labels affixed to them to indicate the resident's name. Resident 87's current medication orders received, on 7/24/24 at 1:19 p.m., from Director of Nursing (DON), indicated the following:	R 0216	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 87 had no adverse effects from self-administering medications without assessment. Resident 20 had no adverse effects from self-administering medications without assessment. Resident 87 had self-administration assessment completed on 7/24/24. Resident 20 had self-administration assessment completed on 7/24/24. Resident 87 had OTC medications labeled at bedside completed on 7/24/24. Resident 20 had OTC medications labeled at bedside completed on 7/24/2024. **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 have the potential to be affected. No resident was adversely affected. DNS was reeducated on 7/24/24 regarding the residents' rights to self-medicate policy. All residents	08/25/2024

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	- To instill one or two drops of Artificial Tears drops in each eye once a day as needed. "MAY KEEP AT BEDSIDE". - Give 2 sprays of Nasal Spray 0.05% into each nostril every 12 hours as needed for congestion "*MAY KEEP AT BEDSIDE*". - Apply two pumps of Theraworx relief foam to affected area as needed "***MKAB*** [sic, may keep at bedside]". - Spray 0.65% saline mist nose spray once in each nostril daily as needed "*MAY KEEP AT BEDSIDE*". A Self-Administration of Medication Review for Resident 87 was dated 9/22/24. An interview conducted with the Director of Nursing (DON), on 7/24/24 at 1:28 p.m., indicated Resident 87's Self-Administration of Medication Review should have been dated 9/22/23 as it was completed when Resident 87 was admitted to the facility. The DON indicated the ability to self-administer medications was to be assessed bi-annually however, the facility failed to ensure Resident 87's bi-annual self-administration of medication review was completed. 2. The clinical record for Resident 20 was reviewed on 7/24/24 at 1:05 p.m. The diagnoses included, but was not limited to, dysphagia (difficulty with swallowing), chronic kidney disease, diverticulosis, and other symptoms and signs concerning food and fluid intake. A medication administration observation with LPN 2 was conducted on 7/24/24 at 9:13 a.m. During the medication administration with Resident 20, it was observed that he had over the counter (OTC) medications in his room. The OTC medications consisted of a bottle of Tylenol		will be interviewed to see if they have OTC medications in their apartments, proper labeling is affixed, and self-administration assessments completed for those who wish to self-administer medications by 8/22/24 by DNS/designee. Audit to be completed to ensure all residents who self-administer medications have appropriate assessment by 8/22/24 by DNS/designee. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All residents will be interviewed to see if they have OTC medications in their apartments, and self-administration assessments completed for those who wish to self-administer medications by 8/22/24 by DNS/designee. Audit to be completed to ensure all residents who self-administer medications have appropriate assessment by 8/22/24 by DNS/designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** All residents will be interviewed to see if they have OTC medications in their apartments, and self-administration assessments completed for those	

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	(acetaminophen) and a bottle of Mylanta (an antacid). Neither medication had labels affixed to them to indicate the resident's name. Resident 20's current medication orders received, on 7/24/24 at 1:19 p.m., from the DON, indicated to give two tablets of acetaminophen 325 mg (milligrams) every 6 hours as needed for pain with an ancillary order of not to exceed 4 grams/4000 mg of acetaminophen in a 24 hour period from all sources. Resident 20's medication orders did not contain an order for Mylanta. An interview conducted with the DON, on 7/24/24 at 1:28 p.m., indicated Resident 20 did not have a completed self-administration of medication review. A Residents' Rights to Self-Medicate policy received, on 7/24/24 at 1:19 p.m., from the DON, indicated the following, "Procedure...The community should assess and determine...whether self-administration of medications is safe and appropriate...The community may routinely assess the resident's cognitive, physical and visual ability to carry out self-medication per community policy...For those residents for which self-administration of medications is safe and appropriate, the resident should be able to: ...Recognize of differentiate medications, state the name, dose, strength, time of day to take the medication and reason for use of his/her medications. ...Read the prescription label. ...Demonstrate sufficient manual dexterity to self-administer medications. ...Understand the possible side effects of his/her medications and should understand that he/she should notify community staff if he/she experiences any such side effects...The		who wish to self-administer medications by 8/22/24 by DNS/designee. Audit to be completed to ensure all residents who self-administer medications have appropriate assessment by 8/22/24 by DNS/designee. Self-administration monitoring tool to be completed weekly x4 weeks, then monthly x3 months. Resident interviews completed weekly x4, then monthly x3 months to ensure OTC bottles in apartments are identified and labeled appropriately. If 90 percent threshold is not met, then disciplinary action and new action will be completed. Monitoring tool will be completed by DNS or ED/designee.	

