STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155238	A. BUILDING 00 B. WING	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
YORKTOWN MANOR	2000 S ANDREWS RD YORKTOWN, IN 47396

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00444578. Complaint IN00444578 - No deficiencies related to the allegations were cited. Survey dates: October, 2, 3, 4, 5, 7, and 8, 2024 Facility number: 000143 Provider number: 155238 AIM number: 100283890 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 5 Medicaid: 54 Other: 10 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 16, 2024.	F 0000	F000 - By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit this response pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective October 31, 2024, to the Recertification and State Licensure Survey completed on October 2, 2024. The facility also respectfully requests that our plan of correction be considered for paper review compliance. The facility will submit any evidence as requested to validate compliance.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure shift to shift narcotic reconciliation was completed for 2 of 3 carts reviewed for medication storage. (300 hall cart and 100 hall cart)	F 0755	F- 755 Pharmacy Services/Procedures/Pharmacist/ Records It is the practice of Yorktown	10/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Bailey	Administrator	10/30/2024

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	Findings include: 1. During a medication storage observation of the 300 hall cart, accompanied by RN 5, on 10/4/24 at 2:00 p.m., the "Controlled Drugs- Count Record" was reviewed and the following dates lacked signatures for shift to shift reconciliation of controlled substances: In October 2024- 10/1 on evening and night shifts, 10/2 on night shift, 10/3 on day and night shifts, 10/4 on day shift. In September 2024- 9/4 on evening shift, 9/14 on night shift. During an interview, at the time of the observation, RN 5 indicated the narcotic count was completed at the beginning and end of each shift. 2. During a review of the 100 hall cart "Controlled Drugs- Count Record", provided by Medical Records on 10/4/24 at 3:00 p.m., the following dates lacked signatures for shift to shift reconciliation of controlled medications: In October 2024- 10/1 on day and night shifts, 10/2 on evening and night shifts, 10/3 on evening and night shifts, 10/4 on day shift. In September 2024-		Manor to receive, store, and maintain signature account for all medication and narcotics stored at the facility. It is the practice that all licensed staff coming on/off scheduled shift will reconcile all scheduled narcotics and both licensed staff will sign Controlled Drug Count record according to facility policy. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy "Controlled Substance" was reviewed by IDT. An in-service was held with all licensed staff on controlled substance policy/procedure. Director of Nursing conducted a complete audit of all narcotic count books and recorded signature sheet. A performance improvement tool has been developed to monitor that all signatures are present with both licensed signatures. How the corrective actions will be monitored to ensure the deficient practice will not recur. A performance improvement tool has been initiated that randomly audits each narcotic count book. The Director of Nursing/Designee will review books upon arrival at the facility, randomly throughout the day and again prior to exit from shift, to ensure monitoring is occurring on all shifts, daily x1	

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	9/10 on evening and night shifts, 9/11 on night shift, 9/12 on evening and night shifts, 9/18 on day and night shifts, 9/20 on day shift. During an interview, on 10/4/24 at 2:52 p.m., the DON indicated the expectation was for oncoming staff and outgoing staff to complete a narcotic reconciliation before the exchange of keys for the medication cart. During an interview, on 10/8/24 at 11:57 a.m., the DON indicated the actual narcotic count number was documented on the separate narcotic sheets for each resident. The staff utilize the separate narcotic count sheets to verify the medication count. The staff sign the "Controlled Drugs-Count Record" after the count is verified as correct. A facility policy, revised 12/12, titled, "Controlled Substances", provided by the Administrator on 10/8/24 at 10:32 a.m., indicated the following: "...9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services...." 3.1- 25(b)(3)		week, then 3x weekly for 3 weeks and then monthly. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of all audits will be reviewed at the Quality Assurance Meeting. Monitoring will remain in place until 100% accuracy has been achieved and PRN to ensure continued practice. By what date systemic changes will be made: 10/31/2024	
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 to ensure proper portions were served	F 0803	F - 803 Menus meet residents Nds/Prep in Adv/Followed	10/31/2024

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	for 1 of 1 meal observed for following menus (10/7/24 Lunch). This deficient practice had the potential to impact 69 of 69 residents. Finding include: An undated facility document titled, "Midwest Fall/Winter 2024-2025," provided by the facility following the entrance conference on 10/2/24, indicated lunch on October 7, 2024 was Baked Ziti with Meat sauce, Tossed Salad with Dressing, and Ice Cream. An undated facility document titled, "Midwest Fall/Winter 2024-2025, Diet Spreadsheet Short Name Format, provided by the Certified Dietary Manager on 10/7/24 at 11:19 a.m., indicated the portion of baked ziti to be served to the residents was 6 ounces. During the lunch meal service observation on 10/7/24 from 10: 58 a.m. to 11:06 a.m. Cook 4 served a 4-ounce serving of baked pasta on 10 plates, which were placed in the meal service cart to be serve to the 200 hall. The cook indicated the trays were prepared and ready for service to the residents. The pasta was prepared in a method which allowed for both regular and mechanical soft diets to eat the some pasta. During an interview on 10/7/24 at 11:06 a.m., Cook 4 indicated she was using #8 scoop to serve the baked pasta entree. She did not know the portion size of the #8, gray handled scoop. During an interview on 10/7/24 at 111:07 a.m., the Certified Dietary Manager (CDM) indicated the cook had served the wrong size portion of pasta in error. The portion which had been plated was 4 ounces. The menued portion of baked pasta		It is the practice of Yorktown Manor to ensure all residents receive the correct portion size to all meals to ensure all nutrition needs are being met. All residents had the potential to be affected by this defiant act. Portion size was corrected prior to meal being served and all residents received correct nutrition serving. Expectation of dietary staff to review policy/serving size for correct meal portions. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy "Standardized Recipes/Portion size" was reviewed by IDT. An in-service was held for all dietary staff on standard menus and portion size policy/procedures. Dietary Manager conducted an audit to dietary utensils to ensure each correct scoop size is present. All current scoop sizes are present and accessible for staff. A performance improvement tool has been developed to monitor that correct portion size is served with each meal. How the corrective actions will be monitored to ensure the deficient practice will not recur. A performance tool has been initiated that randomly audits	

