STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00435599 and Complaint IN00439126. Complaint IN00435599 - Federal/State deficiencies related to the allegations are cited at F659 and F760. Complaint IN00439126 - No deficiencies related to the allegations are cited. Survey dates: August 21, 22, 23, 26, 27, 28, & 29, 2024 Facility number: 000069 Provider number: 155148 AIM number: 100288980 Census Bed Type: SNF/NF: 5 SNF: 78 Total: 83 Census Payor Type: Medicare: 4 Medicaid: 68 Other: 11 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 8, 2024.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 657	Continued From page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure care plan conferences were completed for 3 of 3 residents reviewed for care plan conferences. (Resident M, Resident N, Resident Q) Findings include: 1. On 8/26/24 at 2:35 P.M., Resident M's clinical record was reviewed. Diagnoses included, but	F 657		

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F 657	Continued From page 2	F 657		

were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, diabetes mellitus, generalized anxiety disorder, and depression.

The most current Quarterly Minimum Data Set (MDS) Assessment, dated 7/5/24, indicated Resident M was cognitively intact and was dependent on staff for toileting, and required substantial to maximal assistance of staff (staff does more than half) for bed mobility and bathing.

The clinical record lacked documented care plan conferences between 5/9/23 and 11/6/23.

2. On 8/21/24 at 1:59 P.M., Resident N indicated he did not have care plan meetings to discuss his care.

On 8/22/24 at 11:33 A.M., Resident N's clinical record was reviewed. Diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus, and depression.

The most current Annual Minimum Data Set (MDS) Assessment, dated 8/8/24, indicated Resident N was cognitively intact and was independent for all ADLs (Activities of Daily Living).

The clinical record lacked documented care plan conferences between 6/23/23 and 2/5/24.

3. On 8/21/24 at 10:04 A.M., Resident Q indicated she did not have any care plan meetings until recently.

On 8/23/24 at 10:09 A.M., Resident Q's clinical record was reviewed. Diagnoses included, but

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F 657	Continued From page 3 was not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, irritable bowel syndrome, and generalized anxiety disorder. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 6/13/24, indicated Resident Q was cognitively intact and required partial to moderate assistance of staff (staff does less than half) for bed mobility, transfers, and bathing. The clinical record lacked documented care plan conferences between 7/25/23 and 2/5/24. On 8/27/24 at 12:10 P.M., the Social Services Director indicated that she was unable to find documented care plan conferences for Resident M between 5/9/23 and 11/6/23, for Resident N between 6/23/23 and 2/5/24, and for Resident Q between 7/25/23 and 2/5/24. Care plan conferences were completed quarterly and as needed. On 8/29/24 at 10:51 A.M., the Administrator provided an IDT (Interdisciplinary Team) Comprehensive Care Plan policy, revised 8/2023, that indicated "The care plan review may be conducted face to face, via phone conference, video conference, or through written communication per resident and/or representative preference. Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment". 3.1-35(d)(2)(B)	F 657		
F 659 SS=D	Qualified Persons	F 659		

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F 659	Continued From page 4 CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff were qualified to administer insulin to residents for 3 of 6 residents reviewed for insulin. Qualified Medication Aides (QMAs) who were not insulin certified, administered insulin to residents and held insulin without a physician order or notification of nursing staff. (Resident N, Resident M, and Resident Q) Findings include: 1. On 8/26/24 2:35 P.M., Resident M's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 7/5/24, indicated Resident M was cognitively intact and received insulin during the 7-day look back period. Physician orders included, but were not limited to: insulin lispro (a fast-acting insulin) - insulin pen; 100 unit/mL (units per milliliter) - give 10 units subcutaneous three times a day. Notify MD (Medical Doctor) if blood glucose is below 70 mg/dL (milligrams per deciliter) or above 400 mg/dL, dated 8/27/22.	F 659		

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The February 2024 MAR (Medication Administration Record) indicated:
QMA 8 administered insulin lispro to Resident M on 2/24/24 at 8:00 A.M.

The March 2024 MAR indicated:
QMA 8 administered insulin lispro to Resident M on 3/2/24 at 5:00 P.M. and 3/3/24 at 8:00 A.M.

The April 2024 MAR indicated:
QMA 8 administered insulin lispro to Resident M on 4/3/24 at 5:00 P.M. and 4/11/24 at 5:00 P.M.
QMA 12 administered insulin lispro to Resident M on 4/5/24 at 5:00 P.M., 4/24/24 at 5:00 P.M., and 4/25/24 at 5:00 P.M.

The May 2024 MAR indicated:
QMA 8 administered insulin lispro to Resident M on 5/10/24 at 5:00 P.M.

The August 2024 MAR indicated:
QMA 12 held Resident M's insulin lispro for a blood glucose of 105 mg/dL. The physician was not notified. There was no documentation that a nurse was notified or that the resident was assessed by a nurse.

2. On 8/22/24 at 11:33 A.M., Resident N's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus.

The most current Annual Minimum Data Set (MDS) Assessment, dated 8/8/24, indicated Resident M was cognitively intact and received insulin during the 7-day look back period.

Physician orders included, but were not limited to: insulin glargine (a long-acting insulin) - insulin pen; 100 unit/mL (units per milliliter) - give 45

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units subcutaneous every 12 hours, dated 12/28/23.

Insulin aspart (a rapid-acting insulin) - insulin pen; 100 unit/mL - give 12 units subcutaneous at bedtime. Notify MD (Medical Doctor) if blood sugar is below 50 mg/dL (milligrams per deciliter) or greater than 400 mg/dL, dated 6/2/23.

Insulin aspart (a rapid-acting insulin) - insulin pen; 100 unit/mL - give 15 units subcutaneous three times a day. Notify MD if blood sugar is below 50 mg/dL or greater than 400 mg/dL, dated 6/3/24.

The February 2024 MAR (Medication Administration record) indicated:
QMA 8 administered insulin glargine to Resident M on 2/24/24 at 8:00 A.M.

