STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155617	A. BUILDING 00 B. WING	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY	524 ANDERSON RD CHESTERFIELD, IN 46017

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 9, 10, 11, 12 & 13, 2023 Facility number: 000524 Provider number: 155617 AIM number: 100267090 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicare: 2 Medicaid: 20 Other: 14 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 18, 2023.	F 0000	Plan of Correction Text: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: January 29, 2023. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0582 SS=B Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may			

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

Kimberly Locke | HFA | 01/28/2023

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	be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or			

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	on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to complete a Notice of Medicare Non-Coverage (NOMNC) notification for 1 of 2 residents reviewed for beneficiary notifications. (Resident 89) Findings include: During the Beneficiary Protection Notification Review task on 1/10/23, the facility lacked indication of Resident 89 having been provided a NOMNC prior to discharge. Review of Resident 89's clinical record indicated a discharge from the facility on 12/28/22, following admission for rehabilitation from an acute care hospital on 10/25/22. During an interview, on 1/10/23 at 1:18 p.m., the MDS Coordinator (MDS) indicated she had spoken with the Social Services Director (SSD) who confirmed the resident did receive and sign a NOMNC, but he had shredded his copy. The MDS Coordinator did not have a copy of the form. Review of a current facility policy, revised 11/2018, titled "Policy and Procedure Advanced Beneficiary Notices," provided by the Administrator on 1/11/23 at 11:50 a.m., indicated the following: "...Procedure for issuing a NOMNC (Notice of Medicare Non-Coverage)/(CMS 10123)...12. A copy of the Notice will be stored in the Electronic Health Record System. A copy can also be maintained in the Resident's Financial File...."	F 0582	F582 Medicaid/Medicare Coverage/Liability Notice What corrective action will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility that the facility completes a Notice of Medicare Non-Coverage (NOMNC) and provide the NOMNC to residents prior to discharge from Medicare Services. Resident # 89 no longer resides in the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents that currently reside in the facility and receive Medicare services have the potential to be affected by the alleged deficient practice. Social Service Director or designee will complete a facility wide audit to verify residents previously receiving Medicare services and discharged since 1/13/2023 were provided with a NOMNC prior to discharge. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator educated the Social Service Director on 01/25/2023 on providing NOMNC to residents who are receiving	01/29/2023

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	3.1-4(f)(3)		Medicare services and are discharging. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: "NOMNC audit tool" will be completed 5 days a week x 4 weeks, 3 days a week x 2 months, then weekly x 4 months. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified and any needed Action Plans will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. January 29, 2023	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to obtain daily weights per physician's order, and failed to notify the physician of weight gain per physician's ordered parameters for 1 of 1 resident's reviewed for edema. (Resident 35) Findings include: Resident 35's clinical record was reviewed on 1/10/23 at 11:20 a.m. Diagnoses included heart failure and acute respiratory failure. An admission Minimum Data Set (MDS) assessment, dated 12/29/22, indicated the resident was cognitively intact, had no verbal or physical behaviors, and no rejection of care. Current physician's orders, included the following: Resident to be weighed daily after voiding and before breakfast or medications with same clothing, each day. The staff was to notify the physician of a two pound weight gain in one day and a four pound weight gain in five days (12/24/22). Resident was to be weighed daily for 14 days then switch to weekly weights (12/28/22). Resident to wear oxygen at two liters per minute (LPM), continuously. Staff may remove for showers and beauty shop visits as needed (12/22/22). A review of the resident's clinical records for weights for December 2022, indicated the following:	F 0684	F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility that the facility completes daily weight orders as ordered by the physician. Resident #35 daily weight orders were reviewed. Daily weight order was timed for 14 days and was discontinued per physician order. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with daily weight orders have the potential to be affected by the alleged deficient practice. There are currently not residents with daily weight orders. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: DON/designee provide education to licensed nurses on 1/26/23 related to following physician orders on daily weights. Additionally, any employee who fails to comply with the points of	01/29/2023

