STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING 00 B. WING	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RAWLINS HOUSE HEALTH & LIVING COMMUNITY	300 J H WALKER DR PENDLETON, IN 46064

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 3, 4, 5, 6, 9, 10, and 11, 2024. Facility number: 000248 Provider number: 155357 AIM number: 100291470 Census Bed Type: SNF/NF: 92 SNF: 15 Residential: 51 Total: 158 Census Payor Type: Medicare: 21 Medicaid: 72 Other: 14 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 18, 2024.	F 0000	The plan of correction is to serve as Rawlins House Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rawlins House Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to appropriately date stored medications, discard expired insulin vials, and label medications with resident information in 4 of 5 medication carts observed for medication storage. (South 1 medication cart, South treatment cart, North	F 0761	**F 761 Label/Store Drugs and Biologicals** **I. What corrective actions will be accomplished for those residents found to have been**	09/30/2024

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

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	medication cart, and North treatment cart) Findings include: 1. During a medication storage observation of the South 1 medication cart, accompanied by RN 11 on 9/9/24 at 1:45 p.m., the following was observed: One Lantus Solostar (insulin glargine) injection pen, with approximately 150 units remaining, lacked an open date. RN 11 indicated the insulin pen should have an open date written on the label. 2. During a medication storage observation of the South treatment cart, accompanied by LPN 12, on 9/9/24 at 1:55 p.m., the following items were observed: a. One tube of Biofreeze (a topical pain relief cream/gel), partially labeled with the last name of a discharged resident. b. One medium sized tube of hydrocortisone cream 1% (used to treat skin conditions that cause redness, swelling, rashes, and itching) without resident identifiers. c. One large tube of skin protectant cream without resident identifiers. d. One large tube of Eucerin Skin Calming Itch Soothing Cream, partially labeled with the last name of a discharged resident. e. One medium sized tube of Aspercreme (a topical pain relief cream/gel) without resident identifiers. During that same time, LPN 12 indicated she was unaware these multi-use skin treatments should be labeled. The treatments were used for more than one resident. Some of the tubes had the names of discharged residents on them.		**affected by the practice?** Identified medications were disposed of properly. **II. The facility will identify other residents that may potentially be affected by the practice.** Other medications were audited and properly labeled and dated. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed nurses and qualified medication aides are being educated on medication labeling and dating. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit all medications in carts for labeling and dating daily for 14 days, then weekly for 6 weeks, then monthly for 3 months, then quarterly ongoing through quality assurance. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the	

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	3. During a medication storage observation of the North medication cart, accompanied by RN 4, on 9/9/24 at 1:55 p.m., the following was observed: a. One Humalog (insulin) Kwikpen with approximately 120 units remaining, lacked an open date. b. One Novolog (insulin) Flexpen with approximately 160 units remaining, with an open date of 8/1/24. c. One Levermir (insulin) Flexpen with approximately 250 units remaining, with an open date of 7/25/24. During an interview, at the time of the observation, RN 4 indicated all insulin pens should be dated when opened, and insulin was good for 28 days. RN 4 indicated neither expired insulin pen should be used to provide resident medication. 4. During a medication storage observation of the North treatment cart, accompanied by RN 5, on 9/9/24 on 2:03 p.m., the following was observed: a. One tube of triple antibiotic (to treat infection) ointment, maximum strength without resident identifiers. b. One tube of "Medihoney" (to treat wounds) wound gel without resident identifiers. c. One tube of hemorrhoid treatment ointment without resident identifiers. d. One tube of "Triad" (to treat wounds) wound cream without resident identifiers. During an interview, at the time of the observation, RN 5 indicated medications arrived in large packages and resident identifier information should be written on the separate tubing or bottles.		Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits and frequency will be adjusted as needed.	