The March 2024 MAR indicated:
QMA 8 administered insulin glargine to Resident M on 3/3/24 at 8:00 A.M.
QMA 12 held Resident M's insulin glargine on 3/31/24 at 8:00 P.M. for a blood sugar of 95 mg/dL. The physician was not notified.
QMA 8 administered insulin aspart to Resident M on 3/28/24 at 8:00 P.M.
QMA 12 held Resident M's insulin aspart on 3/31/24 at 8:00 P.M. for a blood sugar of 85 mg/dL. The physician was not notified. There was no documentation that a nurse was notified or that the resident was assessed by a nurse.

The April 2024 MAR indicated:
QMA 8 administered insulin glargine to Resident M on 4/5/24 at 8:00 A.M. and 4/17/24 at 8:00 P.M.
QMA 8 held Resident M's insulin glargine on 4/6/24 "per nursing measure". The physician was

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not notified. There was no documentation that a nurse was notified or that the resident was assessed by a nurse.
QMA 8 administered insulin aspart to Resident M on 4/17/24 at 8:00 P.M.

The May 2024 MAR indicated:
QMA 8 administered insulin glargine and insulin aspart to Resident M on 5/9/24 at 8:00 P.M.
QMA 12 held Resident M's insulin glargine and insulin aspart on 5/13/24 for a blood sugar of 103 mg/dL. The physician was not notified. There was no documentation that a nurse was notified or that the resident was assessed by a nurse.

The July 2024 MAR indicated:
QMA 6 administered insulin glargine to Resident M on 7/13/24 at 8:00 P.M.

3. On 8/23/24 at 10:09 A.M., Resident Q's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus.

The most current Significant Change Minimum Data Set (MDS) Assessment, dated 6/13/24, indicated Resident Q was cognitively intact and received a hypoglycemic medication during the 7-day look back period.

Physician orders included, but were not limited to: insulin degludec (an ultralong-acting insulin) - insulin pen; 100 unit/mL (units per milliliter) - give 10 units subcutaneous at bedtime, dated 7/18/24.

The July 2024 MAR (Medication Administration Record) indicated:
QMA 12 held Resident Q's insulin degludec on 7/22/24 at 8:00 P.M. for a blood sugar of 130 mg/dL (milligrams per deciliter), 7/28/24 at 8:00

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P.M. for a blood sugar of 100 mg/dL, 7/29/24 for a blood sugar of 108 mg/dL, and 7/30/24 for "blood sugar low". The physician was not notified. There was no documentation that a nurse was notified or that the resident was assessed by a nurse.

On 8/27/24 at 2:30 P.M., employee records were reviewed. QMA 8, QMA 12, and QMA 6 were not insulin certified.

In a handwritten statement dated 5/16/24, QMA 8 indicated "it was [QMA 8's] understanding that [former Director of Nursing] said she had communicated with [Clinical Support 7] and that as long as my nurse was present [QMA 8] could give insulin...".

On 8/23/24 at 9:47 A.M., the Administrator, the Director of Nursing (DON), Clinical Support 7, and Clinical Support 5 indicated QMA 8 pushed boundaries and believed she was able to practice outside out her scope of practice because she was a nursing student. Corporate policy did not allow QMAs to administer insulin even if they were certified to do so.

On 8/28/24 at 9:45 A.M., Clinical Support 5 indicated the nurse could have told QMA 12 and QMA 8 to hold insulin. The QMA should have documented that the nurse told her to hold it in the Not Administer Notes, but she didn't. She further indicated that she was unsure what the parameters for holding insulin were since none were listed. She indicated it would depend on the comfort level of the nurse, and the physician should have been notified if insulin with no hold orders was held.

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F 659	Continued From page 9 On 8/29/24 at 8:39 A.M., the DON indicated that even though nursing staff had been provided education on insulin there was still a need for more education. QMAs should not be assessing or holding insulin and should be clear in their documentation that a nurse was consulted. On 8/23/24 at 10:04 A.M., the Administrator provided a QMA Parameters and Scope of Practice policy, revised 7/26/19, that indicated "The QMA shall document in a resident's clinical record all medications that the QMA personally administered. The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all (Medication, refusal, not available, etc.) ... The following tasks shall NOT be included in the QMA scope of practice: Administer medication by the injection route, including the following: ... Subcutaneous route ... Complete any type of nursing assessment". This citation relates to complaint IN00435599.	F 659		
F 677 SS=D	3.1-35(g)(2) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents dependent on staff for ADL (activities of daily living) were showered for 2 of 2 residents reviewed for ADL care. (Resident	F 677		

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33 and Resident Q)

Findings include:

1. On 8/21/24 at 2:21 P.M., Resident 33 indicated that she did not get showers, and that staff only give her bed baths. She further indicated that she didn't feel clean.

On 8/22/24 at 1:41 P.M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to, hypertensive chronic kidney disease and diabetes mellitus.

The most current Quarterly MDS (Minimum Data Set) Assessment, dated 8/9/24, indicated Resident 33 was cognitively intact, required substantial to maximal assistance of staff (staff does more than half) for bathing, and had no rejection of care.

An Assistance with ADLs care plan, dated 6/2/24, indicated for staff to assist with bathing as needed per resident preference. Offer showers two times per week, partial bed bath in between.

A Preferences for Customary Routine and Activities assessment, dated 8/9/24, indicated it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath, and the resident was most used to showers.

On 8/27/24 at 10:00 A.M., a current shower schedule was reviewed. Resident 33 was scheduled to receive showers on Tuesdays and Fridays during the day.

On 8/28/24 at 12:00 P.M., the Director of Nursing (DON) provided bathing performed from 6/1/24

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through 8/23/24; Resident 33 received 2 showers in June, no showers in July, and 2 showers in August.

2. On 8/21/24 at 9:58 A.M., Resident Q indicated she was supposed to get showers twice a week, but she was lucky if she got cleaned up once a week. She indicated that her hair only got washed when she took a shower so she washed her hair every time she got a shower because the showers were so far apart. She further indicated staff didn't offer to set up supplies for her to perform oral care every day.

On 8/23/24 at 10:09 A.M., Resident Q's clinical record was reviewed. Diagnoses included, but was not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, irritable bowel syndrome with diarrhea, and generalized anxiety disorder.