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	On 12/24/22, 12/25/22, and 12/29/22, the resident refused to be weighed. On 12/30/22, the resident's weight was 313.2. On 12/31/22, the resident's weight was 317.8, a 4.6 pound weight gain in one day. A nursing progress note, dated 12/31/22, at 9:33 a.m., indicated the resident complained of shortness of breath and her oxygen saturation level was 85% with the resident wearing oxygen at 2 LPM using a nasal cannula. The resident indicated to the nurse the previous day her oxygen was set at 4 LPM due to her shortness of breath. The nurse increased her oxygen level to 3 LPM and her oxygen saturation level increased to 94%. The progress note lacked any indication of the physician being notified of the resident's 4.6 pound weight gain, or her decreased saturation level on the prescribed 2 LPM oxygen rate. A review of the resident's clinical record for weights for January 2023, indicated the following: The record lacked a recorded weight for 1/2/23, 1/6/23, 1/8/23, 1/9/23, 1/11/23, and 1/12/23 as well as indication of resident refusal. During an interview, on 1/11/23 at 10:18 a.m., the Administrator indicated the staff were not obtaining daily weights as ordered by the physician or notifying the physician of weight gains included with the order. The resident should have been weighed daily. Review of a current, undated, facility policy titled,		the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Daily weight audits will be completed 5 days a week x4 weeks, weekly x2 months, then monthly x4 months. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified and any needed Action Plans will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed. January 29, 2023	

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	"Physician Orders-(Following Physician Orders)," provided by the Administrator on 1/12/23 at 2:04 p.m., indicated the following: "...Policy: It is the policy of the facility to follow the orders of the physician...." 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure recommended weight loss interventions had been implemented and monitored for acceptance for 1 of 3 residents reviewed for nutrition. (Resident 20) Findings include:	F 0692	F692 Nutrition/Hydration Status Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	01/29/2023

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	Resident 20's clinical record was reviewed on 1/10/23 at 2:02 p.m. Diagnosis included abnormal weight loss. Current physician orders included a mechanical soft diet, weekly weights and mirtazapine (anti-depressant used off-label at times for appetite stimulation) 7.5 mg (milligram). A 12/14/22, quarterly, MDS (Minimum Data Set) assessment indicated he had moderate cognitive impairment and required limited assistance with eating. A current care plan, initiated date 9/3/20 and revised on 11/13/22, indicated he was at nutritional risk related to body mass index less than 22, decreased appetite,recent hospitalization, multiple dislikes/intolerances, difficulty chewing, depression, edentulous, gastroparesis, swallow disorder- difficulty or pain pain swallowing, illness, pain; history of pressure injury, history of not drinking minimum of 1500 milliliter daily and on 11/8/22 new weight loss. Interventions included serve four ounces of house supplement at breakfast and serve four ounces of house supplement at lunch, both initiated on 11/8/22. A progress note, dated 11/8/22 at 2:03 p.m., indicated a current weight of 200.1 lbs (pounds), which reflected a 7.7 pound weight loss since the prior month. House-shakes had been added at breakfast and lunch and weekly weights started. A progress note, dated 11/29/22 at 5:25 p.m., indicated a 2.8 lbs weight loss since prior week. House shakes were offered at supper, in addition to breakfast and lunch.		It is the policy of the facility to ensure that dietary progress notes are reviewed and physician orders are received for supplements. Resident #20 was reviewed by Dietician. Resident's weight stabilized and discontinued house shake supplement How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents receiving recommendations by the dietician have the potential to be affected by the alleged deficient practice. The ADON or designee will complete a 30 day look back on dietary recommendations to verify recommendations were reviewed and physician orders were obtained. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Administrator educated ADON on 01/27/2023 on RD recommendations for supplements and updating medical record with physician order for supplement. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated DON/Designee will audit	