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	A current, undated, facility policy, titled, "Drug Storage", provided by the Administrator on 9/9/24 at 4:05 p.m., indicated the following: "... All expired, damaged and/or contaminated medications are removed from resident care areas and stored separately from medications available for administration...." A current, undated, facility skills validation sheet, provided by the Administrator on 9/10/24 at 12:30 p.m., indicated the following: "...5. Check for date opened, expiration date..." A current, undated, facility policy, titled, "Medication Labeling", provided by the Administrator on 9/10/24 at 12:15 p.m., indicated the following: "...All labeling of prescriptions filled... will be the responsibility of the dispensing pharmacist and will be consistent with State and Federal requirements... Over the counter medications used for a specific resident must identify that resident and have an appropriate pharmacy label applied...." 3.1-25(j) 3.1-25(k)			
F 0803 SS=E Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed Based on observation, interview and record review, the facility failed to ensure menus were followed for 4 of 4 residents reviewed for receiving diets/menus as ordered (Residents 45, 10, 42 and 60). Findings include: A current facility document titled "Week at a	F 0803	**Requesting IDR to review additional information.** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Menus were reviewed and are	09/30/2024

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	Glance," provided by Administrator following the entrance conference on 9/3/24, indicated the following: Lunch Menu 9/6/24 Lunch: Tomato Basil Soup- 6 oz Saltine crackers- I pack Ultimate grilled cheese sandwich -1 sandwich Breaded green beans- 4 oz Ranch dressing -2 oz Pineapple tidbits ½ cup. A current facility document titled "Spring/Summer, 2024 Diet Guide Sheet," provided by the Certified Dietary Manager (CDM) on 9/6/24 at 12:15 p.m., indicated the following diet types were menued to receive lunch as follows: Regular Diet Tomato Basil Soup- 6 ounces Saline Crackers- 1 pack Ultimate grilled cheese sandwich -1 sandwich Breaded Green Beans - 4 ounces Ranch dip -2 ounces Pineapple tidbits - ½ cup Mechanical Soft Diet Tomato Basil Soup- 6 ounces Saline Crackers- 1 pack Ultimate grilled cheese sandwich -1 sandwich Breaded Green Beans - 4 ounces Ranch dip -2 ounces Pineapple crushed- ½ cup Finger Foods Tomato Basil Soup- 6 ounces- in a mug Ultimate grilled cheese sandwich -1 sandwich Breaded Green Beans - 4 ounces Ranch dip -2 ounces		being followed for residents 45,10,42, and 60. **II. The facility will identify other residents that may potentially be affected by the practice.** Menus for other residents on the dementia unit have been reviewed and are being followed. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Dietary staff and service staff are being educated regarding following menus. **IV. The facility will monitor the corrective action by implementing the following measures.** The dietary manager, or designee, will audit resident menus to ensure preferences are reflected and menus are followed daily 14 days, then weekly for 6 weeks, then monthly for 3 months, then quarterly ongoing through quality assurance. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of	

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	Pineapple tidbits - ½ cup" During a lunch meal service observation of the secured dementia unit dining room 9/6/24 from 11:56 a.m. to 12:40 p.m., not all residents were being served tomato soup, nor was another soup or alternate to tomato soup, offered. Residents 45, 10, 42 and 60 were not served tomato soup, another soup, or an alternate for tomato soup. During an interview on 9/6/24 at 12:14 p.m., Cook 9, who was dipping up portions and serving the meal trays on the dementia unit, indicated there was no alternate soup nor was she aware of any alternate for the tomato soup. She only served the items listed on the resident's meal tickets. The items on the meal ticket were the items the resident had selected for the meal. She did not know who completed the resident's selections or how they were selected. During an interview on 9/6/24 at 12:15 p.m., the CDM indicated there was no alternate soup for tomato soup, nor a substitute for tomato soup. The select menu system did not call for a replacement if not selected by the resident. She had no information regarding who selected the meals for the residents on the dementia unit. It could be the family, the resident themselves might have chosen, or the staff who knew what the resident liked might have chosen for them. The facility did not have an approach to ensure the caloric values from the menu were received if the meal ticket did not selection did not meet the menus values. During an interview on 9/6/24 at 12:18 p.m., LPN 10 indicated residents with orders for finger food diets did not have soup because they could spill it.		100% is not achieved, the audits and frequency will be adjusted as needed.	

