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	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT ELKHART ASSISTED LIVING	3109 E BRISTOL ELKHART, IN 46514

(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. This visit included the Investigation of Complaints IN00393300 & IN00402868. Complaint IN00393300 - No deficiencies related to the allegations are cited. Complaint IN00402868 - No deficiencies related to the allegations are cited. Dates: April 11 and 12, 2023 Facility number: 010065 Residential Census: 68 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/17/23.	R 0000	This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies. This plan of correction is being submitted as required by the regulation. The provider respectfully requests a desk review with paper compliance to be considered.	
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and interview, the facility failed to ensure food was labeled, dated, and stored in a sanitary manner, failed to ensure outdated foods were removed, and failed to ensure coolers were clean in 1 of 1 kitchens observed. Findings include:	R 0273	**·No residents were found to have been affected by the deficient practice, but all residents have the potential to be affected.** **·All items identified during the survey were discarded. The ice build up in the freezer was fixed by the Director of**	05/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Maupin	Executive Director	04/27/2023

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	1. On 4/11/2023 at 10:05 A.M., during a kitchen observation with the Dietary Manager, the following was observed: a. In the walk-in freezer there was an opened bag of biscuits, bread that was not sealed appropriately, and ice build up on the freezer condenser. There was also a plastic water bottle frozen with no name and or resident identifiers. b. In the walk-in cooler there was a container of beef tips and juice with a used by date of 4/10/2023, an opened box of hamburger not sealed appropriately, and an opened whip cream bag with a layer of aluminum foil wrapped around the bag not sealed. c. The dry storage room had an opened package of corn muffin mix with a used by date of 1/13/2023, an opened package of ranch dressing mix with a used by date of 4/3/2023, and an opened bag of corn chips with a prep date of 1/17/2023 with the used by date unreadable. 2. During a follow-up observation, on 4/12/2023 at 10:00 A.M., the following was observed: a. There was an opened and undated carton of liquid eggs in the small cooler, the seals to the small cooler were dirty and had specs of a black substances and an open area in the seal, and a plate of fish with a used by date of 4/10/2023. b. The seals of the large stand up cooler used for liquids were dirty and had a red sticky substance along the bottom of the cooler with streaks of liquid on the bottom of the cooler itself. During an interview, on 4/11/2023 at 10:38 A.M., the Dietary Manager indicated the food should be		**Maintenance and an outside vendor. The seals to the small cooler were replaced. The seals of the large stand-up cooler were replaced. The large stand-up cooler was cleaned and sanitized.** **·All dining employees and the Culinary Services Director were in-serviced on 1) Sanitary procedures for food labeling, dating, and storage 2) Discarding outdated foods and 3) Kitchen cleaning and sanitation procedures.** **·The Culinary Services Director or Designee will audit for 1) Sanitary procedures for food labeling, dating, and storage 2) Outdated Foods and 3) Kitchen cleaning and sanitation. The Executive Director will ensure completion and oversite of audit findings. Quarterly, the Quality Assurance Committee will review the audits and verify completion to validate ongoing compliance. The Quality Assurance Committee will review the audits and findings through the next annual survey cycle.** **·Date systemic changes completed: 05/01/2023**	

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	sealed tightly, the water bottle was not a resident's and should not be in the freezer, there should be no ice buildup and the foods outdated should have been thrown out During an interview, on 4/12/2023 at 10:15 A.M., Cook 5 indicated the eggs should have been dated, the fish was expired, and the coolers needed to be cleaned. On 4/12/2023 at 8:00 A.M., the Administrator provided the policy titled," Labeling & FIFO Method". The policy indicated"... All prepared, thawing, and ready-to-eat foods that are no longer in their original containers/packaging are labeled with common name and dated with preparation or expiration date and./or time by which they must be served or discarded...." On 4/12/2023 at 8:00 A.M., the Administrator provided the policy titled,"Contamination Prevention In Food Storage & Preparation". The policy indicated"...All leftover food must be labeled, dated and consumed within 3 days of preparation... If equipment in used is soiled with food residue, bacteria an begin to accumulate. For this reason, this type of equipment must be completely cleaned and sanitized on a regular schedule. Equipment, utensils and contact surfaces must be properly cleaned and sanitized at the following times: Before food preparation. When going from raw to cooked or RTE products...." On 4/12/2023 at 12:00 P.M., the Administrator provided the policy titled,"Culinary Sanitation". The policy indicated"...1. Equipment, utensils, and contact surfaces must be properly cleaned and sanitized before food preparation... 3. All kitchen equipment must be cleaned regularly in			