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	community staff should document the self-administration of medications (i.e., which ones, how much, how often)...A review is conducted by the wellness director or licensed nurse with each self-medicating resident to identify medication usage and changes."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the correct handling of stored food items that were past the use-by or expiration date in accordance with state and local sanitation and safe food handling standards in the kitchen with the potential to affect 88 of 88 residents in the facility. (Facility) Findings include: A kitchen tour and observation were conducted, on 7/23/24 at 10:30 a.m., with Cook 2. The dry storage area housed a package of cake mix with an open date, of 3/8/24, and a discard date, of 6/8/24, and a bottle of Lee and Perrins sauce with an open date, of 5/2/23, and a discard date of 5/3/24. The walk-in refrigerator housed a container of black olives with an open date, of 7/16/24, and a use by date, of 7/21/24, and a bag of unopened baby carrots with use by date of 7/18/24. The food preparation area housed a container of parsley spice with an open date, of 6/28/23, and a use by date, of 6/8/24, and a container of dill spice with an open date, of 2/11/23, and a use by date of 2/11/24.	R 0273	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were adversely affected related to improper food labeling. Culinary staff received reeducation on 8/16/24 regarding proper food labeling standards. No residents were adversely affected related to improper food handling standards in the kitchen. Culinary staff received reeducation regarding proper food handling by 8/16/24. **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 had the potential to be affected. No residents were adversely affected related to improper food labeling. Culinary	08/25/2024

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	An interview was conducted, on 7/23/24 at 10:45 a.m., with Cook 2. She indicated that food items should be discarded when it reached the date of expiration, discard by, or use-by date. A current facility policy titled Food Storage, dated 5/24, was provided by the Executive Director (ED) on 7/25/24 at 10:55 a.m. The policy indicated the following, "Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing ...The food must clearly be labeled with the name of the product, the date it was prepared, and marked to indicate the date by which the food shall be consumed or discarded ...Clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded ...Dry storage foods shall be covered or wrapped tightly, labeled and dated".		staff received reeducation on 8/16/24 regarding proper food labeling standards. No residents were adversely affected related to improper food handling standards in the kitchen. Culinary staff received reeducation regarding proper food handling on 8/16/24. Audit of all food storage areas to be completed for proper food storage practices by 8/22/24. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Culinary staff received reeducation on 8/16/24 regarding proper food labeling standards. Culinary staff received reeducation regarding proper food handling on 8/16/24. Culinary staff to be reeducated on facility food storage policy by 8/16/24. Audit of all food storage areas to be completed for proper food storage practices by 8/22/24. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Culinary staff received reeducation on 8/16/24 regarding proper food labeling standards. Culinary staff received reeducation regarding proper food handling on 8/16/24. Culinary staff to be reeducated on facility food storage policy by	

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			8/16/24. Food storage monitoring tool to be completed weekly x4, then monthly x3. If 90 percent threshold is not met, then disciplinary action and new action will be completed. Monitoring tool will be completed by CM or ED/designee.	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview, and record review, the facility failed to ensure a resident's extended release blood pressure medication, which indicated on its packaging "do not chew or crush medication", was not being crushed by the resident when administering medications; not notifying the resident's physician of such practice; and the pharmacy not addressing a possible medication irregularity concerning an ancillary order which indicated, "may crush medications", and a pharmacy warning label which indicated "do not to crush or chew" on the medication packaging. (Resident 87) Findings include: A medication observation for Resident 87 was conducted with Licensed Practical Nurse (LPN) 2 on 7/24/24 at 8:50 a.m. In preparation to administer Resident 87's morning medications, it was observed the resident's Nifedipine (a blood	R 0297	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All residents with ancillary orders for crushed medications have the potential to be affected. Resident 87 had no adverse effects from crushing medications with an indication of not to crush. Resident 87 had no adverse effects from not notifying physician of crushing medications with an indication of not to crush. Resident 87 had not adverse effects from pharmacy not addressing irregularities with ancillary order which indicated may crush medications. MD contacted with clarification given 7/26/24. LPN 2 reeducated on	08/25/2024