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	During an observation on 9/6/24 at 12:20 p.m., Resident 45 was eating in the dining room on the secured dementia unit. She had a grilled cheese sandwich and no tomato soup, other soup, or alternate for tomato soup. She indicated she liked tomato soup. During an observation on 9/6/24 at 12:25 p.m., Resident 60 was eating in the dining room on the secured dementia unit. She had a grilled cheese sandwich and no tomato soup, other soup, or alternate for tomato soup. She indicated she liked tomato soup. During an observation on 9/6/24 at 12:27 p.m., Resident 42 was eating in the dining room on the secured dementia unit. She had a grilled cheese sandwich and no tomato soup, other soup, or alternate for tomato soup. She indicated she liked tomato soup. During an observation on 9/6/24 at 12:29 p.m., Resident 10 was eating in the dining room on the secured dementia unit. She had a grilled cheese sandwich and no tomato soup, other soup, or alternate for tomato soup. She indicated she liked soup and would enjoy some soup, but she did not like tomato soup. During an interview on 9/6/24 at 12:40 p.m., RD 7 (registered dietitian) indicated 235 calories was a fair estimate of the calories contained in six ounces of tomato soup. 1. Resident 45's clinical record was reviewed on 9/9/24 at 9:46 a.m. Current diagnoses included mixed dementia, psychotic disturbance, mood disturbance, anxiety, mixed receptive-expressive language disorder, vitamin deficiency, and			

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	cognitive communication deficit. The resident had a current September 2024 physician's order for a regular diet. This order originated 5/18/23. This resident had a current, September 2024, physician's order to reside on a secured dementia unit. A 7/4/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. The resident had a current care plan problem need related to nutrition risk due to dementia. This problem originated 5/19/23. Approaches to this problem included serve a regular diet as ordered. The resident had a current care plan problem need related to vitamin deficiency. This problem originated 6/5/23. Approaches to this problem included to serve a diet as ordered by the physician. During an interview on 9/9/24 at 2:32 p.m., Resident 45's responsible party indicated they had never been asked to complete a select menu for their resident. They had never been asked anything about their resident's food preferences. It would be a good idea to get their input about food likes. The resident loved grilled cheese and tomato soup. 2. Resident 10's clinical record was reviewed on 9/6/24 at 9:02 a.m.. Current diagnoses included dementia with psychotic disturbances, mixed receptive-expressive language disorder, and depression. The resident had a current September 2024 physician's order for a diet mechanical soft texture with ground meat, with nectar thickened liquids diet. This order originated 6/24/24. This resident had a current, September 2024,			

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	physician's order to reside on a secured dementia unit. A 6/12/24, quarterly, MDS assessment indicated the resident was cognitively intact. The resident had a current care plan problem need related to nutritional risk. This problem originated 3/29/24. Approaches to this problem included to serve a diet as ordered. During an interview on 9/4/24 at 10:39 a.m. Resident 10 indicated she was often times very confused. During an interview on 9/9/24 at 3:47 p.m., Resident 10's responsible party indicated the resident did like soup, but not tomato soup. At this point in time, most days the resident could state what they would like to eat. The facility had never asked them about resident food preferences and select menus. They believed their input would be helpful. 3. Resident 42's clinical record was reviewed on 9/9/24 at 9:52 a.m. Current diagnoses included Alzheimer's disease expressive language disorder, vitamin deficiency, anxiety and depression. The resident had a current September 2024 physician's order for a finger foods diet. This order originated 6/22/23. This resident had a current, September 2024, physician's order to reside on a secured dementia unit. A 7/16/24, quarterly, MDS assessment indicated the resident was severely cognitively impaired. The resident had a current care plan problem need related to nutritional risk due to dementia. This problem originated 4/14/23. Approaches to this			