The most current Significant MDS (Minimum Data Set) Assessment, dated 6/13/24, indicated Resident Q was cognitively intact, required partial to moderate assistance of staff (staff does less than half) for bathing, and had no rejection of care.

An Assistance with ADLs care plan, dated 6/8/22, indicated for staff to assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Prefers showers in the evening.

A Preferences for Customary Routine and Activities assessment, dated 6/13/24, indicated it was somewhat important for the resident to choose between a tub bath, shower, bed bath, or sponge bath, and the resident was most used to

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F 677	Continued From page 12 showers. On 8/27/24 at 10:00 A.M., a current shower schedule was reviewed. Resident Q was scheduled to receive showers on Wednesdays and Saturdays during the day. On 8/28/24 at 12:00 P.M., the Director of Nursing (DON) provided bathing performed from 6/1/24 through 8/23/24; Resident Q received 8 showers in June, 4 showers in July, and 1 shower in August. On 8/28/24 at 12:27 P.M., the Administrator indicated residents got 2 showers a week and could request more. On 8/28/24 at 1:57 P.M., Clinical Support 5 indicated there was no shower/ADL policy and that the facility followed the Resident Bill of Rights. At that time, the policy Resident Bill of Rights, revised 12/17, was provided and indicated "The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Community ... The resident has the right to be treated with consideration, respect and recognition of their dignity and individuality". 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(b)(2) 3.1-38(b)(3)	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure through assessments were completed for 1 of 1 residents receiving a diuretic for congestive heart failure. Daily weights were not obtained as ordered. (Resident 36)

Finding includes:

On 8/27/24 at 10:27 A.M., Resident 36's clinical record was reviewed. Diagnoses included, but were not limited to, chronic systolic (congestive) heart failure, localized edema, primary pulmonary hypertension.

A quarterly MDS (Minimum Data Set) assessment, dated 7/5/24, indicated Resident 36's cognition was intact and received a diuretic medication.

June and July 2024 physician orders and the EMAR (Electronic Medication Administration Record) were reviewed and included but was not limited to:

Daily weight for CHF (congestive heart failure), once a day. Notify MD (Medical Doctor) of weight gain of 3 lbs. (pounds) a day or 5 lbs. in a week, start date 11/25/23, discontinued 7/13/24.

June dates not documented: 6/3, 6/12, 6/13, 6/22,

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F 684	Continued From page 14 6/27. 6/28, 6/30. July dates not documented: 7/4, 7/5, 7/6, 7/8, 7/10. Weights were reviewed and included, but were not limited to: 12/1/23- 133 7/1/24- 127 8/1/24- 132 Progress notes included, but were not limited to: 10/2/23 1:29 P.M., "Sig [significant] change RD [registered dietician] review: This 62 yo [year old] female with multiple recent hospitalizations r/t [related to] chf, fluid overload. Res [resident] noted with hx [history] +3 pitting edema to BLE [bilateral lower extremities], feet. Has order for daily weights...will continue with daily weights to monitor weight trends. RD available." The clinical record did not contain refusals on the dates not documented. On 8/28/24 at 8:31 A.M., the DON (Director of Nursing) indicated there was not a unit manager at that time, it looked like someone was not monitoring, and the weights got missed for different reasons. On 8/28/24 at 10:57 A.M., the Administrator indicated there was not a specific policy for following physician orders, but it was the expectation of the facility that staff follow orders. 3.1-37(a)	F 684		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		

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§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:

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Based on observation, interview, and record review, the facility failed to post accurate actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 5 of 7 days during the annual survey period.

Finding includes:

During an observation on 8/23/24 at 12:33 P.M., a posted nurse staffing data sheet, dated 8/23/24, was observed on the main desk. The sheet included, but was not limited to, the following information:
Census, total number of staff for each shift and total hours of each shift for CNA (Certified Nurse Aide), LPN (Licensed Practical Nurse), and RN (Registered Nurse).
The sheet indicated that 9.5 unlicensed nursing staff worked the day shift but did not specify which half of the shift the staff worked.

During an observation on 8/26/24 at 3:20 P.M., a posted nurse staffing data sheet, dated 8/26/24, was observed on the main desk. The sheet included, but was not limited to, the following information:
Census, total number of staff for each shift and total hours of each shift for CNA (Certified Nurse Aide), LPN (Licensed Practical Nurse), and RN (Registered Nurse).
The sheet indicated that 5.5 licensed nursing staff worked the day shift but did not specify which half of the shift the staff worked.

On 8/28/24 at 1:58 P.M., the Administrator provided a copy of posted nurse staffing sheets for dates 8/21/24, 8/22/24, 8/23/24, 8/26/24, and 8/27/24. Each of these dates did not reflect actual

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F 732	Continued From page 17 hours worked. At that time, the Administrator indicated she was unable to tell by looking at the posted nurse staffing sheet which half of the shift was worked. On 8/29/24 at 10:51 A.M., the Administrator provided a Posted Nurse Staffing Data and Retention Requirements policy, revised 7/2023, that indicated "The facility must post the following information at the beginning of each shift ... total number and actual hours worked by the following categories of licensed and unlicensed nursing staff...".	F 732		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident without diabetes was free from a significant medication error for 1 of 1 resident reviewed for significant medication errors. (Resident L) This deficient practice resulted in Resident L receiving an overdose of rapid-acting and long-acting insulins and a significant change in condition that required emergent, intensive care at an acute care hospital for treatment of low blood sugar. Finding includes: On 8/22/24 at 2:40 P.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. The resident did not have a diagnosis of diabetes.	F 760		

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A Quarterly Minimum Data Set (MDS) Assessment, dated 4/1/24, indicated Resident L was not assessed for cognitive ability because the resident was rarely or never understood, was dependent on staff for eating, did not have insulin orders, and did not receive any insulin injections during the 7-day look back period.

The physician orders, dated 5/1/24 to 8/22/24, did not include documentation to indicate Resident L had a diagnosis or history of diabetes or should receive insulin.