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	pressure lowering medication) 90 mg ER (extended release) pill card had a pharmacy warning label affixed which indicated not to crush or chew the medication. LPN 2 entered her room to administer her medications and Resident 87 sat at a small table which had two pill crushers sitting on the table in front of her. She indicated she has an issue with swallowing some of the medications so, she used the pill crusher to make it easier for her to take her pills. She had commented she has trouble with her vision and after she had crushed the medications, she used her finger to ensure no pill pieces were left in the pill crusher then took the medications. In an interview with LPN 2 conducted, immediately upon exiting Resident 87's room, indicated the order on Resident 87's July 2024 MAR (Medication Administration Record) did not indicate the medication should not be crushed or chewed and included an ancillary order which indicated they may crush medications. LPN 2 indicated by having that ancillary order of may crush medications meant the medications on her med list had been reviewed and it was ok to crush any/all medications on her med list. LPN 2 had not notified Resident 87's physician about the resident crushing the medications herself. An interview conducted with Resident 87's Nurse Practitioner (NP) nurse, on 7/24/24 at 11:24 a.m., indicated Resident 87's NP had not been made aware of her crushing her medications herself. The NP's nurse indicated she had received an order from the NP that they were going to change the extended release Nifedipine to an immediate release since the resident crushed the medications herself. A Storage and Expiration Dating of Medications,		physician notification and reading medication indications and medication pass observation completed with LPN 2. Staff qualified to pass medications reeducated on reading medication indications. Staff qualified to pass medications completed medication pass observation. Nursing staff educated on physician notifications. Pharmacist consultant to review all residents with ancillary orders that can crush medications for irregularities by 8/22/24. **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 with ancillary orders for crushed medications have the potential to be affected. Resident 87 had no adverse effects from crushing medications with an indication of not to crush. Resident 87 had no adverse effects from not notifying physician of crushing medications with an indication of not to crush. Resident 87 had not adverse effects from pharmacy not addressing irregularities with ancillary order which indicated may crush medications. LPN 2 reeducated on physician notification and reading medication indications and medication pass observation completed with LPN 2.	

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	Biologicals policy received on, 7/25/24 at 12:33 p.m., from the Director of Nursing, indicated the following, "General storage procedures...The community should ensure food is not stores in the refrigerator, freezer or general storage areas where medications and biological are stored...The community should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels...Bedside medication storage...The community may not administer/provide bedside medications or biologicals without a physician/prescriber order and approval by community administration."		Staff qualified to pass medications reeducated on reading medication indications. Staff qualified to pass medications completed medication pass observation. Nursing staff educated on physician notifications. Pharmacist consultant to review all residents with ancillary orders that can crush medications for irregularities. Resident interviews to determine crush preferences by 8/22/24. Audit of all residents with ancillary orders to crush medications reviewed for irregularities by 8/22/24. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** LPN 2 reeducated on physician notification and reading medication indications and medication pass observation completed with LPN 2. Staff qualified to pass medications reeducated on reading medication indications. Staff qualified to pass medications completed medication pass observation. Nursing staff educated on physician notifications. Pharmacist consultant to review all residents with ancillary orders that can crush medications for irregularities by 8/30/24. Staff qualified to administer medications in-serviced on storage and expiration dating of medications, biologicals policy by 8/30/24.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; LPN 2 reeducated on physician notification and reading medication indications and medication pass observation completed with LPN 2. Staff qualified to pass medications reeducated on reading medication indications. Staff qualified to pass medications completed medication pass observation. Nursing staff educated on physician notifications. Pharmacist consultant to review all residents with ancillary orders that can crush medications for irregularities by 8/30/24. Staff qualified to administer medications in-serviced on storage and expiration dating of medications, biologicals policy by 8/30/24. Medication storage and expiration dating of medications, biologicals monitoring tool completed weekly x4 and monthly x3. If 90 percent threshold is not met, then disciplinary action and new action will be completed. Monitoring tool will be completed by DNS or ED/designee.	
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			

