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	09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRAIL CREEK PLACE- ASSISTED LIVING	1400 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: September 3 and 4, 2019 Facility number: 010610 Residential Census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/9/19.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency*	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain a clean and orderly environment related to urine odors, dirty window sills, toilets, sinks, and showers, stained and dirty carpet, tables and ceiling vents, scuffed and dirty floors, build up lint in dryers, no face plates for an electrical outlet and thermostat for 2 of 2 buildings. (The Assisted Living and Memory Care)	R 0144	1.Assisted Living corrections 1.Room 107, sink drain cleaned on 9/5/19 2.Room 138, toilet bowl and base cleaned on 9/5/15, request for new flooring placed on 9/16/19 with tentative install date the week of 10/1/19. 3.Room 141, bathroom floor swept and cleaned on 9/5/19	10/16/2019

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

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	Findings include: 1. During the Environmental tour with Maintenance Director on 9/3/19 from 10:15 a.m. to 11:00 a.m., the following was observed: Assisted Living a. Room 107 - there was a black substance noted around the sink drain. There was 1 resident who resided in the room and used the bathroom. b. Room 138 - there was a red/orange discoloration around the toilet base and in the toilet bowl. There was 1 resident who resided in the room and used the bathroom. c. Room 141 - the bathroom floor was dirty with paper debris noted throughout. There was 1 resident who resided in the room and used the bathroom. d. Room 128 - the carpet was dirty with many large stains. There was 1 resident who resided in the room. e. Room 139 - the toilet bowl was dirty with yellow stains. The shower also had an accumulation of dust and dirt on the bottom. There were 2 residents in the room and who used the bathroom. f. Room 106 - the carpet was dirty with numerous stains. There was 1 resident who resided in the room. g. The hand rails in the hallways throughout the building were dusty as well as the baseboards. h. The dryers in the laundry room had a large		4.Room 128, the carpet was cleaned on 9/6/19 5.Room 139, bathroom/toilet/shower cleaned on 9/6/19 6.Room 106, the carpet was cleaned on 9/7/19. New flooring request placed on 9/17/19 with tentative install date of 10/1/19 7.Hand rails and baseboards throughout the community were cleaned on 9/6/19 8.The dryer lint traps were cleaned immediately. Memory Care corrections 1.Source of the urine odor was identified and corrected 2.Room A3, the cover over the electrical wall outlet was replaced by the MT on 9/5/19 3.Room A5, soiled linens immediately taken to the laundry, soiled brief immediately disposed of. Bathroom floor was mopped. Flooring throughout the apartment and bathroom replaced on 9/12/19. 4.Room A7, toilet lift seat was removed as resident does not use it. Family made aware. 5.Room B9, the cover to the thermostat was replaced by the MT on 9/20/19 6.Room C5, the toilet base and bathroom were cleaned on 9/6/19 7.The ceiling vents in the B hallway were cleaned on 9/20/19 8.Table tops ordered on 9/17/19 by the Regional Director of	

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	amount of lint noted in the traps. Memory Care: a. There was a constant urine odor noted in all the hallways. b. Room A 3 - there was no cover on the electrical wall outlet . There was a cord plugged into the outlet. There was 1 resident who resided in the room. c. Room A 5 - there were dirty and soiled linens and a soiled brief on the floor in the bathroom. There were 2 residents who shared the bathroom. d. Room A 7 - the toilet lift seat was rusty. There was 1 resident who resided in the room and used the bathroom. e. Room B 9 - there was no cover on the thermostat. There was 1 resident who resided in the room. f. Room C 5 - the toilet base was dirty. There were 2 residents who used the bathroom. g. The ceiling vents in the B hallway were dirty and dusty. h. There were 11 stained table tops in the dining room. The floor was sticky, scuffed and marred. i. There were 4 dirty and discolored ceiling vents in the dining room. j. The window sills in the dining room were dirty. Interview with the Maintenance Director at that time, indicated all of the above were in need of		Facilities. Purchase request # 26844. Delivery and install date tentatively scheduled for week of 10/1/19 9.Dining room ceiling vents were cleaned on 9/16/19 10.Window sills in the dining room were cleaned on 9/20/19 1.Cleaning and repair needs identified throughout the community and corrected. Residents who do not have laundry baskets or receptacles in their apartments were identified. Families contacted to provide or community will purchase and place in apartments. 2.ED, CSM and Maintenance director were educated on 9/5/19 by the Regional Director of Care services regarding the state regulation for sanitation and safety standards. Midnight staff cleaning schedule updated and staff educated on expectations on 9/20/19 Candidate for housekeeping position interviewed on 9/4/19 and hired on 9/9/19. Housekeeper given education regarding cleaning expectations and daily/weekly/monthly schedule updated and provided as job requirements. 3.The ED is responsible for sustained compliance. The ED or designee in conjunction with MT and housekeeper will make environmental rounds and audit the cleanliness and overall repair of the buildings weekly for 6	

