STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AZALEA HILLS	3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey date: January 3, 2023 Facility Number: 012161 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 9, 2023.	R 0000		
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cassandra McCoun		01/21/2023

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

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	dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure the employees required training's were completed for dementia training (QMA 3, Dietary Aide 4, and LPN 5), annual inservicing on abuse (QMA 3 and Dietary Aide 4), and annual inservicing on resident rights (QMA 3, Dietary Aide 4, LPN 7 and LPN 6) for 5 of 5 personnel files reviewed. Findings include: The review of the Personnel files on 1/3/22 at 10:00 a.m., indicated the following: - QMA (Qualified Medication Aide) 3's personnel file lacked documentation of resident rights and abuse inservicing, and the facility could only provide documentation of 2 hours of dementia inservicing in the last 12 months. - Dietary Aide 4's personnel file lacked documentation of resident rights and abuse inservicing, and the facility could only provide documentation of a half an hour of dementia	R 0120	The facility shall ensure that all employees are compliant with on-going in-service training within 60 days of new hire and on going to ensure the individual employee receives 8 hours nursing and 4 hours non-nursing in-service hours. In-services will include an initial training of 6 hours for Dementia for all newly hired employees. On-going in-services yearly shall include three hours Dementia training. All training shall include, but not limited to, resident rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of the specialized populations served, medication administration and nursing care. The frequency and content shall	03/01/2023

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	training in the last 12 months. - LPN (Licensed Practical Nurse) 5's personnel file was reviewed and the facility could provide documentation of 2 hours of dementia training since her hire date of 10/21/22. - LPN 6's personnel file lacked documentation of resident rights inservicing and the facility could only provide documentation of 2 hours of dementia training since her hire date of 3/31/22. - LPN 7's personnel file lacked documentation of any resident rights inservicing since her hire date of 10/7/22. During an interview on 1/3/22 at 2:02 p.m., the Executive Director indicated she could not locate any of the missing inservice or training documentation requested for the above individuals. The most current In-service requirements "Comprehensive" Licensure policy, provided on 1/3/23 at 2:59 p.m. by the Executive Director, included, but was not limited to, "... There shall be an organized in-service education and training program planned in advance for all personnel. This training shall include, but not be limited to... Residents' rights... 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... and three (3) hours annually thereafter..."		be in accordance with the skills and knowledge of the facility personnel; Nursing (8) eight hours and (4) four hours form non nursing personnel. The training shall include a record and maintained for each employee with the Record of In-service, Time, date, location, name of the instructor, title of the instructor, names of participants, and written signature of the employee who is in attendance of the in-service. As a means to ensure ongoing compliance and quality assurance, with accurate records to indicate the on-going training is being conducted, the Facility Director shall monitor individual records of in-service training on each employee weekly for 12 months to ensure the academics of training are being completed. If an employee is not in compliance of in-service training, they will not be permitted to return to their work station until the training is up to date.	
R 0244 Bldg. 00	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation, record review, and	R 0244	The facility shall ensure residents'	02/15/2023

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	interview, the facility failed to ensure appropriate administration of medications related to medication set up for 19 of 42 residents who received medication administration services from the facility. (Residents 1, 2, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23) Findings include: During an observation of medication administration for Resident 6 on 1/3/23 at 1:34 p.m., LPN (Licensed Practical Nurse) 8 indicated the resident's medication were already set up in a medicine planner. She opened a cabinet in the medication storage room and several medication planners were observed to be set up in the cabinet. She opened the planner she indicated was Resident 6's, and dispensed a tablet she identified as gabapentin 600 mg into a medication cup. The MAR indicated the resident was to receive one tablet of gabapentin 600 mg three times daily. LPN 8 indicated every residents' medications they administered were set up weekly in medication planners. She took the medication to the dining room where the resident was playing bingo, and left the medication sitting beside the resident on the dining room table. During an interview on 1/3/23 at 2:08 p.m., the Director of Nursing (DON) indicated the facility had a nurse who came in and filled the resident's medication planners weekly. She was not a contracted employee, she was one of the facility's nurse's and the only thing she did was fill the medication planners. It was what they had been doing for at least a year, and it was something corporate was making them do. All of the residents in the facility received physician prescribed medications, they did not have any who did not take medications.		medication are administered within the time frame per the MD order and not to exceed more than 8 hours. As all residents may be affected, the medication administration shall not be pre-packed and if so, it should be done by a third party contracted to do so. As means to ensure ongoing compliance with accurately recording medication administration, all nursing staff shall receive in-service training addressing administration of the medication and documentation completed in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment, as per the physician's order. All meds shall be administered in the time frame window according to the way the medication(s) were intended to be given per the MD order. As a means of quality assurance, the Director of Nursing shall be responsible to monitor medication administration on a daily basis for four weeks and monthly for a minimum of six months to confirm accurate medication administration as per physician's orders. Should an omission or discrepancy be identified, immediate corrective action shall	