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	The clinical record lacked a physician order for house-shake supplements. A Dietary Progress Note, dated 1/6/23 at 1:36 p.m., indicated a current weight of 188.6 lbs, which reflected a 9.2% weight loss in 90 days. Meal intake was usually 50-100%. A Dietary Progress Note, dated 1/13/23 at 1:22 p.m., indicated mirtazapine 7.5 mg at bedtime had recently been added. During an interview, on 1/13/23 at 10:06 a.m., C.N.A. 7 indicated the resident did not receive dietary supplements such as house shakes. During an interview, on 1/13/23 at 10:08 a.m., LPN 5 indicated the resident's appetite varied. He usually ate in his room and did not receive dietary supplements of house shakes. During an interview, on 1/13/23 at 10:24 a.m., the Administrator indicated the house supplement was not written as an order and should have been. Without the physician order, there was no way to monitor for intake. Review of a current, undated, facility policy, titled "S.W.A.T. PROGRAM (SKIN AND WEIGHT ASSESSMENT TEAM)," and provided by the Administrator on 1/13/23 at 11:00 a.m., indicated the following: "...5. Interventions determined by the team will be recorded on the individual resident monitoring record form...Physician orders will be obtained as warranted...7. The S.W.A.T. meeting will also discuss and review the list of residents currently receiving nutritional supplements monthly...." 3.1-46(a)(1)		dietary recommendations to verify supplement recommendations have a physician order in the medical record. 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: RD recommendation audit will be completed 1x weekly for 4 months, then monthly x2 months. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified and any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed. January 29, 2023	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to place humidification on oxygen concentrator machines for resident comfort for 3 of 4 residents reviewed for respiratory care. (Residents 4, 8 and 33) Findings include: 1. During an interview, on 1/9/23 at 10:10 a.m., Resident 4 indicated she wanted to get rid of her oxygen because it dried her nose out so badly and was uncomfortable. During an observation at the time of the interview, the oxygen concentrator had the nasal cannula tubing directly connected to the machine, without any humidification source present. Resident 4's clinical record was reviewed on 1/11/23 at 10:24 a.m. Diagnoses included multiple sclerosis, edema, and heart failure. A current physician's order, dated 12/27/22, indicated to change the oxygen tubing, humidifier, and nebulizer equipment weekly. 2. During an observation, on 1/11/23 at 11:57 a.m.,	F 0695	F695 Respiratory/Tracheostomy Care and Suctioning What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility to ensure residents who prefer humidity on the oxygen concentrator receive humidity. · Residents #4 and #33 refused for humidity to placed on oxygen concentrator machine. Resident #8 had humidity placed on oxygen concentrator machine. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents receiving oxygen through an oxygen concentrator have the potential to be affected by the alleged deficient practice. All residents receiving oxygen will	01/29/2023

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	Resident 8's oxygen concentrator was without humidification present on the concentrator. Resident 8's clinical record was reviewed 1/12/23 at 1:51 p.m. Diagnoses included Parkinson's disease, asthma, and heart disease. A current physician's order, dated 12/3/22, indicated the resident was to have oxygen at 1 to 3 liters per minute per nasal cannula as needed for shortness of breath. 3. During an observation, on 1/12/23 at 10:19 a.m., Resident 33's oxygen concentrator was without humidification present on the concentrator. Resident 33's clinical record was reviewed on 1/13/23 at 10:31 a.m. Diagnoses included pneumonia, asthma, chronic obstructive pulmonary disease, and heart failure. A current physician's order, dated 11/15/22, indicated to change the oxygen tubing, humidifier, and nebulizer equipment weekly. During an interview, on 1/12/23 at 2:15 p.m., the Administrator indicated she had previously thought the humidification bottles had been back-ordered by suppliers, but had found some bottles in a storage room. She had not realized the concentrators lacked humidification. Review of a current, undated, facility policy titled, "Oxygen Administration Guidelines," provided by the Administrator on 1/11/23 at 11:50 a.m., indicated the following: "...II. Equipment Required...c. Humidifier (if indicated)...III. Procedure...c. Implementation...ii. Apply oxygen device to oxygen tubing and attach		be reviewed to verify if the resident wants humidification and if humidity is present on concentrator. Orders will be updated as needed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Licensed nurses will be educated on verifying humidity is present per physician order by the DON/Designee on 1/26/2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Oxygen Concentrator with humidity audit will be completed 5 days a week x4 weeks, weekly x2 months, then monthly x4 months. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified and any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic	