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	cleaning and/or repair. A confidential resident interview, indicated "The housekeeping is lousy." A confidential resident interview, indicated "My room could be cleaner." Interview with the Administrator on 9/4/19 at 10:40 a.m., indicated the resident rooms were cleaned one time a week, including the toilets and showers. The carpets were also cleaned weekly, sometimes twice a week.		weeks, then every 2 weeks for 6 weeks then monthly for 3 months. Audits will be reviewed at monthly QI meeting. Continued review will be based on 6 months of sustained compliance. 4.Completion date-10/16/19	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to maintain kitchen areas in a state of good repair related to dust on ceiling vents and lime build up on walls for 1 of 2 kitchens. (Memory Care Kitchen) 1. During the Kitchen Sanitation tour on 9/3/19 at 9:22 a.m., with the Dietary Food Manager (DFM), the following was observed in the Memory Care Kitchen: a. The ceiling vent located in front of the ice machine had a thick accumulation of dust. b. The base of the wall located behind the dishwasher had an accumulation of lime build up. The legs of the dishwasher also had an accumulation of lime build up.	R 0154	1.Ceiling vent in the MC kitchen was cleaned on 9/10/19. The lime build up at the wall base and the legs of the ice machine were cleaned on 9/12/19. Ecolab rep de-limes monthly at each visit. DSM to follow up with Ecolab rep and MT to discuss reasons for buildup and assess water softener. 2.No residents were affected by this alleged deficient practice. 3.The ED and MT were educated on 9/4/19 by the Regional Director of Care services regarding the ISDH regulation on Safety and sanitation. The ED provided education to the dining services manager on 9/6/19.	10/16/2019

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	Interview with the DFM at the time, indicated all of the above were in need of cleaning.		Kitchen cleaning schedules reviewed and updated with education also provided to DSM. 4.ED is responsible for sustained compliance. ED or designee in conjunction with the DSM will audit the kitchen for cleanliness weekly for 6 weeks then every other week for 6 weeks then monthly for 3 months. Audits will be reviewed at the monthly QI meeting. Continued review will be based on 6 months of sustained compliance. 5.Completion date 10/16/19	
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 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.			

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	(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 a resident's service plan was updated related to behaviors for 1 of 7 residents reviewed for service plans. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 9/3/19 at 10:40 a.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, major depressive disorder, pseudobulbar affect, and psychosis. The Service Plan, dated 7/15/19, indicated the only behaviors the resident had was trouble recalling the day, date, and where she was located. The Service Plan did not address any other behaviors. A Vanguard Psychiatry Progress Note, dated 6/10/19, indicated the resident continued with behaviors of yelling and loud outbursts during care. Nurse's Notes, dated 5/3/19 (no time), indicated yelling out during meals and while awake. Nurse's Notes, dated 5/9/19 at 10:00 a.m., indicated screaming and yelling at staff. Nurse's Notes, dated 5/10/19 at 11:35 a.m., indicated continues to have screaming episodes.	R 0217	1.Resident 5 service plan was updated on 9/9/19 by the Care services manager. 2.Service plans of residents with identified behaviors reviewed by the CSM on 9/16/19. No residents were identified with service plans that required updating. 3.Education provided to the CSM on 9/5/19 by the Regional Director of Care regarding the need to ensure that service plans reflect the most updated information regarding behaviors and plan of care. Best practice initiated that CSM will manually update service plans with changes in between quarterly assessments as behaviors and changes warrant. 4.CSM is responsible for sustained compliance. CSM or designee will audit resident records routinely for changes and update service plans as warranted. 5 records will be reviewed weekly for 2 weeks then, 3 records weekly for 2 weeks, then 2 records weekly for 2 weeks then 1 record weekly on-going. Audits will be reviewed at monthly QI. Continued review will be	10/16/2019

