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	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BICKFORD OF CROWN POINT	140 E 107TH AVENUE CROWN POINT, IN 46307

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00425516. Complaint IN00425516 - No deficiencies related to the allegations are cited. Survey dates: February 27 and 28, 2024 Facility number: 012940 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/1/24.	R 0000		
R 0030 Bldg. 00	410 IAC 16.2-5-1.2(e)(1-6) Residents' Rights - Noncompliance (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jillian Sell	Executive Director	04/05/2024

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

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	The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. Based on record review and interview, the facility failed to have a current disclosure form for the Alzheimer's/Dementia Special Care Unit. Finding includes: The Alzheimer's/Dementia Special Care Unit disclosure form was requested on 2/27/24 and 2/28/24. The Administrator presented the disclosure form during the exit conference on 2/28/24 at 4:50 p.m. She indicated she had just completed the form and was unable to provide any documentation the disclosure form had been completed prior.	R 0030	¿ R030 Residents' Rights – Noncompliance¿ What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ ·0 residents were affected by this deficient practice.¿ ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken¿ ·Alzheimer's and dementia special care unit disclosure form was completed 2/28/24 ¿¿ What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ·Divisional Director of Operations will re-educate Executive Director on the facilities requirement to submit an Alzheimer's and dementia special care unit disclosure form under IC	03/01/2024

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			12-10-15-9 ·The Executive Director will be responsible for submitting annually an Alzheimer's and dementia special care unit disclosure form under IC 12-10-15-9. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ ·Divisional of Operations to confirm the Alzheimer's and dementia special care unit disclosure form is submitted under IC 12-10-15-9 annually.	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on record review and interview, the facility failed to ensure an employee had an active license/ certification. This had the potential to affect all 57 residents who resided in the facility. Finding includes: The employee licenses and certifications were reviewed on 2/28/24 at 3:00 p.m. QMA 4 was hired on 4/17/17. QMA 4's license	R 0118	¿ R118 Personnel - Deficiency What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? ·No residents were affected by the deficient practice, but had the potential to affect all 57 residents that reside at the facility.	04/06/2024

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	had expired on 11/7/23. The staff schedule for February 2024 indicated QMA 4 had worked on 2/12/24, 2/13/24, 2/14/24, 2/15/24, 2/17/24, 2/18/24, 2/20/24, 2/21/24, 2/22/24, and 2/24/24. During an interview on 2/28/24 at 4:28 p.m., the Administrator indicated the QMA's license was expired. The QMA had worked since her license expired.		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken¿ ·The Executive Director will complete an audit of all licensed/certified employee files to ensure current license/certifications on file and in compliance. To be completed by 4/6/24 ¿ What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. ·Divisional Director of Operations will re-educate Executive Director on policy 410 IAC 16.2-5-1.4 completed by 3/16/24 ·The Executive Director is responsible for ensuring all licensed/certified employees have active license/certification on file. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. ·Divisional Director of Health & Operations will audit 6 QMA employee files and on routine visits to ensure compliance for six months.	

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to record weights upon admission for 2 of 7 residents reviewed. (Residents 3 and 8) Findings include: 1. Resident 3's record was reviewed on 2/27/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus and hypothyroidism. The resident was admitted to the facility on 10/21/23. A Service Plan and Nursing Assessment, dated 10/23/23, was completed upon entrance to the facility. There were no weights documented for the resident. During an interview on 2/28/24 at 3:15 p.m., the Registered Nurse Coordinator indicated they had	R 0216	R216 Evaluation- Noncompliance 0 residents were harmed by this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? ·0 residents were harmed by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.¿ ·Weight has been obtained and documented in the medical record of all residents.¿Completed by 4/6/24	04/06/2024