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	problem included serve diet per physician's orders. During an interview on 9/9/24 at 2:25 p.m., Resident 42's responsible party indicated the facility had never asked them to choose a select menu for their resident. They had often times told people the resident liked peanut butter and jelly, bananas, and yogurt. The resident was so advanced in their illness that they should maybe be asked each meal, at the time of the meal what they would like to eat. A good idea would be to offer them an item and see if they liked it that day. 4. Resident 60's clinical record was reviewed in 9/9/24 at 9:49 a.m. Current diagnoses included dementia severe with psychotic disturbance, anxiety, vitamin deficiency, and mixed expressive-receptive language disorder. The resident had a current September 2024 physician's order for a diet. a regular diet. This order originated 2/15/24. This resident had a current, September 2024, physician's order to reside on a secured dementia unit. A 6/24/24, significant change, MDS assessment indicated the resident was severely cognitively impaired. The resident had a current care plan problem need related to nutritional risk related to dementia. This problem originated 6/22/20. Approaches to this problem included serve diet as ordered. The resident had a current care plan problem need related to a risk for weight loss due to dementia. This problem originated 6/11/20. Approaches to this problem included serve diet per order. During an interview on 9/9/24 at 1:26 p.m., the			

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	Administrator indicated the facility's select menu system did not indicate who made the selections for the residents selected meal ticket. On the dementia unit, many families chose. The system did not address if residents who had dementia or memory impairment had not chosen an alternate for food items. The residents chose their alternate when they made their selections. During an interview on 9/9/24 at 1:49 p.m., RD 6 indicated the facilities system did not indicate who made the selections on the resident select menu. Their was no system to ensure residents who could not make their wants and needs known had their likes and dislikes honored. There was not a system for ensure alternatives were offered to residents with dementia. A current facility policy titled, "Meal Service", dated 2012 and provided by the Administrator on 9/10/24 at 11:10 a.m. indicated the following: "...Individual Substitutions...Policy: The Dining Services Department strives to meet the preferences of residents. Substitutions are available to individual residents as listed on the planned menu and through a standard stock to substation alternatives...." A current facility policy titled, "Nutrition and Clinical Care," dated 2012 and provided by the Administrator on 9/10/24 at 12:34 p.m. indicated the following: "...Diet Orders...Policy: Diet orders are written by the physician based on the medical needs and physical capabilities of the resident. They follow the approved diet manual and the regimens included in the menu program...." 3.1-20(i)(4)			

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F 0806 SS=E Bldg. 00	483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes Based on observation, interview, and record review, the facility failed to ensure resident food preferences were reviewed and honored for 4 of 4 residents reviewed for food preferences (Residents 45, 10, 42 and 60). Findings include: 1. During an observation on 9/6/24 at 12:20 p.m., Resident 45 was eating in the dining room on the secured dementia unit. She had a grilled cheese sandwich and no tomato soup, other soup, or alternate for tomato soup. She indicated she liked tomato soup. During an interview on 9/9/24 at 2:32 p.m., Resident 45's responsible party indicated they had never been asked to complete a select menu for their resident. They had never been asked anything about Resident 45's food preferences. It would be a good idea to get their input about food likes. The resident loved grilled cheese and tomato soup. Resident 45's clinical record was reviewed on 9/9/24 at 9:46 a.m. Current diagnoses included mixed dementia, psychotic disturbance, mood disturbance, anxiety, mixed receptive-expressive language disorder, vitamin deficiency, and cognitive communication deficit. The resident had a current September 2024 physician's order for a regular diet. This order originated 5/18/23. This resident had a current, September 2024, physician's order to reside on a secured dementia unit. A 7/4/24, quarterly, Minimum Data Set (MDS)	F 0806	**Requesting IDR to review additional information.** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Preferences have been reviewed and updated as indicated for resident's 45, 10, 42, and 60. **II. The facility will identify other residents that may potentially be affected by the practice.** Preferences for other residents on the dementia unit have been reviewed and updated as indicated. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Dietary staff and service staff are being educated regarding reviewing and honoring resident's food preferences. **IV. The facility will monitor the corrective action by implementing the following measures.**	09/30/2024