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	accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility also failed to ensure its medication storage practices followed accepted pharmacy storage guidelines by not labeling two over the counter (OTC) medications in the medication storage room with required information and not ensuring a resident's insulin pens were labeled with the necessary information (Resident 17). Findings include: 1. A medication administration observation was conducted, on 7/24/24 at 11:00 a.m., with LPN 2. When LPN 2 went to get Resident 17's insulin for administration, he pulled down a basket which had Resident 17's room number on it. Inside the basket were two insulin pens, one was aspart (short-acting insulin) and the other was glargine (long-acting insulin). Neither of the pens were labeled with the resident's name, prescription number, physician's name, or name of the pharmacy that filled the prescription affixed to the pen. 2. An observation of the medication room was completed with Assistant Director of Nursing (ADON) on 7/25/24 at 10:45 a.m. In the medication room, there were two over the counter (OTC) medications. One was Striction D (a blood sugar supplement), and the other was Phytoplex (an antifungal) powder. Neither of these medications had resident labels affixed to them. The ADON indicated they were unable to identify what resident the medications were for.	R 0300	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 17 had no adverse effects from not ensuring the resident's insulin pens were labeled with the necessary information. No residents were affected by OTC medications not being labeled in the medication storage room. LPN 2 and all staff qualified to administer insulin reeducated on storage and expiration dating of medications and biologicals. All staff qualified to administer medications reeducated on storage and expiration dating of medications and biologicals. **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 have the potential to be affected. Resident 17 had no adverse effects from not ensuring the resident's insulin pens were labeled with the necessary information. No residents were affected by OTC medications not being labeled in the medication storage room. LPN 2 and all staff qualified to administer insulin	08/25/2024

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	A Storage and Expiration Dating of Medications, Biologicals policy received on, 7/25/24 at 12:33 p.m., from the Director of Nursing, indicated the following, "General storage procedures...The community should ensure food is not stores in the refrigerator, freezer or general storage areas where medications and biological are stored...The community should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels...Bedside medication storage...The community may not administer/provide bedside medications or biologicals without a physician/prescriber order and approval by community administration."		reeducated on storage and expiration dating of medications and biologicals. All staff qualified to administer medications reeducated on storage and expiration dating of medications and biologicals. DNS/designee to audit medication storage room to identify any irregularities in medication labeling and storage by 8/23/24. DNS/designee to audit insulin storage to identify any irregularities in labeling and dating insulin storage by 8/23/24. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** LPN 2 and all staff qualified to administer insulin reeducated on storage and expiration dating of medications and biologicals. All staff qualified to administer medications reeducated on storage and expiration dating of medications and biologicals. DNS/designee to audit medication storage room to identify any irregularities in medication labeling and storage by 8/23/24. DNS/designee to audit insulin storage to identify any irregularities in labeling and dating insulin storage by 8/23/24. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place; LPN 2 and all staff qualified to administer insulin reeducated on storage and expiration dating of medications and biologicals. All staff qualified to administer medications reeducated on storage and expiration dating of medications and biologicals. DNS/designee to audit medication storage room to identify any irregularities in medication labeling and storage by 8/23/24. DNS/designee to audit insulin storage to identify any irregularities in labeling and dating insulin storage by 8/23/24. Medication storage audit completed weekly x4 and then monthly x3. Insulin storage audit completed weekly x4 and then monthly x3. If 90 percent threshold not met, then disciplinary action and new action will be completed. DNS or ED/designee will complete monitoring tools.	
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.			