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	used the weight obtained from the hospital paperwork and could not locate any documentation of a weight obtained at admission. 2. Resident 8's closed record was reviewed on 2/27/24 at 2:20 p.m. Diagnoses included, but were not limited to, chronic kidney disease and chronic respiratory failure. The resident was admitted to the facility on 8/3/23 and discharged on 1/23/24. There were no weights documented for the resident. During an interview on 2/28/24 at 3:15 p.m., the Registered Nurse Coordinator indicated they had used the weight obtained from the hospital paperwork and could not locate any documentation of a weight obtained at admission.		¿¿ ¿What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ·Weights has been added to the admission assessment process. ·Divisional Director of Health and Wellness will re-educate Director of Health and Wellness on the policy assessments, including but not limited to the requirement that resident weights be checked and documented on admission and at minimum semi-annually thereafter. Completed by 3/16/24 ·Health and Wellness Director is responsible for ensuring all residents have weight recorded on admission and at least semiannually thereafter. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. ·Divisional Director of Health and Wellness will review the next 5 new move-ins to ensure weights were entered and then new admissions for the next six months.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the			

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	services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure the Service Plan was signed by the resident and/or their responsible party for 1 of 7 records reviewed. (Resident 5) Finding includes: Resident 5's record was reviewed on 2/27/24 at 1:36 p.m. Diagnoses included, but were not limited to, cirrhosis of the liver. The resident was admitted to the facility on 5/19/23. A Service Assessment was completed on 5/23/23.	R 0217	¿R217 Evaluation- Deficiency ¿¿ ¿ What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ ·0 residents were harmed by this deficient practice. ¿ How the facility will identify other	04/06/2024

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	It was not signed by the resident or responsible party. During an interview with the RN Coordinator on 2/28/24 at 10:55 a.m., she indicated she was unable to provide any further information.		residents having the potential to be affected by the same deficient practice and what corrective action will be taken¿. ·The Health and Wellness Director will audit all resident service plans to identify those requiring signatures and schedule care conference to review and obtain required signatures. Completed by 4/6/24 ¿¿¿ What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. ·Care Conference have been scheduled to get responsible parties signature on R5 service plan Completed by 4/6/24¿ ·Divisional Director of Health and Wellness will re-educate Director of Health and Wellness on the Service Planning and Agreements Policy and procedure.¿Completed by 3/16/24 ·The Health and Wellness Director will be responsible for ensuring service plans have the signatures of responsible parties. ¿ How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ ·Divisional Director of Health and Wellness will review the next 5	

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			updated service plans during branch visit and at least annually thereafter.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure qualified medication aides (QMAs) received authorization from a licensed nurse or physician prior to giving as needed (prn) medications, for 4 of 7 records reviewed. (Residents 4, 5, 8 and 2) Findings include: 1. Record review for Resident 4 was completed on 2/27/24 at 11: 00 a.m. Diagnoses included, but were not limited to, vertigo, hyperlipidemia, fibromyalgia, hypothyroidism, and hypertension. The February 2024 Physician's Order Summary (POS) indicated an order for hydrocodone/apap (narcotic pain medication) 5/325 mg (milligrams). Give one tablet every 4 hours as needed for pain. The February 2024 Medication Administration Record (MAR) indicated the prn hydrocodone/apap was administered by a QMA on the following date and time. - 2/12/24 at 11:36 a.m. Administered by QMA 1	R 0246	¿ R246 Health Services- Deficiency ¿¿ ¿ What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ ·0 residents were harmed by this deficient practice but had the potential to harm all residents with prn medication orders.¿ ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken¿ ·Health and Wellness Director responsible for printing and signing PRN given report from e-mar to ensure QMA received approval from licensed nurse received prior	03/16/2024