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	assessment indicated the resident was severely cognitively impaired. The resident had a current care plan problem need related to nutrition risk due to dementia. This problem originated 5/19/23. Approaches to this problem included provide resident with food and snacks they enjoy. The clinical record lacked indication of the resident's food preferences and/or food likes or dislikes. 2. During an observation on 9/6/24 at 12:25 p.m., Resident 60 was eating in the dining room on the secured dementia unit. She had a grilled cheese sandwich and no tomato soup, other soup, or alternate for tomato soup. She indicated she liked tomato soup. Resident 60's clinical record was reviewed in 9/9/24 at 9:49 a.m. Current diagnoses included dementia severe with psychotic disturbance, anxiety, vitamin deficiency, and mixed expressive-receptive language disorder. The resident had a current September 2024 physician's order for a diet. a regular diet. This order originated 2/15/24. This resident had a current, September 2024, physician's order to reside on a secured dementia unit. A 6/24/24, significant change, MDS assessment indicated the resident was severely cognitively impaired. The resident had a current care plan problem need related to nutritional risk related to dementia. This problem originated 6/22/20. Approaches to this problem included honor food preferences.		The dietary manager, or designee, will audit resident menus to ensure preferences are reflected and menus are followed daily for 14 days, then weekly for 6 weeks, then monthly for 3 months, then quarterly ongoing through quality assurance. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits and frequency will be adjusted as needed.	

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	155357	A. BUILDING 00 B. WING	09/11/2024

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	The resident had a current care plan problem need related to a risk for weight loss due to dementia. This problem originated 6/11/20. Approaches to this problem included honor resident's food preferences. The clinical record lacked indication of the resident's food preferences and/or food likes or dislikes. 3. During an observation on 9/6/24 at 12:27 p.m., Resident 42 was eating in the dining room on the secured dementia unit. She had a grilled cheese sandwich and no tomato soup, other soup, or alternate for tomato soup. She indicated she liked tomato soup. During an interview on 9/9/24 at 2:25 p.m., Resident 42's responsible party indicated the facility had never asked them to choose a select menu for their resident. They had never been asked about the resident's food preferences. They had often times told people the resident liked peanut butter and jelly, bananas, and yogurt. The resident was so advanced in their illness that they should maybe be asked each meal, at the time of the meal what they would like to eat. A good idea would be to offer them an item and see if they liked it that day. Resident 42's clinical record was reviewed on 9/9/24 at 9:52 a.m. Current diagnoses included Alzheimer's disease expressive language disorder, vitamin deficiency, anxiety and depression. The resident had a current September 2024 physician's order for a finger foods diet. This order originated 6/22/23. This resident had a current, September 2024, physician's order to reside on a secured dementia unit.			

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	A 7/16/24, quarterly, MDS assessment indicated the resident was severely cognitively impaired. The resident had a current care plan problem need related to nutritional risk due to dementia. This problem originated 4/14/23. Approaches to this problem included honor residents food preferences and involve family in plan of care. The clinical record lacked indication of the resident's food preferences and/or food likes or dislikes. 4. During an observation on 9/6/24 at 12:29 p.m., Resident 10 was eating in the dining room on the secured dementia unit. She had a grilled cheese sandwich and no tomato soup, other soup, or alternate for tomato soup. She indicated she liked soup and would enjoy some soup, but she did not like tomato soup. During an interview on 9/9/24 at 3:47 p.m., Resident 10's responsible party indicated the resident did like soup and did not like tomato soup. At this point in time, most days the resident could state what they would like to eat. The facility had never asked them about the resident's food preferences or a select menu. They believed their input would be helpful. Resident 10's clinical record was reviewed on 9/6/24 at 9:02 a.m.. Current diagnoses included dementia with psychotic disturbances, mixed receptive-expressive language disorder, and depression. The resident had a current September 2024 physician's order for a diet mechanical soft texture with ground meat, with nectar thickened liquids diet. This order originated 6/24/24. This resident had a current, September 2024, physician's order to reside on a secured dementia			