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	end of tubing to humidified oxygen source adjusted to prescribed flow rate...." 3.1-47(a)(6)		changes for each deficiency will be completed. January 29, 2023	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and			

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	155617	A. BUILDING 00 B. WING	01/13/2023

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	what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record review and interview, the facility failed to ensure consultant pharmacist recommendations had been presented to the physician for review, and consideration for order changes, for 2 of 5 residents reviewed for unnecessary medications. (Residents 3 and 18) Findings include: 1. Resident 3's clinical record was reviewed on 1/10/23 at 1:30 p.m. Diagnosis included GERD (Gastro-Esophageal Reflux Disease. Current physician orders included omeprazole (proton-pump inhibitor) 20 mg (milligram), one tablet once a day at 5:00 a.m. for GERD, ordered on 2/26/22. A Pharmacist Consultant Note, dated 12/15/22 at 6:04 p.m., indicated a medication regimen review had been performed and the report given to the DON. A review of the pharmacist consultant medication record review, dated 12/15/22, indicated the following recommendation: the resident	F 0756	F756 Drug Regimen Review, Report Irregular, Act On What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility to ensure that consultant pharmacy recommendation are presented to the physician for review and consideration. Resident #3 and #18 had a medication regimen review done by the consultant pharmacists on 1/20/2023 with recommendations presented to the physician for review and consideration. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents residing in the facility have the potential to be affected by the alleged deficient practice.	01/29/2023

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	continued on omeprazole 20 mg daily, started on 2/27/22. Long-term use of proton pump inhibitors was a concern in the healthcare community due to possible adverse effects. The "de-prescribing" process involves slow withdrawal, dose reduction, or discontinuation of medications, with the goal of decreasing polypharmacy and inappropriate medication use, improved outcomes. Please consider discontinuation of omeprazole 20 mg daily and start famotidine (antihistamine and antacid) 20 mg twice a day for six weeks or omeprazole 20 mg every other day for 14 days then 20 mg as needed daily for 30 days. The clinical record lacked indication of prescriber review of the recommendation. 2. Resident 18's clinical record was reviewed on 1/10/23 at 2:35 p.m. Diagnoses included, but were not limited to, dementia, major depression, and delusion disorder. Current physician orders included the following: Depakote (an anticonvulsant used to treat certain mental illness as well) DR (delayed release) 125 mg (milligrams), one two times daily in the morning and at bedtime, on Monday, Tuesday, Thursday, Friday and Saturday, for mood stabilization related to intermittent mood outbursts. Hold on Wednesday and Sunday. The order was dated 2/24/22. Zoloft (to treat depression) 25 mg, daily on Monday, Tuesday, Thursday, Friday, and Saturday for depression. The order was dated 10/13/22. A Psychotropic Medication Note to Physician/Prescriber, dated 11/28/22, indicated a		The facility will complete a 30 day look back review of pharmacy recommendations to verify that recommendations were presented to the physician for review and consideration. The look back was completed on 1/26/23. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: DON/ADON were educated on 1/25/2023 on presenting all pharmacy recommendations to the physician for review and consideration and completing the recommendations. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. Administrator/designee will audit pharmacy recommendations to verify physician was presented with recommendations for review and consideration. 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: Pharmacy recommendation audit will be completed monthly x 4 and then quarterly thereafter. The results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have	

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	recommendation for a dose reduction of the resident's Depakote 125 mg daily on Tuesday, Thursday, and Saturday; hold Monday, Wednesday, Friday, and Sunday. The clinical record lacked indication of prescriber review of the recommendation. A Psychotropic Medication Note to Physician/Prescriber, dated 12/15/22, included a recommendation for a dose reduction of the resident's Depakote 125 mg daily on Tuesday, Thursday, and Saturday; hold Monday, Wednesday, Friday, and Sunday. The clinical record lacked indication of prescriber review of the recommendation. During an interview, on 1/12/23 at 10:19 a.m., the Administrator indicated the pharmacy recommendations for December 2022 were not reviewed by the prescriber(s). She was unsure when the recommendations had last been reviewed, as the documentation was no longer in the facility and may have been shredded. Review of a current, undated, facility policy titled, "Policy and Procedure-Pharmacy Recommendations," provided by the Administrator on 1/12/23 at 2:04 p.m., indicated the following: "...Policy: ...3. The DON [Director of Nursing] will coordinate through the nursing department, the notification of physicians of the recommendations received from the Pharmacy Consultant's report. This process will begin within 72 hours of the receipt of the Pharmacy Consultant's report....6. A response as to the action to be taken regarding the Pharmacy Consultant's recommendation will		been addressed. However, any patterns will be identified and any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed. January 29, 2023	