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	and documented as effective by QMA 1. There was a lack of documentation to indicate the QMA had received authorization from a licensed nurse or physician prior to administering the medication. During an interview on 2/28/24 at 10:50 a.m., the Director of Nursing (DON) indicated the PRN medications were supposed to be documented in a progress note for prior authorization before administering them. She was unable to provide any documentation the prior authorization had been completed.2. Resident 5's record was reviewed on 2/27/24 at 1:36 p.m. Diagnoses included, but were not limited to, cirrhosis of the liver. The Physician's Order Summary, dated 2/2024, indicated an order for morphine sulfate 0.25-0.5 ml (milliliters), 5-10 mg (milligrams), sublingual every 2-3 hours PRN (as needed) for pain. The Medication Administration Record (MAR), dated 2/2024, indicated PRN morphine 0.25 ml was given by QMA 2 on 2/3/24, and 0.5 ml was given by QMA 3 on 2/4/24. Both administrations were documented as effective by QMA 4. There was a lack of documentation to indicate the QMAs had received authorization from a licensed nurse prior to administering the medication. During an interview with the RN Coordinator on 2/28/24 at 9:19 a.m., she indicated the QMAs would ask for verbal permission and should have documented in the MAR notes, progress notes, or the nurse would assess the medication effectiveness. No further information was provided.3. Resident 8's record was reviewed on 2/27/24 at 2:20 p.m. Diagnoses included, but were		to administering as needed medication. ¿¿¿ What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ·In-service scheduled by Health and Wellness Director with QMAs to review the expectation of contacting a licensed nurse to request giving as needed medication. As well as follow ups for PRNs needing to be documented by a licensed nurse. Completed by 3/16/24 ·Divisional Director of Health and Wellness will re-educate Director of Health and Wellness on monitoring PRN given report and verifying QMA noted the request to give was approved by a licensed nurse prior to administration. Completed by 3/16/24 ¿ How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ ·Divisional Director of Health and Wellness will review the PRN given report and verify it is signed by Health and Wellness Director for approval monthly and PRN follow up was completed by a licensed nurse during routine branch visits x's 2 months and at least annually thereafter.¿	

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	not limited to, chronic kidney disease and chronic respiratory failure. A Progress Note, dated 8/12/23 at 3:37 a.m., indicated the resident was coughing and an as needed (PRN) Robitussin (a cough syrup) was administered by QMA 4. A Progress Note, dated 8/16/23 at 4:50 a.m., indicated the resident was complaining of itching and a PRN 25 milligram (mg) capsule of banophen (an antihistamine) was administered by QMA 4. A Progress Note, dated 8/16/23 at 4:00 p.m., indicated the resident was coughing and QMA 4 administered a PRN liquid Robitussin. A Progress Note, dated 10/1/23, indicated a PRN banophen dose was administered by QMA 5. A Progress Note, dated 10/6/23, indicated a PRN banophen was administered at 4:20 p.m. and PRN norco (a pain medication) was administered for complaints of pain at 8:30 p.m. by QMA 5. During an interview on 2/28/24 at 3:15 p.m., the Registered Nurse Coordinator indicated she was unable to find documentation of prior authorization for the QMAs to administer the PRN medications. 4. Record review for Resident 2 was completed on 2/27/24 at 11:30 a.m. Diagnoses included but were not limited to, Alzheimer's, major depressive disorder, and dementia. The February 2024 Physician's Order Summary indicated and order for acetaminophen (pain/fever reducer) 325 mg. Give 2 tablets every 6 hours as needed. The February 2024 Medication Administration			

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	Record (MAR) indicated the prn acetaminophen was administered by QMA's on the following dates and times. - 2/1/24 at 11:26 p.m. Administered by QMA 2 and documented as effective by QMA 4. - 2/7/24 at 10:49 p.m. Administered by QMA 6 and documented as effective by QMA 4. - 2/13/24 at 10:23 p.m. Administered by QMA 6 and documented as effective by QMA 6. During an interview on 2/28/24 at 4:40 p.m., the DON indicated she was unable to provide any documentation the QMA's received prior authorization before administering the PRN medications.			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, record review, and interview. the facility failed to ensure modified diets were prepared properly according to the recipe. This had the potential to affect 1 resident who resided in the facility and received a puree diet. Finding includes: During an observation on 2/27/24 at 12:00 p.m., Dietary 1 was observed preparing a puree modified diet with the Kitchen Manager present. Dietary 1 took 2 scoops of the regular texture turkey in gravy from a serving pan, put it in the	R 0270	R270 Food and Nutritional Services - Deficiency¿ ¿ What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ ·0 residents were harmed by this deficient practice but had the potential to harm 1 resident.¿ ¿ How the facility will identify other residents having the potential to be affected by the same deficient	03/16/2024