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	unit. A 6/12/24, quarterly, MDS assessment indicated the resident was cognitively intact. The resident had a current care plan problem need related to nutritional risk. This problem originated 3/29/24. Approaches to this problem included honor resident's food dislikes, and provide the resident's with food and snacks which they enjoy. The clinical record lacked indication of the resident's food preferences and/or food likes or dislikes. During an interview on 9/4/24 at 10:39 a.m. Resident 10 indicated she was often times very confused. A current facility document titled "Week at a Glance," provided by the Administrator following the entrance conference on 9/3/24, indicated the following: Lunch Menu 9/6/24 Lunch: Tomato Basil Soup- 6 oz Saltine crackers- I pack Ultimate grilled cheese sandwich -1 sandwich Breaded green beans- 4 oz Ranch dressing -2 oz Pineapple tidbits ½ cup. During the lunch meal service observation on the secured dementia unit dining room on 9/6/24 from 11:56 a.m. to 12:40 p.m., not all residents were being served tomato soup nor was another soup or alternate to tomato soup being offered. Residents 45, 10, 42 and 60 were not served tomato soup, another soup or an alternate for			

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	tomato soup. During an interview on 9/6/24 at 12:14 p.m., Cook 9, who was dipping up portions and serving the meal trays on the dementia unit, indicated there was no alternate soup nor was she aware of any alternate for the tomato soup. She only served the items listed on the resident's meal tickets. The items on the meal ticket were the items the resident had selected for the meal. She did not know who completed the resident's selections or how they were selected. During an interview on 09/06/24 at 12:15 p.m., the Certified Dietary Manager (CDM) indicated she had no information regarding who selected the meals for the residents on the dementia unit. It could be the family, the resident themselves might have chosen, or the staff who knew what the resident liked might have chosen for them. The facility did not interview the residents and/or their families about their food likes and dislikes. During an interview on 9/9/24 at 1:26 p.m., the Administrator indicated the facility's select menu system did not indicate who made the selections for the residents selected meal ticket. The facility did not interview residents and/or their families about food likes/dislikes or food preferences. The select menu was supposed to identify the likes and dislikes. The select menu system did not identify who made the selections for the resident nor when the selection were made. During an interview on 9/9/24 at 1:49 p.m., RD 6 indicated the facility's system did not indicate who made the selections on the resident select menu. Their was no system to ensure residents who could not make their wants and needs known had their likes and dislikes honored. There was			

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	not a system for ensure alternatives were offered to residents with dementia. A current facility policy titled "Resident Food Preference," dated 7/2017 and provided by Administrator on 9/9/24 at 4:05 p.m., indicated the following: "...Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team ... 1. Upon the resident's admission (or within twenty- four (24) hours after his/her admission) the Dietitian or nursing staff will identify a resident's food preference. 2. When possible staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes...." A current facility policy titled "Meal Service", dated 2012 and provided by the Administrator on 9/10/24 at 11:10 a.m., indicated the following: "...Policy: The Dining Services Department strives to meet the preferences of residents. Substitutions are available to individual residents as listed on the planned menu and through a standard stock to substation alternatives...."			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to follow infection prevention and control procedures during wound care related to Enhanced Barrier Precautions (EBPs) for 1 of 2 resident reviewed for skin impairments. Findings include:	F 0880	**I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** LPN 10 and LPN 13 were educated regarding infection prevention and control procedures during wound care related to EBP.	09/30/2024