A Medication/Treatment Error Report, dated 5/15/24, indicated Resident L was mistaken for another resident and was given an incorrect dosage of insulin. The physician was notified at 10:00 P.M. and gave orders to administer 1 milligram (mg) Glucagon (medication used to raise blood sugar) intramuscularly (IM), recheck the blood sugar, and send the resident to the Emergency Room (ER) for treatment and monitoring if needed. The report did not include the specific type and amount of insulin administered to the resident.

Nursing progress notes, dated 5/15/24 at 11:04 P.M. to 5/16/24 at 1:30 P.M., indicated Resident L had a blood sugar of 49 mg/dL (milligrams per deciliter) at 11:00 P.M. The nurse attempted to give the resident orange juice, but the resident was not swallowing. The blood sugar was rechecked at 11:30 P.M. and was 47 mg/dL. Glucagon was administered in the resident's right thigh. The blood sugar at 12:00 A.M. was 110 mg/dL. At 12:30 A.M., the blood sugar was 69 mg/dL. At 1:04 A.M., Emergency Medical Services (EMS) was called. Emergency Medical

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Technicians (EMTs) started an intravenous (IV) line and transported the resident to the ER by ambulance.

A hospital triage report, dated 5/16/24 at 1:02 A.M., indicated facility staff reported Resident L was given 45 units of Lantus (a long-acting insulin) and 12 units of Novolog (a rapid-acting insulin) that were not prescribed to her. The EMTs gave the resident 250 milliliters (mL) of D10 (dextrose 10% solution given to symptomatic or suspected patients with low blood sugar). Blood sugar rose to 220 mg/dL in route to the hospital but was 110 mg/dL upon arrival to the ER. Resident L was admitted to the Intensive Care Unit (ICU) where she required a D10 IV drip and frequent blood sugar checks.

An untimed handwritten statement from Qualified Medication Aide (QMA) 8, dated 5/16/24, indicated that on the night of 5/15/24, she prepared insulins for her hallway "as we always have done" and asked a nurse to administer them to the residents. The nurse administering the insulins came to QMA 8 and indicated she had accidentally given Resident L insulin that was meant for Resident N.

Hospital discharge papers, dated 5/17/24, indicated Resident L was discharged back to the facility on 5/17/24 with a diagnosis of incidental insulin overdose and hypoglycemia.

An untimed handwritten statement from Registered Nurse (RN) 32, dated 5/17/24, indicated on 5/15/24, she accidentally administered two doses of insulin in insulin pens to Resident L that were prepared by QMA 8 for Resident N. RN 32 indicated she thought the

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facility's protocol was for the QMAs to check a resident's blood sugar, draw up the insulin, and then a nurse would administer the insulin. RN 32 indicated the usual practice was for a QMA to prepare the insulin dose, label the insulin pen with a permanent marker, and set the insulin pen on the top of a medication cart. RN 32 indicated she was an internal float nurse, and she was not familiar with the residents on QMA 8's assignment for 5/15/24.

On 8/23/24 at 9:47 A.M., the Administrator, Director of Nursing (DON), Clinical Support 5, and Clinical Support 7 indicated Resident L received the wrong medication resulting in an overdose because QMA 8 drew up insulin and RN 32 went to a hall she was not assigned to or was familiar with to give insulin that she hadn't prepared. Corporate policy did not allow for QMAs to administer insulin, and medications should only be given by the nurse who prepared them.

On 8/23/24 at 10:04 A.M., the Administrator provided a QMA Parameters and Scope of Practice policy, revised 7/26/19, that indicated "The following tasks shall NOT be included in the QMA scope of practice: Administer medication by the injection route, including the following: ... Subcutaneous route...".

On 8/29/24 at 10:51 A.M., the Administrator provided a Medication Administration policy, revised 7/2034, that indicated "Medications are prepared for one resident at a time ... Perform the 5 [five] rights of medication: Right Resident, Right Medication, Right Dose, Right Route, Right Time".
On 8/29/24 at 10:51 A.M., the Administrator

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provided an Insulin Pen Administration policy, dated 6/2018, that indicated "Verify resident, physician orders and drug allergies ... Ensure that insulin pen is labeled with resident name and used for only that resident".

The article, "LANTUS Labeling - Package Insert," dated 6/29/23, was retrieved on 9/4/24 from the Federal Drug Administration (FDA) website at www.fda.gov/drugsatfda. The guidance included: "LANTUS is a long-acting human insulin analog indicated to improve glycemic control in adult and pediatric patients with diabetes mellitus ... Adverse reactions commonly associated with LANTUS include hypoglycemia, allergic reactions, injection site reactions, lipodystrophy, pruritus, rash, edema, and weight gain ... Hypoglycemia is the most common adverse reaction associated with insulins, including LANTUS. Severe hypoglycemia can cause seizures, may be life-threatening or cause death ... Severe symptomatic hypoglycemia was defined as an event with symptoms consistent with hypoglycemia requiring the assistance of another person and associated with either a blood glucose below 50 mg/dL ...or prompt recovery after oral carbohydrate, intravenous glucose, or glucagon administration ... Excess insulin administration may cause hypoglycemia and hypokalemia".

The article, "NOVOLOG Labeling - Package Insert," dated 2/28/23, was retrieved on 9/4/24 from the Federal Drug Administration (FDA) website at www.fda.gov/drugsatfda. The guidance included: "NOVOLOG is rapid acting human insulin analog indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus ... Adverse reactions

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F 760	Continued From page 22 observed with NOVOLOG include: hypoglycemia, allergic reactions, local injection site reactions, lipodystrophy, rash, and pruritus ... Hypoglycemia is the most common adverse reaction of all insulins, including NOVOLOG. Severe hypoglycemia can cause seizures, may lead to unconsciousness, may be life threatening or cause death ... Severe hypoglycemia was defined as hypoglycemia associated with central nervous system symptoms and requiring the intervention of another person or hospitalization ... Excess insulin administration may cause hypoglycemia and hypokalemia". The article, "GLUCAGON Labeling - Package Insert," dated 7/14/22, was retrieved on 9/4/24 from the Federal Drug Administration (FDA) website at www.fda.gov/drugsatfda. The guidance included: "Glucagon for Injection is an antihypoglycemic agent and a gastrointestinal motility inhibitor indicated: for the treatment of severe hypoglycemia in pediatric and adult patients with diabetes ... Most common adverse reactions (>5% or greater incidence): Injection site swelling, injection site erythema, vomiting, nausea, decreased blood pressure, asthenia, headache, dizziness, pallor, diarrhea, and somnolence ... If overdosage occurs, the patient may experience nausea, vomiting, inhibition of GI tract motility, increase in blood pressure and pulse rate". This citation relates to complaint IN00435599. 3.1-48(c)(2)	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that medications were properly stored and labeled in 2 of 6 medication carts and 2 of 2 treatment carts observed. (E-Hall, F-Hall, Short Hall Cottage Treatment Cart, A-Hall Treatment Cart)