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	blender, and turned on the blender for 10 seconds. He stirred the contents of the blender and turned on the blender for another 5 seconds. He poured the puree turkey in to a bowl, covered it with plastic wrap, and indicated he was done. The puree turkey was liquid consistency. During an interview with Dietary 1, at this time, he indicated the puree consistency was "pretty thin" and he could add some thickener. He was not aware of where he could find a recipe for the puree turkey and indicated he would usually just add one scoop of thickener as he wasn't sure if there was a specified amount he should add. During an interview with the Kitchen Manager, on 2/27/24 at 12:10 p.m., he indicated he had just found the puree recipe binder and the amount of thickener to add was based on the serving size prepared. He indicated the puree turkey was not the correct consistency.		practice and what corrective action will be taken¿ ·Kitchen staff have been in-service on modified diets including preparation of pureed diets and following recipes. Completed by 3/16/2024. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ¿ ·Executive Director to observe preparation pureed diets 3 times per week times 1 month to ensure recipes are followed. ·Executive Director will complete dining service quality audit to monthly x's 3 months to ensure continued compliance in the preparation of modified diets per recipe and annually thereafter.¿¿ ¿ ¿ How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ ·Divisional Director of Operations will monitor compliance on routine site visits x's 3 months and a quality audit will be completed annually.	

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		A. BUILDING 00 B. WING	02/28/2024

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain proper food sanitation related to hairnets and beard guards not worn, unlabeled and undated food and drinks, dirty refrigerators and freezers, dirty and sticky floors, splatter on the walls and ceiling, and debris on shelves and floors. This had the potential to affect the 57 residents who received food from the kitchen. Findings include: 1. On 2/27/24 at 9:20 a.m., on the initial tour of the kitchen with the Kitchen Manager, the following was observed: a. The Kitchen Manager was not wearing a hairnet or beard guard. b. In the small stand-up refrigerator, there was an unlabeled and undated apple pie covered with tin foil, and 5 pitchers of juice uncovered, unlabeled and undated. The shelves and bottom of the refrigerator were dirty. c. In the large stand-up refrigerator, there was an undated and unlabeled block of cheese covered with plastic wrap, and a plastic bag with multiple heads of lettuce open to air, undated and unlabeled. The shelves and bottom of the refrigerator were dirty. d. In the large stand-up freezer, there was an	R 0273	¿R273 Food and Nutritional Services - Deficiency¿ ¿¿ ¿ What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ ·0 residents were harmed by this deficient practice but had the potential to affect 57 residents. ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken¿ ·An audit of all food storage items was immediately completed on 2/28/24 and all compromised food was discarded. ·Walls, cabinets, ceiling and floor thoroughly cleaned on 2/28/24 ·Kitchen Staff instructed to put on hairnets¿and beard-nets in designated areas on 2/28/24 · All remaining staff will be trained on the proper use of hairnets¿and beard-nets in designated areas.¿Completed by 4/7/24 ¿¿	04/06/2024