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	During an observation on 9/5/24 at 1:15 p.m., Resident 100 was lying in bed. On the wall by the window, a small plastic container holding personal protective equipment (PPE) and an orange sign indicated EBP lying on top of the container. Resident 100's clinical record was reviewed on 9/6/24 at 10:48 a.m. Diagnoses included wedge compression fracture of first thoracic vertebra, dementia in other diseases classified elsewhere, and age-related physical debility. Resident 100's current physician's order, dated 8/28/24, indicated cleanse coccyx wound with normal saline, pat dry, apply Xeroform (to treat wounds), and cover with Alleyvn (foam dressing) daily and as needed for spoilage and displacement. A precautions care plan, dated 8/19/24, indicated Resident 100 required enhanced barrier precautions related to a wound. Approaches included the following: apply gown and gloves for high contact activities and wound care, and provide family, staff, and resident education as needed. A pressure ulcer care plan, dated 8/20/24, indicated an unavoidable stage 2 (partial thickness loss of dermis) pressure wound to the sacrum. Approaches included the following: administer treatment as ordered, assist resident with turning and repositioning, and family and resident education. A "Wound Note", dated 9/2/24, indicated a stage 2 pressure ulcer (an open sore that can appear as a blister, abrasion, or shallow crater in the skin) measuring 0.5 centimeters (cm) by 0.5 cm (the size of a pea). The wound was improving, the tissue		**II. The facility will identify other residents that may potentially be affected by the practice.** Other licensed nurses are being educated regarding proper isolation procedures for enhanced barrier precautions. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Other licensed nurses are being educated regarding proper isolation procedures for enhanced barrier precautions. **IV. The facility will monitor the corrective action by implementing the following measures.** The IP/DON, or designee, will observe 3 employees providing care for residents requiring EBP to ensure compliance with infection control practices daily for 6 weeks, then weekly for 6 weeks, then monthly for 3 months, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee	

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	remained fragile, and was unable to blanch effectively. During a wound care observation on 9/6/24 at 10:50 a.m., LPN 10 and LPN 13 entered Resident 100's room. On the wall, above the head of the resident's bed, was an orange sign that indicated EBP. The resident was lying in a low bed. LPN 10 deposited wound treatment supplies on a towel-covered bedside table. LPN 10 and LPN 13 completed hand washing and donned gloves. LPN 10 removed the previous dressing, dated 9/5/24. The dressing had minimal yellow colored drainage. LPN 10 cleaned the wound using normal saline, patted the area dry with gauze, removed her dirty gloves, and completed hand hygiene using hand sanitizer. LPN 13 was asked to exit the room to gather additional supplies needed. LPN 13 removed her gloves and completed hand hygiene utilizing hand sanitizer. LPN 10 donned clean gloves and applied the ordered treatment to the wound bed and applied the appropriate dressing on top of the treatment. LPN 13 returned with towels and a brief and donned gloves. LPN 10 and LPN 13 changed the resident's brief and did peri-neal care. Neither LPN 10 or LPN 13 donned a gown during the wound care observation. During an interview, on 9/6/24 at 10:50 a.m., LPN 10 and LPN 13 both indicated they should have worn gowns during the wound care treatment. LPN 13 further indicated EBP's were to protect residents and others from infections. During an interview, on 9/9/24 at 4:03 p.m., the Administrator indicated he was advised only chronic wounds over 3 months required EBP and his staff were not required to wear gowns during the previous wound care observation.		meeting monthly for no less than 6 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.**	