Findings include:

1. On 8/21/24 at 8:50 A.M., the following loose pill was observed in the E-Hall Medication Cart for rooms 141-147:

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1/2 small round white pill

2. On 8/21/24 at 8:55 A.M., the following loose pills and unlabeled medications were observed in the E-Hall Medication Cart for rooms 131-140:
2 1/2 small round white pills
1 bottle of Honey Robitussin (cough medicine) with [Resident 33] on bottle but no label or open date

3. On 8/21/24 at 9:05 A.M., the following unlabeled materials were observed in the Short Hall of the Cottage:
1 Honey Dressing (medicated) package no label or open date

4. On 8/21/24 at 9:25 A.M., the following unlabeled materials were observed in the A-Hall Treatment Cart:
1 tube of opened antifungal cream for [Resident 27] no label
1 bottle of wound cleaner open with [Resident 8] no label

On 8/23/24 at 12:04 P.M., the following unlabeled materials were observed in the A Hall Treatment Cart:
1 opened antifungal cream ointment for [Resident 52] with no label
1 bottle of wound cleanser [Resident 8] no label

During an interview on 8/21/24 at 9:00 A.M., RN (Registered Nurse) 37 indicated there should be no loose pills and that the medications should be labeled.

On 8/29/24 at 10:54 A.M., the Administrator provided a current "Medication Storage" policy, dated August 2023. The policy indicated "Proper

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F 761	Continued From page 25 medication storage is a standard or practice... Medications are properly labeled with name, lot number... Medication is available for all active medication orders...". 3.1-25(b)(4) 3.1-25(j)	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 trays tested for temperature. (A-Hall) Finding includes: On 8/21/24 at 10:06 A.M., Resident Q indicated the food was always cold. On 8/21/24 at 10:44 A.M., Resident 36 indicated the food was usually cold. On 8/21/24 at 2:20 P.M., Resident 33 indicated the food was cold all the time. On 8/23/24 at 1:06 P.M., a test tray was obtained.	F 804		

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F 804	Continued From page 26 Food temperatures for that meal were: chicken 114 F (Fahrenheit) fries 109 F coleslaw 55.5 F mandarin oranges 60 F On 8/29/24 at 8:50 A.M., the Dietary Manager indicated food temperatures should be palatable. On 8/29/24 at 10:51 A.M., the Administrator provided a Food Temperatures policy, revised 6/23, that indicated "All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food". The Retail Food Establishment Sanitation Requirements 410 IAC 7-24 Sec. 166, effective November 13, 2004, indicated "(a) ...refrigerated, potentially hazardous food shall be at a temperature of forty-one (41) degrees Fahrenheit or below when received ... (c) received hot shall be at a temperature of one hundred thirty-five (135) degrees Fahrenheit or above". 3.1-21(a)(2)	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure dishwasher temperatures were within range and food was prepared under sanitary conditions for 1 of 1 kitchens observed. The temperature on the final rinse of the dishwasher did not reach required levels, hairnets did not cover hair, and staff touched food with their bare hands. (Kitchen, Cook 10, Dietary Aide 25)

Findings include:

1. On 8/21/24 at 8:45 A.M., a dishwasher cycle was observed. The final rinse reached 173 degrees Fahrenheit (F).

On 8/21/24 at 10:36 A.M., the Dietary Manager indicated the regulation stated the dishwasher final rinse needed to reach 180 F, but the manufacturer said 175 F was acceptable. A service technician had been called that morning. At that time, a high temp dishmachine temperature log was provided. Final rinse temperatures recorded for the month of August ranged from 168 F to 178 F.

On 8/29/24 at 10:51 A.M., the Administrator

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provided a Work Order for the dishwasher, dated 8/21/24, that indicated "Customer stated that dish machine was not getting to 180 degrees. Upon inspection seen [sic] dish machine was at 177-178 degrees. Checked the booster set point temp and it was at 180 degrees. Changed set point to 185 degrees".

2. On 8/23/24 at 11:50 A.M., Cook 10 and Dietary Aide 25 were observed plating food for lunch. Hairnets for Cook 10 and Dietary Aide 25 did not cover all their hair.

3. On 8/23/24 at 11:50 A.M., Cook 10 was observed plating food for lunch. Cook 10 used her bare hands to grab sandwich buns out of a bag, separate the sandwich bun, and place it on a plate. At that time, the Dietary Manager indicated gloves were supposed to be used because food cannot be touched with bare hands.

On 8/29/24 at 8:50 A.M., the Dietary Manager indicated hairnets should be covering all hair.

On 8/29/24 at 10:51 A.M., the Administrator provided a Recording Dish Machine Temperature/Sanitizer policy, revised 7/23, that indicated "Dishwashing staff will be trained to report any problems with the dish machine temperatures and/or sanitizer concentration to the Culinary Manager as soon as they occur. The Culinary Manager will promptly assess any dish machine problems and take corrective action to assure appropriate cleaning and sanitizing of dishes".

On 8/29/24 at 10:51 A.M., the Administrator provided a Use of Gloves policy, revised 10/22, that indicated "Employees will not use bare hand

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F 812	Continued From page 29 contact with foods. Clean gloves will be used when handling any food directly". On 8/29/24 at 10:51 A.M., the Administrator provided a Culinary Personal Hygiene policy, revised 5/24, that indicated "All employees working in the culinary department must wear a clean hair restraint which effectively covers all hair". 3.1-21(i)(2) 3.1-21(i)(3)	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure documentation was complete for 5 of 6 residents reviewed for medications. Medications on the Medication Administration Record (MAR) were not documented as completed. (Resident M, Resident N, Resident Q, Resident 86, and Resident 45)

Findings include:

1. On 8/26/24 at 2:35 P.M., Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, diabetes mellitus, generalized anxiety disorder, chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity, and chronic pain syndrome.