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	undated and unlabeled bag of biscuits. The shelves and bottom of the freezer were dirty. e. The floors throughout the kitchen were sticky and dirty with crumbs and debris. 2. On 2/27/24 at 11:45 a.m., with the Kitchen Manager, the following was observed: a. The Kitchen Manager was not wearing a hairnet or beard guard. Dietary 1 was not wearing a beard guard. b. The wall behind the oven was dirty with food splatter. c. The ceiling above the oven was dirty with food splatter. d. There was a buildup of crumbs and debris under the refrigerators, freezers, and oven. e. There was a buildup of crumbs on the shelves of the island. During an interview with the Kitchen Manager on 2/27/24 at 12:15 p.m., he indicated the kitchen was in need of cleaning. No further information was provided. A Facility Policy, titled "Food Storage Labeling and Dating," received as current, indicated, "...1. All cooked foods, pre-packaged open containers, protein-based salads and desserts are labeled, dated and securely covered...2. All dates are to be written on the container and represent the date it was opened or prepared. All foods that are prepared at the branch must be discarded at the end of the third day..."		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ·The Executive Director will complete a dining service quality audit weekly x's 2 months to ensure compliance. ·Executive Director will complete an in-service with all kitchen staff on the Food storage labeling and dating policy¿completed by 3/16/24 ·Divisional Director of Dining will provide retraining for all cooks, including the Kitchen Manager, to ensure proper food sanitation related to labeling and dating food in the refrigerators and freezers, to identify the contents and the date opened, storing freezer items, and proper hair and facial hair coverings.¿Completed by 4/6/24 ¿ How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ ·Kitchen Manager/Designee will be responsible for monitoring all food storage areas for proper storage. ·Executive Director will audit weekly for one month and then monthly for the next three¿months.¿ This monitoring cycle will start over if improper storage or labeling is found.¿	

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	A Facility Policy, titled "Dining Service Hygiene," received as current, indicated, "...1. Hairnets shall be worn which shall completely cover all hair. Men may wear baseball caps if hair is no longer than below the ears or is pulled back in a ponytail. 2. All mustaches and beards must be covered while on duty..."		·Divisional Director of Operations will monitor compliance on routine site visits x's three months	
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to ensure medications were secured in a resident's room in the dementia unit. (Resident 2) Finding includes: On 2/27/24 at 11:30 a.m., Resident 2 was observed to have prescription eye drops and a prescription cream in her room on the table. The labels read as follows: - timolol 0.5% Ophthalmic Solution (a medication used to treat and manage open-angle glaucoma and ocular hypertension). There were 2 boxes of the eye drop on the table. - travoprost 0.004% Ophthalmic (a medication used to treat increased pressure in the eye caused by open-angle glaucoma or hypertension of the eye). There were 2 boxes of the eye drop on the table. - ciclopirox 8% Topical Solution (a topical medicated cream used to treat fungal infections of the fingernails and toenails). The record for Resident 2 was reviewed on 2/27/28	R 0295	¿R295 Pharmaceutical Services Noncompliance ¿ ¿ What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ ·0 residents were harmed by this deficient practice.¿ ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken¿ ·All prescription medication(s) removed from residents apartments in the Dementia Unit and locked in the medication room. ·Residents residing in the Dementia Unit will not have	03/16/2024

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	at 1:39 p.m. Diagnoses included, but were not limited to, dementia, major depressive disorder, and Alzheimer's disease. The resident resided on a closed memory care unit. During an interview on 2/27/24 at 2:30 p.m., LPN 1 indicated the resident was cognitively impaired and should not have medications left unsecured in her room.		medications in their apartment. ·Health and Wellness Director will hold an in-service with all nurses/ QMA's on the Medication administration policy. Completed by 3/16/24 ¿¿ What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ¿ ·Health and Wellness Director will audit med cart weekly to ensure medications are kept in the medication room. ¿ How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ ·Divisional Director of Health and Wellness will review med audit report weekly and check memory care medication room x's 3 on routine branch visits and annually thereafter to ensure compliance.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented.			