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	During an interview, on 9/9/24 at 4:21 p.m., the DON indicated EBP was for the protection of residents, families, and staff to prevent the spread of infection. She indicated EBP was utilized for chronic wounds and any skin opening requiring a dressing. A current facility policy, revised 4/1/24, titled, "Enhanced Barrier Precautions Policy and Procedure", provided by the Administrator, on 9/9/24 at 4:05 p.m., indicated the following: "... EBP is used in conjunction with standard precautions and expand the use of PPE to donning gown and gloves during high-contact resident care activities...Use of EBP is indicated for residents with:...Any skin opening requiring a dressing...." 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 3, 4, 5, 6, 9, 10, and 11, 2024. Facility number: 000248 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 18, 2024.	R 0000	The plan of correction is to serve as Rawlins House Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rawlins House Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview and record review, the facility filed to ensure the kitchen was neat, clean and in good repair. This deficient practice had the potential to impact 51 of 51 residents who received meals from the residential building. Findings include: During a kitchen tour on 9/11/24 at 8:22 a.m., the following kitchen sanitation concerns were identified: a. The floor tiles throughout the kitchen, against equipment, under equipment, in corners, and against baseboards, had a dull thick gray film. b. There was a sticky, dark, thick residue on the floor tile in front of the refrigerators and freezers. c. The grout between the floor tiles had dark staining. d. Floor tiles were cracked throughout the kitchen. e. A large strip of floor, about 5 feet by 3 inches, was missing in the dish room. f. The table mounted can opener had a sticky, thick substance on both the blade and base. g. The drip pan located under the burners on the stove was covered in a brown/black burnt on substance. During an interview at the time of the tour, Cook 15 indicated she was in charge of the oversight for the residential kitchen. The floors should be	R 0273	The facility respectfully requests desk review for the following citations. **R 273 Food and Nutritional Services-Deficiency** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Floor deep cleaned and repaired. Equipment deep cleaned. Floor tiles replaced. **II. The facility will identify other residents that may potentially be affected by the practice.** Kitchen cleaning schedule to be followed and monitored by Dietary Manager. Entire kitchen is scheduled for a remodel late this year to include new kitchen floor. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Dietary Kitchen Staff being educated on proper cleaning of kitchen and reporting on maintenance issues.	09/30/2024

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	mopped two times a day. The can opener should be washed at least once a day. The drip pan under the stove burns should be cleaned a minimum of once a week. During an interview on 9/11/24 at 9:50 a.m., the Administrator indicated the floor in the residential kitchen was in need of a deep cleaning. An untitled, September 2024 kitchen cleaning schedule for assisted living, provided by Administrator on 9/11/24 at 9:02 a.m. indicated: "...Daily AM Cook ...Spills in oven ... Daily Prep Cook ...prep table ...walls and shelves in prep area ...sweep & mop ... Daily AM Servers ...sweep & mop ... Daily PM Server ... Daily AM Dishes ...sweep & mop dish room ... Daily PM Dishes ...sweep & mop dish room ... Weekly ... AM dish-sweep/mop stock room...."		**IV. The facility will monitor the corrective action by implementing the following measures.** The Dietary Manage, or designee, will audit Kitchen cleaning schedule and equipment maintenance daily for 14 days, then weekly for 6 weeks, then monthly for 3 months, then quarterly ongoing through quality assurance. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits and frequency will be adjusted as needed.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on interview and record review, the facility failed to develop and implement an infection control program which enabled the facility to analyze patterns of known infectious symptoms, prevent the spread of infection, and/or develop programs to prevent recurrence. This deficient practice had the potential to impact 51 of 51 residents who resided in the facility. Findings include: During an interview, on 9/10/24 at 11:25 a.m., the Administrator indicated the facility did not	R 0407	**I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** The facility has implemented an infection control process to analyze patterns of known infectious symptoms to prevent the spread of infection and/or recurrence. **II. The facility will identify**	09/30/2024

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	complete any tracking or trending of infections in the Assisted Living facility. During an interview, on 9/11/23 at 11:40 a.m., the Infection Preventionist indicated she had not been tracking or trending any signs or symptoms of infections in the Assisted Living. The resident's electronic medical record (EMAR) contained documentation of any infections for each resident only. A current facility policy, dated 6/6/19, titled, "Policies and Practices- Infection Control", provided by the Administrator on 9/10/24 at 11:25 a.m., indicated the following: "... The objective of our infection control policies and practices are to: Prevent, detect, investigate, and control infections and communicable diseases in the facility; Written standards, policies, and procedures for the program, which must include, but are not limited to: A system of surveillance designed to identify possible communicable disease or infections before they can spread to others persons in the facility...."		**other residents that may potentially be affected by the practice.** Other residents have been reviewed for infectious symptoms and trends addressed as needed. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** The residential nurse manager is being educated to analyze patterns of known infectious symptoms to prevent the spread of infection and/or recurrence. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will review to ensure the residential facility has analyzed patterns of known infectious symptoms monthly for 3 months, then quarterly ongoing. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits and frequency will be adjusted as needed.	