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	Hard to redirect. Nurse's Notes, dated 5/13/19 (no time), indicated the resident had intermittent screaming out this shift. Interview with the Care Service Coordinator on 9/4/19 at 10:00 a.m., indicated the resident's Service Plan was not updated to reflect her behaviors.		based on 6 months of sustained compliance. 5.Completion date-10/16/19	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and interview the facility failed to ensure an insulin kwikpen was primed prior to use and sliding scale insulin was documented as being administered for 1 of 5 residents observed during medication pass and 1 of 7 residents reviewed for Physician's Orders. (Residents 4 and 1) Findings include: 1. On 9/4/19 at 7:45 a.m., during medication pass, LPN 1 was observed preparing an insulin injection for Resident 4. At that time, the LPN placed the needle on the Basaglar Insulin Kwikpen and dialed it to 25 units. She wiped the resident's abdomen with an alcohol pad and administered all 25 units via the kwikpen. Interview with LPN 1 at that time, indicated she	R 0241	1.Education provided to licensed nursing staff regarding the manufacturer's guidelines for priming the insulin Kwik pens on 9/11/19. The medication administration record was updated on 9/5/19 by the CSM with the glucose monitoring and sliding scale flow sheet to reflect documentation of the dosage given of sliding scale insulin. 2.3 residents receive insulin via Kwik pens and 2 residents have physician's orders for blood glucose monitoring and sliding scale insulin and have the potential to be affected by this alleged deficient practice. 3.CSM was educated on 9/5/19	10/16/2019

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	was unaware the kwikpen needed to be primed prior to use. The record for Resident 4 was reviewed on 9/4/19 at 8:05 a.m. Physician's Orders, dated 8/18/19, indicated Basaglar Insulin Kwikpen give 25 units every morning. Interview with the Care Service Coordinator on 9/4/19 at 8:20 a.m., indicated he was unaware the insulin kwikpen was supposed to be primed prior to use. The insert and instructions for use of the Basaglar Insulin Kwikpen, indicated "Prime before each injection. Priming means removing the air from the needle and cartridge that may collect during normal use. It is important to prime your pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top."2. The record for Resident 1 was reviewed on 9/3/19 at 10:50 a.m. Diagnoses included, but were not limited, dementia, bladder cancer, hypertension, and depression. A Physician's Order, dated 12/27/18, indicated Novolog (insulin), inject per sliding scale after blood sugar checks three times a day: 0 - 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 215 - 300 = 6 units, 301 - 350 = 8 units, and greater than 350 give 10 units. A Physician's Order, dated 12/27/18, indicated		by the Regional Director of Care Services on proper MAR documentation of administered sliding scale insulin dosage and manufacturer's guidelines for proper priming and administration of insulin with a Kwik pen. Licensed staff were educated by the CSM on 9/11/19. 4.CSM is responsible for sustained compliance. CSM or designee will audit the MAR weekly for 6 weeks, then every two weeks for 6 weeks then monthly for 3 months to ensure proper documentation is present. CSM or designee will complete quarterly medication pass competency audits with licensed staff to ensure proper technique is used when administering insulin via a Kwik pen. MAR and competency audits will be reviewed at monthly QI. Continued review will be based on 6 months of sustained compliance. 5.Completion date 10/16/19	