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	(3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented, related to follow up documentation after a fall, for 1 of 2 residents reviewed for falls. (Resident 3) Finding includes: Resident 3's record was reviewed on 2/27/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, chronic back pain, and orthostatic hypotension. A Service Plan, dated 10/23/23, indicated the resident was cognitively intact, independent for activities of daily living, and self-administered medications. A Progress Note, dated 11/3/23, indicated the resident was observed on the floor with bleeding noted to her forehead. Her vital signs were assessed, 911 was called, and she was sent to the hospital. The Power of Attorney (POA), Registered Nurse Coordinator (RNC) and Nurse Practitioner (NP) were notified. A Progress Note, dated 1/28/24 at 9:45 a.m., indicated the resident was found on the floor with no injuries noted. She had a small skin tear on her right knee and her left toenail was broken. The POA and RNC were notified. During an interview on 2/28/24 at 3:15 p.m., the RNC indicated she was unable to locate documentation of a fall investigation or incident report for the falls that occurred on 11/3/23 and 1/28/24, but they should have been completed.	R 0349	R349 Clinical Records Noncompliance What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? ·0 residents were harmed by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken ·Residents who have a fall will have an unusual occurrence report and an unusual occurrence nurse evaluation report, which include the fall investigation. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ·The Health and Wellness Director will ensure follow-up documentation is completed for each fall and will review and sign each unusual occurrence nurse evaluation report. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into	03/16/2024

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	A Policy titled, "Falls," indicated "...Re-establish Order: Once help has arrived and situation is secured, calm the other residents, if necessary. Give appropriate information about the situation in brief and accurate terms. Complete an Incident Report and the Fall Investigation Form following established procedures and contact appropriate supervisors..."		place. ·The Divisional Director of Health and Wellness will review the next 5 falls to ensure a fall follow up was completed and falls monthly on routine visits for the next six months.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 3 of 7 residents reviewed for annual health statements. (Residents 5, 3, and 8) Finding includes: 1. Resident 5's record was reviewed on 2/27/24 at 1:36 p.m. Diagnoses included, but were not limited to, cirrhosis of the liver. The resident was admitted to the facility on 5/19/23. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview with the RN Coordinator on 2/28/24 at 10:55 a.m., she indicated the annual health statement had not appeared on the Physician's Order Summary (POS) because there was a box they had to check prior to printing it out. The annual health statement should have appeared on the POS under the informational	R 0409	R409 Infection Control - Noncompliance What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ ·0 residents were affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken¿ ·Health Statements completed on R 5, 3, and 8 2/28/24 ·An audit of resident EMAR was completed on 2/28/24 to ensure compliance. ¿¿	03/01/2024

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	orders section. She provided the current POS, and the annual health statement was dated 2/28/24.2. Resident 3's record was reviewed on 2/27/24 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes mellitus, chronic back pain, and orthostatic hypotension. The resident was admitted to the facility on 10/21/23. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 2/28/24 at 3:15 p.m., the Registered Nurse Coordinator indicated when the Physician Order Summary (POS) was generated the health statement was not being marked to print with the report. It should have been on each POS that was signed off by the Physician. 3. Resident 8's record was reviewed on 2/27/24 at 2:20 p.m. Diagnoses included, but were not limited to, chronic kidney disease and chronic respiratory failure. The resident was admitted to the facility on 8/3/23 and discharged on 1/23/24. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 2/28/24 at 3:15 p.m., the Registered Nurse Coordinator indicated when the POS was generated the health statement was not being marked to print with the report. It should have been on each POS that was signed off by the Physician.		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ¿ ·Divisional Director of Health & Wellness will provide retraining to the Executive Director and Director of Health & Wellness on requirement for annual health statement that indicates resident is free of contagious disease.¿ ·Health and Wellness Director will be responsible for ensuring each resident has an annual health statement that indicates resident free of contagious disease. ¿ How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ ·Divisional Director of Health & Wellness will audit next 3 new admissions and on routine site visits for next 3 months and then annually thereafter to ensure compliance.¿	