The most current Quarterly Minimum Data Set (MDS) Assessment, dated 7/5/24, indicated Resident M was cognitively intact, required supervision for eating, and received an antianxiety medication, anticoagulant, opioid, and insulin during the 7-day look back period.

Physician orders included, but were not limited to:
insulin lispro (a rapid-acting insulin) - insulin pen; 100 unit/mL (units per milliliter) - give 10 units subcutaneous three times a day, dated 8/27/22
lorazepam (an antianxiety mediation) tablet - Give 1 mg (milligram) by mouth every 8 hours, dated 11/7/21
hydrocodone-acetaminophen (an opioid) tablet -

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Give 7.5-325 mg by mouth every 6 hours, dated 2/25/24
insulin glargine (a long-acting insulin) insulin pen; 100 unit/mL - give 35 units subcutaneous every 12 hours, dated 7/3/24
Baclofen (muscle relaxer) - give 10 mg by mouth three times a day, dated 7/4/24
Baclofen - give 5 mg with 10 mg by mouth to equal 15 mg three times a day, dated 7/4/24
Eliquis (an anticoagulant) - give 5 mg twice a day, dated 8/7/23

The May 2024 MAR indicated:
Insulin lispro was left blank on 5/8 at 12:00 P.M., 5/15 at 5:00 P.M., 5/17 at 8:00 A.M., 5/19 at 12:00 P.M., and 5/21 at 5:00 P.M.
Hydrocodone-acetaminophen was left blank on 5/4 at 12:00 P.M.
Lorazepam was left blank on 5/17 at 8:00 A.M.

The June 2024 MAR indicated:
Insulin lispro was left blank on 6/27 at 8:00 A.M.
Lorazepam was left blank on 6/27 at 8:00 A.M.

The July 2024 MAR indicated:
Insulin lispro was left blank on 7/26 at 8:00 A.M. and 7/29 at 5:00 P.M.
Insulin glargine was left blank on 7/26 at 8:00 A.M.

The August 2024 MAR indicated:
Insulin lispro was left blank on 8/4 at 5:00 A.M., 8/19 at 8:00 A.M., and 8/19 at 5:00 P.M.
Insulin glargine was left blank on 8/19 at 8:00 A.M.
Baclofen was left blank on 8/19 at 8:00 A.M.
Eliquis was left blank on 8/19 at 8:00 A.M.
Lorazepam was left blank on 8/19 at 8:00 A.M.

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2. On 8/22/24 at 11:33 A.M., Resident N's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.

The most current Quarterly Minimum Data Set (MDS) Assessment, dated 6/25/24, indicated Resident N was cognitively intact, required setup assistance for eating, and received insulin during the 7-day look back period.

Physician orders included, but were not limited to:
insulin glargine (a long-acting insulin) - insulin pen; 100 unit/mL (units per milliliter) - give 4 units subcutaneous every 12 hours, dated 12/28/23
insulin aspart (a rapid-acting insulin) - insulin pen; 100 unit/mL - give 12 units subcutaneous at bedtime, dated 6/2/23
insulin aspart (a rapid-acting insulin) - insulin pen; 100 unit/mL - give 15 units subcutaneous at bedtime, dated 6/3/24
amlodipine (a medication to treat high blood pressure) tablet - give 5 mg (milligrams) once a day, dated 8/17/23

The May 2024 MAR indicated:
Insulin glargine was left blank on 5/6 at 8:00 A.M., 5/7 at 8:00 P.M., and 5/22 at 8:00 A.M.
Insulin aspart (12-unit dose) was left blank on 5/7
Amlodipine was left blank on 5/17

The June 2024 MAR indicated:
Insulin glargine was left blank on 6/27 at 8:00 A.M. and 6/29 at 8:00 P.M.
Insulin aspart (15-unit dose) was left blank on 6/27 at 8:00 A.M.
Insulin aspart (12-unit dose) was left blank on 6/4 and 6/29

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The July 2024 MAR indicated:
Insulin glargine was left blank on 7/26 at 8:00 A.M.
Insulin aspart (15-unit dose) was left blank on 7/26 at 8:00 A.M. and 7/27 at 12:00 P.M.

The August 2023 MAR indicated:
Insulin glargine was left blank on 8/19 at 8:00 A.M.
Insulin aspart (15-unit dose) was left blank on 8/4 at 5:00 P.M., 8/19 at 8:00 A.M. and 5:00 P.M., and 8/20 at 5:00 P.M.

3. On 8/23/24 at 10:09 A.M., Resident Q's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, generalized anxiety disorder, hypertension, irritable bowel syndrome, glaucoma, atrial fibrillation, hypertension, gastro-esophageal reflux disease, and depression.

The most current Significant Change Minimum Data Set (MDS) Assessment, dated 6/13/24, indicated Resident Q was cognitively intact, required setup assistance for eating, and received an antianxiety medication, antidepressant, anticoagulant, diuretic, and a hypoglycemic medication during the 7-day look back period.