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	check blood sugar before each meal (7:00 a.m., 12:00 p.m., and 5:00 p.m.) and follow sliding scale accordingly. The 8/2019 Medication Administration Record indicated there was no documentation related to the amount of insulin administered on the following dates and times: - 8/1 at 12:00 p.m., blood sugar 183 and 5:00 p.m., blood sugar 254 - 8/2 at 7:00 a.m., blood sugar 165 and 12:00 p.m., blood sugar 155 - 8/3 at 12:00 p.m., blood sugar 289 and 5:00 p.m., blood sugar 289 - 8/4 at 12:00 p.m., blood sugar 233 and 5:00 p.m., blood sugar 264 - 8/5 at 7:00 a.m., blood sugar 162, 12:00 p.m., blood sugar 200, and 5:00 p.m., blood sugar 194 - 8/6 at 12:00 p.m., blood sugar 235 and 5 :00 p.m., blood sugar 366 - 8/7 at 12:00 p.m., blood sugar 165 and 5:00 p.m., blood sugar 186 - 8/8 at 12:00 p.m., blood sugar 220 and 5:00 p.m., blood sugar 185 - 8/9 at 12:00 p.m., blood sugar 156 and 5:00 p.m., blood sugar 192 - 8/11 at 12:00 p.m., blood sugar 157 - 8/12 at 5:00 p.m., blood sugar 205 - 8/13 at 5:00 p.m., blood sugar 197 - 8/14 at 7:00 a.m., blood sugar 265, 12:00 p.m., blood sugar 245, and 5:00 p.m., blood sugar 302 - 8/15 at 7:00 a.m., blood sugar 173 - 8/16 at 7:00 a.m., blood sugar 344, 12:00 p.m., blood sugar 256, and 5:00 p.m., blood sugar 344 - 8/17 at 7:00 a.m., blood sugar 219, 12:00 p.m., blood sugar 173, and 5:00 p.m., blood sugar 166 Interview with the Care Service Manager on 9/3/19 at 11:32 p.m., indicated there should have been			

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	documentation to indicate the amount of insulin administered.			
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 and interview, the facility failed to ensure food was dated when opened, as well as ensure lids were clean and food was not touched with bare hands by employees for 2 of 2 kitchens in the facility. (Memory Care and Assisted Living) Findings include: 1. During the Kitchen Sanitation tour on 9/3/19 at 9:22 a.m., with the Dietary Food Manager (DFM), the following was observed: Memory Care Kitchen a. A bag of whipped topping was opened and not dated. b. A ham portion was observed in a stainless steel container. There was plastic wrap covering the ham, however, some areas were exposed to air. c. A plastic bag containing three frozen pork patties was tied in a knot. There was no date as to when the bag was opened. d. There was dried food spillage on the lids of the bins containing flour. 2. During the Kitchen Sanitation tour on 9/3/19 at	R 0273	1.Undated or improperly stored food items in both kitchens were immediately (9/4/19) disposed of by the Dietary Services Manager. Dried food spillage on the lids of the flour bins in both kitchens was immediately cleaned by the DSM. Cook 1 was immediately educated by the DSM regarding proper food handling and use of gloves. 2.Current residents have the potential to be affected by this alleged deficient practice. 3.DSM was educated by the ED regarding sanitation and safe food handling standards on 9/5/19. Kitchen staff were educated on 9/12/19 by the DSM regarding sanitation and safe food handling standards. Serve safe class is scheduled for early November, cook and Chef are scheduled to attend. 4.DSM is responsible for sustained compliance. Dining services scorecard will be completed by the DSM or designee weekly for 6 weeks then every other week for 6 weeks then monthly for 3 months. Scorecard	10/16/2019

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	9:39 a.m., with the Dietary Food Manager, the following was observed: Assisted Living Kitchen a. There was dried food spillage on the lids of the bins containing flour. b. There was a zip loc bag of frozen chicken in the freezer. There was no open date on the bag. c. A bag of frozen pork cut cutlets had been opened. There was no open date on the bag. d. A plastic bag containing cinnamon roll dough was tied in a knot. There was no open date on the bag. Interview with the DFM at the time, indicated the food should have been dated and the dried food spillage should have been cleaned up. 3. On 9/3/19 at 12:14 p.m., Cook 1 was observed preparing grilled cheese sandwiches in the Assisted Living Kitchen. The Cook was observed touching utensils and other items in the kitchen with her bare hands. The Cook proceeded to open a package of cheese slices and obtained how many slices she would need. She touched the cheese slices with her bare hands. The Cook then proceeded to touch the bread with her bare hands. She prepared all 3 grilled cheese sandwiches with her bare hands. Interview with the DFM on 9/4/19 at 9:30 a.m., indicated the Cook should not have been touching the cheese and bread with her bare hands.		audits will be reviewed at monthly QI. Continued review will be based on 6 months of sustained compliance. 5.Completion date-10/16/19	

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R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, record review and interview, the facility failed to ensure the recipe	R 0274	1.Cook 1 and Cook 2 were immediately educated on proper	10/16/2019