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	(4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to maintain an infection control program by touching the rim and/or inside of a medication cup and/or water cup (Residents 84 and 58), not maintaining a clean technique when preparing medications (Residents 20, 84, and 58), touching medications with bare hands (Residents 20, 84, and 58) and not cleaning an insulin pens' rubber hub prior to placing a sterile needle (Residents 17 and 72). The facility failed to ensure kitchen staff followed facility guidelines for the use of gloves in processing food orders causing possible cross contamination with the potential of affecting 1 out of 5 residents eating meals prepared in the kitchen grill area. (Facility) Findings include: 1. A medication administration observation was conducted, on 7/24/24, with Licensed Practical Nurse (LPN) 2 and the following was observed: a. At 9:13 a.m., LPN 2 was preparing to dose Resident 20's morning medications. LPN 2 picked up a medication cup to write the resident's room number on it, when he did, he placed his index finger into the cup and pinched the cup between his index finger and thumb to write on the cup. LPN 2 performed hand hygiene then touched the medication carts drawer handle to pull out a medication pill card. When dispensing the medications into the medication cup, LPN 2 would pop the pills from the pill card into his hand and then dump the pill into the medication cup with each of the medications that were to be given.	R 0407	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 84 had no adverse effects from staff touching the rim and inside of medication cup and water cup. Resident 58 had no adverse effects from staff touching the rim and inside of medication cup and water cup. Resident 20 had no adverse effects from staff not maintaining a clean technique during medication preparation. Resident 84 had no adverse effects from staff not maintaining a clean technique during medication preparation. Resident 58 had no adverse effects from staff not maintaining a clean technique during medication preparation. Resident 17 did not have any adverse effects from staff not cleaning insulin pens' rubber hub prior to placing sterile needle. Resident 72 did not have any adverse effects from staff not cleaning insulin pens' rubber hub prior to placing sterile needle. No residents had adverse effects from staff not following glove guidelines in the kitchen. LPN 2 provided reeducation on medication administration procedures and skills validation completed. LPN 2 provided reeducation on insulin administration procedures and	08/25/2024

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	LPN 2 did not pull all the medication pill cards at once but rather he pulled one card at a time. So, he was repeatedly touching a medication cart drawer handle after popping the pills out into his hand and placing the pill in the cup. LPN 2 repeated that procedure in between preparing Resident 20's hydralazine (blood pressure medication), loratadine (allergy medication), magnesium oxide (mineral supplement), metoprolol (blood pressure medication), omeprazole (an acid reducer), and oxybutynin (treats overactive bladder), potassium (supplement), sodium bicarbonate (an antacid), and torsemide (treats fluid retention). b. At 9:39 a.m., LPN 2 was preparing Resident 84's medications. LPN 2 picked up a medication cup to write the resident's room number on it. When he did, he placed his index finger into the cup and pinched the cup between his index finger and thumb to write on the cup. LPN 2 performed hand hygiene then touched the medication carts drawer handle to pull out a medication pill card. When dispensing the medications into the medication cup, LPN 2 would pop the pills from the pill card into his hand and then dump the pill into the medication cup with each of the medications that were to be given. LPN 2 repeated that procedure with Resident 84's aspirin, duloxetine (an antidepressant and nerve pain medication), iron, Gemtesa (treats overactive bladder), lisinopril (a blood pressure medication), magnesium, pantoprazole (an acid reducer), and potassium. Once all the pills were dispensed, LPN 2 performed hand hygiene and grabbed the cup of water by pinching the rim in between his index finger and thumb and, with the same hand, wedged the medication cup into the thumb part of his hand so, the entire rim of the medication cup was in full contact with his palm area.		skills validation completed. Cook 3 provided reeducation on glove use in the kitchen, handwashing and glove use skills validation completed by 8/23/24. **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 have the potential for adverse effects. Resident 84 had no adverse effects from staff touching the rim and inside of medication cup and water cup. Resident 58 had no adverse effects from staff touching the rim and inside of medication cup and water cup. Resident 20 had no adverse effects from staff not maintaining a clean technique during medication preparation. Resident 84 had no adverse effects from staff not maintaining a clean technique during medication preparation. Resident 58 had no adverse effects from staff not maintaining a clean technique during medication preparation. Resident 17 did not have any adverse effects from staff not cleaning insulin pens' rubber hub prior to placing sterile needle. Resident 72 did not have any adverse effects from staff not cleaning insulin pens' rubber hub prior to placing sterile needle. No residents had adverse effects from staff not following glove guidelines	