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	be documented within 7 days of the receipt of the recommendation...." 3.1-25(i)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (6) Care of cognitively impaired residents. (p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations served in the facility, for example: (E) care of cognitively impaired; residents. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (q) Each facility shall maintain current and accurate personnel records for all employees. The	F 9999	F9999 Personnel What corrective action will be accomplished for the staff found to have been affected by the deficient practice: It is the policy of the facility that the facility ensures staff have completed personnel files that include an annual 3 hours of dementia training, signed job description and job specific orientation, new hire 2 step and annual TB assessment, and have a criminal background check completed prior to orientation. How other staff have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All staff that currently work in the facility have the potential to be affected by the alleged deficient practice. The Business Office Manager or designee will complete a facility wide audit to verify that active personnel files are complete with dementia training, job specific orientation, TB assessments, job descriptions, and criminal background checks.	01/29/2023

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	personnel records for all employees shall include the following: (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Business Office Manager or designee will complete the "Personnel File Audit" tool to verify active staff and new hire files are complete. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: "Personnel File Audit" tool will be completed 5 days a week x 4 weeks, 3 days a week x 2 months, then weekly thereafter. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified and any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. January 29, 2023	

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	dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: A. Based on record review and interview, the facility failed to ensure annual dementia was completed for 5 of 5 employees, provided specific orientation for 3 of 5 employees, ensure a TB (tuberculosis) assessment was performed for 2 of 5 employees, and failed to provide a job description for 2 of 5 employees whose personnel records were reviewed. (Certified Nursing Assistant (CNA) 13, Licensed Practical Nurse (LPN) 12, Dietary Aide (DA) 10, LPN 9, CNA 11, and Social Services Director (SSD)) B. Based on record review and interview, the facility failed to complete a criminal background check which included the entire State of Indiana for 1 of 5 newly hired employees whose personnel records were reviewed. (Registered Nurse (RN) 8) Findings include: A. The employee files were reviewed on 1/11/23 at 9:40 a.m. and indicated the following: 1. LPN 9, Dietary Aide 10, CNA 11, LPN 12, and CNA 13's indicated they received 1.5 hours of dementia training. The records lacked the additional 1.5 hours of dementia training for annual in-service training. 2. CNA 4, CNA 6, and SSD's personnel files lacked job specific orientation documentation for newly hired employees.			

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	3. SSD and CNA 4's personnel files lacked TB testing prior to employment. 4. CNA 6 and CNA 4's personnel files lacked job descriptions for newly hired employees. B. During employee file review on 1/11/23 at 9:53 a.m., RN 8's criminal background check documentation indicated a specific county search was performed. The documentation for the search provider lacked indication of a state-wide criminal background search. During an interview, on 1/13/23 at 11:06 a.m., the Business Office Manager (BOM) indicated the facility did not have a job description for certified nursing assistants. The employee files provided were the only documentation she had for each employee. Review of a current, undated, facility policy titled, "New Hire Process," provided by the Administrator on 1/13/23 at 1:01 p.m., indicated the following: "...5. HR [Human Resources] will complete background check using {provider}...c. {provider} will run the following additional checks...e. State Criminal Records Search...10. Schedule Candidate to come in 2 days before Orientation to complete the following:...e. New Hire will receive 1st TB, previous positive TB test will result in Chest X-Ray. i. HR will send calendar reminder when 2nd Step TB test is due...12. Orientation...d. New Hire will meet with Department Manager and receive 2-week schedule...."			