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		A. BUILDING 00 B. WING	09/04/2019

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	was followed during pureed food preparation. This had the potential to affect the 4 residents who received pureed diets. Findings include: 1. On 9/3/19 at 11:51 a.m., Cook 2 was observed during the pureed food preparation. He indicated in Memory Care, there were 3 residents who received a pureed diet. The Cook proceeded to put three 3 ounce scoops of rice into the food processor. He then added three 3 ounce scoops of meat to the rice and then added 3 ounces of hot water and blended. After preparing the meat and rice mixture, the Cook washed the food processor and proceeded to prepare pureed egg rolls. The Cook placed 3 egg rolls in the food processor as well as 4 ounces of rice and 2 ounces of hot water. While the mixture was being blended, the Cook added 3 more ounces of hot water and blended until smooth. Interview with Cook 2 at the time, indicated there was no recipe for the pureed egg rolls. He indicated he had been instructed to use rice and hot water to help with the consistency. 2. On 9/3/19 at 12:14 p.m., Cook 1 was observed during the pureed food preparation. She indicated one resident received a pureed diet in Assisted Living. The Cook proceeded to use tongs and place slices of meat and peppers in a small bowl. The meat was placed in the food processor and blended. The mixture was then placed back in the bowl. The pureed basic meat recipe indicated for 1 serving use 2 ounces of cooked meat, 1/3 cup hot broth and 2 tablespoons of cooked rice.		technique for puree food recipe preparation and presentation by the Dietary Service manager 2.4 resident who receive pureed diets have the potential to be affected by this alleged deficient practice. 3.DSM contacted the corporate dietician and Director of Dining services for recipe for puree eggroll. Kitchen staff and cooks educated on 9/12/19 by the DSM regarding proper technique for puree food recipe preparation and presentation. 4.DSM is responsible for sustained compliance. DSM or designee will audit puree diet recipe preparation and presentation weekly for 6 weeks, then every other week for 6 weeks then monthly for 3 months. Audits will be reviewed in monthly QI. Continued review will be based on 6 months of sustained compliance. 5.Completion date-10/16/19	

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	The pureed rice or pasta recipe indicated for 1 serving use 1/2 cup of cooked rice, 2 tablespoons of margarine, 1/4 cup of hot water and 1 tablespoon of nectar thick water. Interview with the Dietary Food Manager on 9/4/19 at 9:30 a.m., indicated there was no recipe for the pureed egg rolls and she would contact the Registered Dietitian. She also indicated the recipe should have been followed as written related to the pureed meat and rice.			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, record review, and interview, the facility failed to ensure all over the counter medications were labeled with the resident's and Physician's name for 1 of 5 residents observed during medication pass. (Resident 10) Finding includes: 1. On 9/4/19 at 7:15 a.m., during medication pass, LPN 1 was observed pouring medications for Resident 10. She removed 1 Aspirin 81 milligrams (mg) tablet from an over the counter bottle. There was no label on the bottle with the resident's or Physician's name. The record for Resident 10 was reviewed at on 9/4/19 at 8:10 a.m.	R 0302	1.Aspirin bottle for resident 10 was immediately labeled with resident name, the physician's name, drug expiration date, dame of drug and strength. LPN 1 was educated immediately regarding the regulation of OTC medication labeling. 2.Medication cart audit performed on 9/5/19 by the CSM. No other residents were identified to have unlabeled OTC medications. 3.CSM was educated on 9/5/19 by the Regional Director of Care Services regarding the regulation for labeling OTC medications.	10/16/2019

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	A Physician's Order, dated 8/20/19, indicated Aspirin 81 mg daily. Interview with LPN 1 on 9/4/19 at 8:15 a.m., indicated a label should have been on the bottle of Aspirin. Interview with the Care Service Coordinator on 9/4/19 at 8:20 a.m., indicated all over the counter medications should be labeled.		CSM educated community nurses and QMAs regarding the regulation for OTC med labeling on 9/11/19 4.CSM is responsible for sustained compliance. Medication cart audits will be completed by the CSM or designee weekly. Audits will be reviewed in monthly QI meeting. Ongoing review will be based on 6 months of sustained compliance. 5.Completion date 10/16/19	