Physician orders included, but were not limited to:
Diabetic orders: Accu-Chek (test to determine blood glucose level) - Notify MD (medical doctor) if Accu-Chek is below 70 or greater than 400 - every Monday, dated 11/14/2022
gabapentin (an anticonvulsant) capsule - give 300 mg (milligrams) three times a day, dated 8/5/23
Xanax (an antianxiety medication) tablet - give 0.25 mg three times a day, dated 5/31/23

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insulin degludec (an ultralong-acting insulin) - insulin pen; 100 unit/mL - give 10 units subcutaneous at bedtime, dated 7/18/24
acetazolamide (a diuretic) tablet - give 250 mg twice a day, dated 12/17/23
colestipol (medication to treat high cholesterol levels) tablet - give 1 gram twice daily, dated 10/13/23
Combigan (medication to treat glaucoma) drops 0.2-0.5 % - give 1 drop in left eye twice daily, dated 12/17/23
Eliquis (an anticoagulant) tablet - give 5 mg by mouth twice a day, dated 5/20/24
metformin (a hypoglycemic medication) tablet - give 250 mg by mouth twice daily, dated 7/18/24
metoprolol tartrate (medication to treat high blood pressure) tablet - give 25 mg by mouth twice a day, dated 12/17/23
omeprazole (a proton-pump inhibitor) capsule, delayed release - give 20 mg by mouth once a day, dated 8/12/22
Zoloft (an antidepressant) tablet - give 100 mg by mouth once a day, dated 5/22/24

The May 2024 MAR indicated:
Accu-Chek was left blank on 5/6.
Gabapentin was left blank on 5/6 at 7:00 A.M., 5/10 at 7:00 A.M., 5/16 at 7:00 A.M., 5/17 at 7:00 A.M., 5/18 at 7:00 A.M., 5/19 at 7:00 A.M., 5/24 at 7:00 A.M., 5/25 at 7:00 A.M., and 5/29 at 7:00 A.M.
Xanax was left blank on 5/6 at 7:00 A.M., 5/10 at 7:00 A.M., 5/16 at 7:00 A.M., 5/17 at 7:00 A.M., 5/18 at 7:00 A.M., 5/19 at 7:00 A.M., 5/24 at 7:00 A.M., 5/25 at 7:00 A.M., and 5/29 at 7:00 A.M.

The June 2024 MAR indicated:
Accu-Chek was left blank on 6/3, 6/17, and 6/24.
Gabapentin was left blank on 6/3 at 7:00 A.M.

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Xanax was left blank on 6/3 at 7:00 A.M.

The July 2024 MAR indicated:
Accu-Chek was left blank on 7/22 and 7/29.
Gabapentin was left blank on 7/25 at 7:00 A.M., 7/28 at 7:00 A.M., and 7/29 at 7:00 A.M.
Xanax was left blank on 7/22 at 7:00 A.M., 7/25 at 7:00 A.M., 7/28 at 7:00 A.M., and 7/29 at 7:00 A.M.

The August 2024 MAR indicated:
Accu-Chek was left blank on 8/5 and 8/19.
Gabapentin was left blank on 8/5 at 7:00 A.M., 8/7 at 7:00 A.M., 8/18 at 7:00 A.M., 8/19 at 7:00 A.M., and 8/20 at 7:00 A.M.
Xanax was left blank on 8/5 at 7:00 A.M., 8/7 at 7:00 A.M., 8/18 at 7:00 A.M., 8/19 at 7:00 A.M., and 8/20 at 7:00 A.M.
Insulin degludec was left blank on 8/1.
Acetazolamide was left blank on 8/19 at 7:00 A.M. - 11:00 A.M.
Eliquis was left blank on 8/19 at 7:00 A.M. - 11:00 A.M.
Metformin was left blank on 8/19 at 7:00 A.M. - 11:00 A.M.
Colestipol was left blank on 8/19 at 7:00 A.M. - 11:00 A.M.
Combigan drops was left blank on 8/19 at 7:00 A.M. - 11:00 A.M.
Omeprazole was left blank on 8/19 at 7:00 A.M. - 11:00 A.M.
Metoprolol tartrate was left blank on 8/19 at 7:00 A.M. - 11:00 A.M.
Zoloft was left blank on 8/19 at 7:00 A.M. - 11:00 A.M.

4. On 8/26/24 at 12:36 P.M., Resident 86's clinical record was reviewed. Diagnoses included, but were not limited to, back pain, dementia with

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agitation, body posture rigidity, and major depressive disorder.

The most current Admission Minimum Data Set (MDS) Assessment, dated 6/10/24, indicated Resident 86 was rarely or never understood, required supervision for eating, and received an antipsychotic medication, an antianxiety medication, and a hypoglycemic medication during the 7-day look back period.

Physician orders included, but were not limited to:
acetaminophen (a pain reliever) capsule - give 650 mg (milligrams) by mouth three times a day, dated 7/23/24
memantine (a medication to treat dementia symptoms) tablet - give 10 mg by mouth every 12 hours, dated 6/4/24
carbidopa-levodopa tablet (a medication to treat symptoms of Parkinson's disease) - give one 25-100 mg tablet by mouth three times a day, dated 7/25/24 and discontinued on 8/22/24
Xanax (an antianxiety medication) tablet - give 0.25 mg by mouth twice daily, dated 6/4/24
risperidone (an antipsychotic) tablet - give 0.25 mg by mouth twice daily, dated 8/13/24

The July 2024 MAR indicated:
Acetaminophen was left blank on 7/26 at 2:00 P.M.
Memantine was left blank on 7/5 at 8:00 P.M., 7/6 at 8:00 P.M, and 7/11 at 8:00 P.M.
Carbidopa-levodopa was left blank on 7/26 at 2:00 P.M.
Xanax was left blank on 7/14 at 2:00 P.M., 7/20 at 2:00 P.M., 7/21 at 2:00 P.M., and 7/26 at 2:00 P.M.

The August 2024 MAR indicated:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

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Acetaminophen was left blank on 8/3 at 8:00 P.M., 8/4 at 2:00 P.M., 8/17 at 2:00 P.M., 8/19 at 8:00 P.M., 8/22 at 8:00 P.M., and 8/25 at 8:00 P.M.
Memantine was left blank on 8/3 at 8:00 P.M., 8/19 at 8:00 P.M., 8/22 at 8:00 P.M., and 8/25 at 8:00 P.M.
Risperidone was left blank on 8/19 at 7:00 P.M. - 10:00 P.M., 8/22 at 7:00 P.M. - 10:00 P.M., and 8/23 at 7:00 P.M. - 10:00 P.M.
Carbidopa-levodopa was left blank on 8/4 at 2:00 P.M., 8/13 at 6:00 P.M., 8/14 at 6:00 P.M., and 8/17 at 2:00 P.M.
Xanax was left blank on 8/4 at 2:00 P.M. and 8/17 at 2:00 P.M.