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	accordance with the Culinary Cleaning Log..." 410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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.			
R 0300 Bldg. 00	Based on observation, interview, and record review, the facility failed to date medications when opened, failed to have resident identifiers (pharmacy label) on ear and eye drop bottles, failed to ensure a medication refrigerator was free from a build up of ice, and failed to store a narcotic medication in a safe manner in 1 of 1 medication room and 2 of 2 medication carts observed. (300/400 Hall medication cart & 100/200 Hall medication cart) Findings include: 1. During a medication storage observation, on 4/12/2023 at 10:40 A.M., with LPN 2 on the 300/400 medication cart, the following was observed: an opened and undated bottle of eye drops with no resident identifiers and an opened and undated bottle of ear drops with no resident identifiers. 2. In the medication room, the following was observed: in the medication refrigerator there was an opened undated vial of tubersol and a build up of ice in the freezer of the refrigerator. There were 2 bottles of normal saline that expired on 2/1/2023 and 3 boxes of glucose test strips that expired on 3/31/2023. There was no temperature gauge present in the fridge at the time. 3. A Daily Refrigerator Temperature Control Log	R 0300	· **No residents were found to have been affected by the deficient practice, but all residents have the potential be affected.** · **The eyedrops, eardrops, tubersol, saline, and glucose test strips were disposed of per policy. The medication refrigerator was replaced and a temperate gauge added. A new Daily Refrigerator Temperature Control Log was created to prompt staff to notify the Director of Maintenance of any abnormal temperatures.** · All clinical employees (Including LPN2 and QMA4) and the Director of Nursing were in-serviced on the following policies 1) Medication Services 2) Expired Medications 3) Medication Storage of Centrally Stored Medications including Locked Storage of All Medications 4) Daily Refrigerator Temperature Control Log procedure · **The Director of Nursing or Designee will audit for 1) Proper medication storage and**	05/05/2023

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	sheet, dated March 2023 through April 2023, included the date of recording, Results (36 to 40 degrees), and a comment section, and indicated the temperatures of the medication refrigerator were documented as followed: On March 1/1 through 1/7, 1/9 through 1/12, 1/14 through 1/16, 1/18, 1/20 through 1/22, 1/25, and 1/30 & 1/31/2023 the temperature was documented at 30 degrees. On 1/8, 1/19 and 1/23/2023 the temperature was documented at 28 degrees, and on 1/13/2023 the temperature was documented at 32 degrees. All dates listed on the form for March lacked any comments of the abnormal temperatures. The temperatures documented for April 2023 were as follows: On 4/4, 4/9, and 4/10/2023 the temperature was documented at 30 degrees. On 4/6/2023 the temperature was documented at 33 degrees. On 4/7/2023 the temperature was documented at 34 degrees and on 4/8/2023 the temperature was documented at 28 degrees. All dates listed on the form for April lacked any comments of the abnormal temperatures. 4. During a medication administration on 4/12/2023 at 11:13 A.M., QMA 4 handed resident 10 her glass of water and a medicine cup. The water got spilled on the resident and the medicine cup, with the 2 medications Gabapentin (nerve pain medication) and a Oxycodone (narcotic) landing on the floor. QMA 4 picked up the pills and indicated she would get new pills to give to the resident. QMA 4 placed the medicine cup with the dirty pills in the medication cart and indicated when the nurse comes by, she will have her signed that the pills will be destroyed. LPN 2 walked to the medication cart and QMA 4 removed the medicine cup and explained to LPN 2 what had happened and indicated they needed to be destroyed. QMA 4 locked the medication cart		**labeling 2) Medication Refrigerator Temperatures 3) Expired Supplies and/or Medications and 4) Locked Storage of All Medications.** **The Executive Director will ensure completion and oversite of audit findings. Quarterly, the Quality Assurance Committee will review the audits and verify completion to validate ongoing compliance.** **The Quality Assurance Committee will review the audits and findings through the next annual survey cycle.** **· Date Systemic Changes Completed: 05/05/2023**	

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	and proceeded to administer the new medications to the resident. When QMA 4 returned to the medication cart, the medicine cup with the spilled medications was sitting on top of the medication cart with a non nursing staff member and another resident right beside the cart. During an interview, on 4/12/2023 at 11:18 A.M., QMA 4 indicated " she left them on the cart". She indicated the medications should have been locked up in the med cart. On 4/12/2023 at 12:00 P.M., the Administrator provided the policy titled,"Medication Services". The policy indicated"...d. Over-the-counter medications, prescription drugs, and biological's used in the facility must be labeled in accordance with currently accepted professional principles...." On 4/12/2023 at 12:00 P.M., the Administrator provided the policy titled,"Expired Medications". The policy indicated"...1. Expired medication are not used. 2. All Nurses/QMA's are to confirm expiration dates of medications during the medication pass...." On 4/12/2023 at 12:00 P.M., the Administrator provided the policy titled,"Medication Storage of Centrally Stored Medications". The policy indicated"... 1. All medications, including over-the - counter (OTC), are kept in locked storage at all times... 3. Medication requiring refrigeration is stored in a separate refrigerator that is used solely for medication storage. Temperature is to be between 36 and 42 degrees F. a). The refrigerator temperature is to be checked daily. b). If the temperature results are outside of the required parameters, the Community staff will notify the Maintenance Director, in accordance with Community safety guidelines..."			