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	c. At 9:45 a.m., LPN 2 went to prepare Resident 58's medications. LPN 2 performed hand hygiene, then touched the medication cart drawer handle, popped a divalproex (seizure medication) tablet into his hand and then placed the tablet into the medication cup. He then opened a bottle of Primidone (seizure medication) and dug out one tablet with his finger, cracked the tablet in half in his hands, placed one half of the tablet into the medication cup and the other half back into the bottle with his bare hands. LPN 2 then placed the bottle back into the medication cart. LPN 2 popped Vitamin B12 and Vitamin D3 into his hands first then placed them in the medication cup. When going to administer the medications to Resident 58, LPN 2 grabbed the cup of water by pinching the rim in between his index finger and thumb and, with the same hand, wedged the medication cup into the thumb part of his hand so, the entire rim of the medication cup was in full contact with his palm area. 2. An insulin administration observation with LPN 2 was conducted, on 7/24/24, in the diabetic clinic. a. At 11:00 a.m., LPN 2 was preparing the aspart insulin pen for Resident 17 when he took off the cap and immediately placed a sterile needle onto the pen. LPN 2 did not scrub the rubber seal on the pen with alcohol prior to placing the sterile needle on the pen. b. At 11:07 a.m., LPN 2 was preparing a Humalog insulin pen for Resident 72. He took off the insulin pen's cap and immediately placed a sterile needle onto the pen. LPN 2 did not scrub the rubber seal on the pen with alcohol prior to placing the sterile needle on the pen. An interview conducted with Director of Nursing		in the kitchen. LPN 2 provided reeducation on medication administration procedures and skills validation completed. LPN 2 provided reeducation on insulin administration procedures and skills validation completed. Cook 3 provided reeducation on glove use in the kitchen, handwashing and glove use skills validation completed by 8/23/24. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Inservice all staff on proper glove use and infection control. Medication pass audits on all qualified staff by 8/25/24. Handwashing skills validation for culinary staff. Pharmacy to do medication pass audit with qualified staff. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** LPN 2 provided reeducation on medication administration procedures and skills validation completed. LPN 2 provided reeducation on insulin administration procedures and skills validation completed. Cook 3 provided reeducation on glove use in the kitchen, handwashing and glove use skills validation	

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	(DON), on 7/24/24 at 1:28 p.m., indicated medication pills/tablets/capsules should not be handled with bare hands. The Instructions for use Humalog Kwik-pen provided, on 7/24/24 at 11:32 a.m., from the DON, indicated the following, "Step 1: Pull the Pen Cap straight off. Do not remove the Pen Label. Wipe the Rubber Seal with an alcohol swab..." A General Dose Preparation and Medication Administration policy was received, on 7/24/24 at 11:32 a.m., and indicated the following, "Procedure 1. Prior to preparing to administer, assist or observe a resident take his/her medications, an authorized and competent community staff member should follow the community's infection control policies...The community staff should not touch the medication when opening a bottle or unit dose package." 3. During an observation, on 7/23/24 at 11:35 a.m., Cook 3 picked up a stack of 4 plates from the clean plate supply for lunch service with her ungloved right hand and placed her thumb in the middle of the top plate. Cook 3 then gloved her hands and placed her gloved left hand on the corner of the countertop three times while making one sandwich containing bread, deli-meat, lettuce, cheese, and tomato. A facility policy, titled Use of Gloves, dated 5/24, was provided by the Executive Director (ED) on 7/25/24 at 10:15 a.m. The policy indicated the following, "Gloves are just like hands; they get soiled. Anytime a contaminated surface is touched, gloves must be changed, and hands washed". A facility policy, titled Hand Washing in the		completed by 8/23/24. Culinary glove use QA tool used weekly x4 and then monthly x3. Handwashing QA tool used weekly x4 and then monthly x3. Medication pass observation QA tool used weekly x4 and then monthly x3. If 90 percent threshold not met, then disciplinary action and new action will be completed. DNS or ED/designee will complete monitoring tools.	

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	Kitchen, dated 7/23, was provided by the ED on 7/25/24 at 10:15 a.m. The policy indicated the following, "Culinary staff will wash hands ...before placing gloves on hands". An Infection Control and Prevention policy received, on 7/24/24 at 10:51 a.m., from the ED indicated the following, " Policy: To guide the activities of the Infection Control and Prevention Program...the Community shall establish and Infection Control and Prevention Program to: investigate, control and prevent infection in the community; to determine appropriate procedure; and to maintain records of the Community's incidence and corrective actions."			