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	During an interview on 1/3/23 at 2:11 p.m., QMA (Qualified Medication Aide) 8 indicated they had a nurse who filled up the medication planners at the beginning of the week. All they did when they administered medication to the residents was to place the medications into cups and deliver them to the residents' rooms. They did it for almost everybody. There were a few residents' who administered their own medications, but if they did not administer their own this was the process they used. During an observation on 1/3/23 at 2:19 p.m., LPN 10 opened the cabinet in the 200 Hall medication room. There were 3 shelves in the cabinet. LPN 10 indicated the top two shelves were the medications prepared for the current week and the third drawer was for the next week. The top two shelves were medications set up through 1/8/23, and the third shelf was medications set up through 1/15/23. The medication planners on the top two shelves included filled medication planners with room numbers and names written on them for Residents 6, 7, 8, 2, and 10. There was one medication planner on the second shelf with only a room number and no name on it. LPN 10 indicated it belonged to Resident 11. The third shelf contained duplicate planners for each resident, labeled in the same manner. The planners were all observed to have several days worth of medication prepared within them. During an observation on 1/3/23 at 2:25 p.m., LPN 10 opened the cabinet in the 100 Hall medication room. There were 3 shelves in the cabinet. LPN 10 indicated the top two shelves were the medications set up for the current week and the third drawer was for the next week. The top two shelves were medications set up through 1/8/23,		be taken.	

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	and the third shelf was medications set up through 1/15/23. The medication planners on the top two shelves included filled medication planners with room numbers and names written on them for Residents 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, and 1. There was one planner with no name on it, only a room number, which was Resident 20's room number. LPN 10 indicated this planner belonged to a resident who she only knew by a nick name. She did not know the resident's actual name. On 1/3/23 at 2:30 p.m., the DON provided a list of residents in the facility which indicated whether they self administered or if they utilized a medication planner. Of the 42 residents in the facility 21 residents utilized a medication planner, 20 of which the facility filled and administered. One planner was filled by family. During an observation on 1/3/23 at 3:00 p.m., LPN 10 obtained the medication planners for Residents 12,12 14, 16, and 23. She removed pills from their "Tuesday Evening" medication slots and placed them into medication cups with each resident's room number written on them before delivering them to the residents in their rooms. Resident 12's medications were left at her bedside at 3:19 p.m., Resident 14's medications were left in her room at her bedside at 3:20 p.m., Resident 16's medications were left at her bedside at 3:21 p.m., and Resident 23's medication was left at her bedside at 3:23 p.m. During this observation she indicated LPN 11 filled the medication planners weekly. During an interview on 1/3/23 at 3:24 p.m., the ED (Executive Director) indicated LPN 11 worked directly for the facility and was not a contracted policy. She was aware of the facilities current policy, however corporate had told them not to			

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	worry about it. During an interview on 1/3/23 at 3:25 p.m., the DON indicated she was aware they were not supposed to have a facility nurse filling the medications weekly, however it was how corporate had told them to do it and they told them not to worry about it at this time. On 1/3/23 at 2:30 p.m. the DON provided the most current policy, titled Medication Dispenser (Opening Lids and Reminding Residents to Administer. The policy included, but was not limited to, "... If designated by the responsible party, a resident of the facility shall have maintained by staff a medication dispenser and reminders shall be given to the resident at specific times... Procedure... 1.) Daily medication dispensers shall be maintained at the facility. Such dispensers will have labeled with the resident name... Medication Administration... Daily medications will not be stored in a centralized location, nor set up in medication dispensers except by a third party... [Name of Facility Corporation] staff will not be responsible to dispense medications, however may be requested to verbally remind the resident of the need to self-administer the previously dispensed medication found in the pill dispenser... Should the resident/family member not have a designated individual to fill the weekly dispenser, the facility will secure a third party to do so..."			