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R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed when completing a blood sugar check during 1 of 2 medication observations. (Resident 9) Finding includes: During a medication pass observation, on 4/12/2023 at 7:20 A.M. with LPN 2, the following was observed: LPN 2 applied gloves, wiped Resident 9's finger with an alcohol pad, then with an opened hand she fanned the area she had just cleansed with the alcohol pad. LPN 2 went to the medication cart and retrieved the insulin pen and before going back into the resident's room, another resident approached LPN 2 and informed her that a piece of her finger had fallen off. LPN 2 stated the resident had suffered frost bite. LPN 2 held this resident's hand and moved her fingers around it to assess the skin. She then went back into Resident 9's room, applied gloves and administered the insulin injection. LPN 2 did not wash her hands	R 0407	**-No residents were found to have been affected by the deficient practice, but all residents have the potential to be affected.** **-All clinical employees (Including LPN2) and the Director of Nursing were in-serviced on 1) Infection Control Practices Including Handwashing and PPE Use When Completing Blood Sugar Checks** **-The Director of Nursing or Designee will audit Infection Control Practices Including Handwashing and PPE Use during Blood Sugar Checks.** **The Executive Director will ensure completion and oversite of audit findings. Quarterly, the Quality Assurance Committee will review the audits and verify completion to validate ongoing compliance.**	05/01/2023

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	prior to applying the gloves after touching another resident's hand. During an interview, on 4/12/2023 at 7:26 A.M., LPN 2 indicated she did not know they were not supposed to "do that" (fanning the area) and indicated she should have washed her hands before applying gloves. On 4/12/2023 at 12:00 P.M., the Administrator provided the policy titled, " Infection Control 04-Personal Protective Equipment (PPE)". The policy indicated..." 3. Gloves a). Wear gloves for all resident care/contact and/or tasks where the potential for contact with blood, secretions, or other body fluids may exist...."		**The Quality Assurance Committee will review the audits and findings through the next annual survey cycle.** **Date Systemic Changes Completed: 05/01/2023**	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure an annual health statement from the physician was obtained on admission and yearly thereafter for 5 of 8 residents whose clinical records were reviewed. (Residents 3, 6, 8, D & E) Findings include: 1. A clinical record review was completed on 4/11/2023 at 2:15 P.M. Resident 3's diagnoses included, but were not limited to depression, heart failure, chronic obstructive pulmonary disease. Resident 3's clinical record lacked the	R 0409	· **The physicians for residents 3, 6, D, and E were contacted and completed the annual health statement which included the residents being free from tuberculosis in an infectious state. Resident 8 no longer resides in the community.** · **All current resident files were audited to verify completion of the annual health statement including the residents being free from**	05/05/2023

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	documentation of an annual health statement of being free from tuberculosis in an infectious state. 2. A clinical record review was completed on 4/12/2023 at 9:17 A.M. Resident 6's diagnoses included, but were not limited to diabetes, osteoporosis, hypertension and hyperlipidemia. Resident 6's clinical record lacked the documentation of an annual health statement of being free from tuberculosis in an infectious state. 3. A closed record review was completed on 4/12/203 at 11:45 A.M. Resident 8's diagnoses included, but were not limited to hypertension, asthma, peripheral vascular disease and hypothyroidism. Resident 8's clinical record lacked the documentation of an annual health statement of being free from tuberculosis in an infectious state. 4. A clinical record review was completed on 4/11/2023 at 2:28 P.M. Resident D's diagnoses included, but were not limited to depression, chronic obstructive pulmonary disease and sleep apnea. Resident D's clinical record lacked the documentation of an annual health statement of being free from tuberculosis in an infectious state. 5. A clinical record review was completed on 4/11/2023 at 3:25 P.M. Resident E's diagnoses included, but were not limited to hypertension, spinal stenos, osteoarthritis, and fibromyalgia. Resident E's clinical record lacked the documentation of an annual health statement of being free from tuberculosis in an infectious state.		**tuberculosis in an infectious state.** **· The Director of Nursing and Resident Care Coordinator were in-serviced on annual health statement completion by a physician that includes a statement the resident is free from tuberculosis in an infectious state.** **· A tracking system was created to ensure completion of the annual health statement by the physician that includes a statement the resident is free from tuberculosis in an infectious state. The Director of Nursing or Designee will audit the tracking system. The Executive Director will ensure completion and oversite of audit findings. Quarterly, the Quality Assurance Committee will review the audits and verify completion to validate ongoing compliance. The Quality Assurance Committee will review the audits and findings through the next annual survey cycle.** **· Date Systemic Changes Completed: 5/5/2023**	

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	During an interview, on 4/11/2023 at 3:38 P.M., the Administrator indicated the clinical records did not have the annual health statement and should have. On 4/12/2023 at 8:00 A.M., the Administrator provided the policy titled,"Resident Pre-Admission Appraisal". The policy indicated"...5. b. Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter...."			