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	was 6 ounces. The facility would need to add 2 ounces additional pasta to correct the error. During an interview on 10/08/24 at 11:30 a.m., the Administrator indicated 69 of 69 residents ate food prepared in the facility kitchen. A current, 7/2023 facility policy titled, "Standardized Recipes", which was left on the conference table by facility leadership on 10/8/24 at 9:05 a.m., indicated: "...Standardized recipes (in appropriate portion sizes) for each set of cycle menus are provided and maintained in the facility... Cooks are expected to use and follow the recipes provided..." 3.1-20(i)(l)		meals being served to ensure correct portion size is present. Dietary Manager will offset daily x1 week, then 3x weekly for 2 weeks and then monthly observation of meals being served to ensure each resident is receiving the correct portion size indicated for each food item. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of all audits will be reviewed at the Quality Assurance Meeting. Monitoring will remain in place until 100% accuracy has been achieved and PRN to ensure continued practice. By what date systemic changes will be made: 10/31/2024 ="" div ="" div ="" div ="" div ="" div ="" div	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to ensure hand hygiene was completed during medication administration for 3 of 5 residents observed. (Resident 12, Resident 36, and Resident 50) Findings include:	F 0880	F- 880 Infection Prevention and Control It is the practice of Yorktown Manor to provide all residents with a safe, sanitary, and comfortable environment and to help prevent	10/31/2024

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	During a medication administration observation on 10/7/24, at 11:24 a.m., RN 5 removed medications for Resident 12 from the 300 Hall medication cart. Prior to removing medications, the RN did not perform hand hygiene. Three oral medications, one nasal spray, and one bottle of eye drops, were removed from the cart. RN 5 handed the medications and a cup of water to the resident. She donned clean gloves to administer the eye drops to the resident. On the way out of the room, the RN removed and disposed of the gloves. No hand hygiene was performed after glove removal or as she exited the room. On 10/7/24, at 11:30 a.m., RN 5 removed medications for Resident 50, including three oral medications. No hand hygiene was performed prior to removing the medications. The nurse handed the medications and a cup of water to the resident, watched as the resident took the medications, then left the resident's room. No hand hygiene was observed upon exiting the room. On 10/7/24, at 11:36 a.m., RN 5 removed one medication for Resident 36. She did not perform hand hygiene. She handed the medication and a cup of water to the resident, watched the resident take the medications, then left the room. No hand hygiene was performed upon exiting the room. During an interview with RN 5, on 10/7/24 at 11:41 a.m., she indicated there was no hand sanitizer available on the medication cart. She usually had her own with her, but did not. She had forgotten to use the available hand sanitizer on the wall. During an interview with the DON on 10/7/24 at 2:45 p.m., she indicated RN 5 should have used		the development and transmission of communicable diseases and infections. All residents had the potential to be affected by this defiant act. The expectation is for all nursing staff administering medication review and follow policy Handwashing/Hygiene. All nurses should preform hand hygiene prior and post medication administration. What measures were put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy "Handwashing/Hand hygiene" was reviewed by IDT. An in-service was held for all licensed staff providing medications. A performance improvement tool was created and initiated to monitor proper hand washing/hygiene pre/post medication pass. How the corrective actions will be monitored to ensure the deficient practice will not recur. A performance tool has been initiated that randomly audits handwashing/hygiene pre/post medication pass. All licensed staff will be observed, and competency skills check with return demonstration will be completed. Director of Nursing/designee will observe offset medication pass to ensure proper hand hygiene is completed pre/post medication	

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	hand sanitizer. A current facility policy titled "Handwashing/Hand Hygiene", provided by the DON on 10/7/24 at 2:44 p.m., indicated the following: "...Policy Statement - This facility considers hand hygiene the primary means to prevent the spread of infections...1) All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2) All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3) Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies...6) Use an alcohol-based hand rub alternatively...for the following situations...b) Before and after direct contact with residents; c) Before preparing or handling medications;...8) The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections...." 3.1-18(a)(l)		administration. DON will observe 5 staff members weekly x1 one week, 3 members 3x weekly for 2 weeks and 6 members monthly. All areas of concern will be corrected immediately and addition education and training provided. All results will be presented to the Quality Assurance Meeting. Monitoring will continue until 100% accuracy is achieved and PRN to ensure continued practice. By what date systemic changes will be made: 10/31/2024.	