5. On 8/27/24 at 1:30 P.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, chronic atrial fibrillation, unspecified, age-related osteoporosis without current pathological fracture, malignant neoplasm of colon, unspecified, malignant neoplasm of prostate, and gastro-esophageal reflux disease without esophagitis.

A Quarterly MDS (Minimum Data Set) Assessment, dated 7/11/24, indicated Resident 45's cognition was severely impaired and received an anticoagulant and opioid medication.

Care plans included but were not limited to: [name of resident] is at risk for pain related to diagnosis of prostate and colon cancer, osteoporosis and GERD (gastroesophageal reflux disease) Approach: Administer meds as ordered, start date 7/9/22.

Resident is at risk for ineffective tissue perfusion related to heart failure, ASHD, A-Fib,

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hypokalemia and hyperlipidemia. Approach: Administer meds as ordered, start date 7/9/22.

Resident has a urinary tract infection (UTI). Approach: Administer antibiotic as ordered, start date 8/22/24.

Discomfort related to gastric reflux disease. Approach: Administer medications as ordered, start date 12/10/22.

August 2024 physician orders and EMAR (Electronic Medication Administration Record) were reviewed and included, but were not limited to:

bicalutamide (nonsteroidal antiandrogen) tablet, 50 mg (milligram) amount to administer: 50 mg (milligrams), once a day, start date 4/16/24.
On 8/3 the medication was not documented given for the morning dose.

amiodarone (antiarrhythmic) tablet 200 mg amount to administer: 200 mg once a day, start date 4/16/24.
On 8/3 the medication was not documented as given for the morning dose.

calcium 600+D(3) (nutritional supplement) tablet, 600 mg- 10 mcg (microgram) (400 unit) twice a day, start date 4/16/24.
On 8/3 the medication was not documented as given for the morning dose.

Eliquis (anticoagulant) (apixaban) tablet, 2.5 mg, twice a day, start date 6/21/24.
On 8/3 the medication was not documented as given for the morning dose.

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midodrine (vasoconstrictor) 5 mg twice a day, start date 4/16/24
On 8/3 the medication was not documented as given for the morning dose.

Namenda (N-methyl D-aspartate inhibitor) (memantine) tablet 10 mg twice a day, start date, 4/16/24.
On 8/3 the medication was not documented as given for the morning dose.

omeprazole capsule delayed release 20 mg once a day, start date 4/16/24.
On 8/3 the medication was not documented as given.

hydrocodone-acetaminophen (pain medication) 5-325 mg, oral, start date 4/22/24.
The morning dose on 8/3 and the evening dose on 8/9 was not documented as given.

cephalexin 500 mg oral, twice a day, start date 8/21//24.
The evening dose on 8/26 was not documented as given.

On 8/27/24 at 11:07 A.M., the Director of Nursing (DON) indicated she was unsure why there were blank spaces in the MAR. She indicated the medication could not have been given due to the resident refusing or being on a leave of absence, but since the nurse did not document it, she couldn't be sure. She indicated the medication was probably given and that staff were not being diligent to mark it done once completed.

On 8/29/24 at 10:57 A.M., the Administrator indicated staff were expected to completely and accurately document in the clinical record and

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F 842	Continued From page 41 follow physician orders. On 8/29/24 at 10:51 A.M., the Administrator provided a current Medication Administration policy, revised 7/2023, that indicated "Medication administration will be recorded on the MAR/EMAR [electronic medication administration record] or TAR [treatment administration record] after given ... Refusal of medication document as appropriate".	F 842		
F 880 SS=D	3.1-50(a)(1) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		

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F 880	Continued From page 42 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure staff performed proper hand hygiene and disinfection of equipment during 2 of 2 random observations of resident care. (Resident 9)

Findings include:

1. On 8/23/24 at 6:45 A.M., CNA (Certified Nursing Aide) 18 and CNA 4 were observed performing peri care for Resident 9. CNA 18 had gloves on and touched the nightstand and bedside table. CNA 4 turned Resident 9 to the right side and removed the soiled brief. CNA 18 cleaned Resident 9's buttocks with wipes and placed the soiled brief in a plastic bag. After placing the soiled brief in the plastic bag and without changing gloves, CNA 4 placed barrier cream on the resident's buttocks and positioned a new brief. CNA 4 donned new gloves without sanitizing or washing hands, applied cream to scrotal area with same gloves, and attached a clean brief. CNA 18 and CNA 4 did not change gloves before touching and placing clean clothes on Resident 9. CNA 4 removed gloves and placed the Hoyer pad under Resident 9 without hand sanitizing and proceeded to touch controls. CNA 18 touched the Hoyer Lift with soiled gloves and lowered the resident into his Broda chair. CNA 18 removed gloves and did not sanitize hands before straightening the sheets. CNA 18 placed soiled linen and trash into plastic bags, and did not sanitize hands. After Resident 9 was placed in Broda Chair, the Hoyer Lift was placed in hallway outside of room and was not cleaned.

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F 880	Continued From page 44 2. On 8/23/24 at 7:05 A.M., LPN (Licensed Practical Nurse) 27 took a blood pressure of 143/71 on Resident 9 and put it on the medication cart. She did not clean the equipment after using it on the resident. During an interview on 8/23/24 at 11:50 A.M., Clinical Support 5 indicated hand hygiene should be done before applying gloves. Once gloves were applied things should only be touched that were needed to complete tasks. Gloves should be changed before and after peri care. Equipment should be cleaned in between residents. On 8/29/24 at 10:55 A.M., the Administrator provided a current "Hand Hygiene" policy, revised 12/2021. The policy indicated "...health care professionals should use an alcohol-based rub for the following reasons: before moving from work on a soiled body site to clean body site on the same resident...after contact with body fluids, immediately after glove or PPE (Personal Protective Equipment) removal...". On 8/29/24 at 10:56 A.M., the Administrator provided a current policy "Standard and Transmission-Based Precautions (Isolation)" policy, revised 4/24/24. The policy indicated "... standard precautions refer to infection prevention practices that apply to all residents...change gloves during care and perform hand hygiene if hands move from a contaminated site to a clean site...shared equipment should be cleaned and disinfected in-between each resident use...". 3.1-18(b) 3.1-18(l)	F 880		

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