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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FIVE STAR RESIDENCES OF CLEARWATER	4519 EAST 82ND STREET INDIANAPOLIS, IN 46250

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00420876. Complaint IN00420876 - No deficiencies related to the allegations are cited. Survey dates: July 1 and 2, 2024 Facility number: 014016 Residential Census: 61 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 8, 2024.	R 0000	**432520** This plan of Correction constitutes Five Star Residences of Clearwater's written allegation of compliance for the alleged deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Five Star Residences of Clearwater respectfully requests a desk review for this Plan of Correction. Alleged date of compliance is August 1st, 2024.	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to ensure weights were obtained per policy for 1 of 6 resident records reviewed. (Resident 34) Findings include:	R 0091	R_0091 Administration and Management- Noncompliance 1. Corrective action for those residents affected	08/01/2024

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

Shane Patterson | Executive Director | 08/21/2024

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	The clinical record for Resident 34 was reviewed on 7/1/24 at 1:30 p.m. The diagnosis for Resident 34 included, but was not limited to, hypertension. The weights log for Resident 34 indicated the resident's weight was not obtained in March 2024 or May 2024. An interview was conducted with Qualified Medication Aide (QMA) 1 on 7/1/24 at 2:50 p.m. She indicated the residents' weights should be obtained once a month. An interview was conducted with the Director of Nursing (DON) on 7/2/24 at 10:18 a.m. She indicated she was unable to provide weights that had been obtained, in March or May of 2024, for Resident 34. The weights should be recorded in the weights tab in the residents' medical chart. A "Monitoring Resident Weight Changes" policy was provided by the Executive Director on 7/2/24 at 9:38 a.m. It indicated "...IV. Provision(s) and Procedure(s) A. Resident weights are measured upon admission to obtain a baseline and then are obtained monthly thereafter..."		Resident #34 chart was reviewed. The community implemented the use of a form of record for specific residents to be weighed on day, evening, and night shift according to their availability of daily routine. These forms have instruction of weights and vital signs to be recorded within the first five days of each month. 1. measure to identify and correct this problem for residents with the potential of being affected: The above listed information contained in the above mentioned forms will be audited on the 6th day of the month for quality assurance. If the 6th day of the month is on a weekend, it will be audited the first Monday following. 2. Systematic Change: Director of Nursing or designated personel will provide these forms at the end of previous month for availability of the current month and be placed in the Resident Assistant's office in a clear an noticed location. 3. Monitoring: Director of Resident Care of designee will visual look at documented progress of weight and vital signs obtainment daily until all entries are completed. This manner of daily review will be conducted each 5th day of each month for the next 5 months, then periodic auditing during first 5 days of each month for the next 7 months.	

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			Compliance date 8/1/24	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a staff person, on every shift, was certified in Cardiopulmonary Resuscitation (CPR) and First Aid. This had the potential to affect 61 of 61 residents that reside in the facility. Findings include: The staff schedule, as worked, dated 6/24/24 to 6/29/24, was reviewed on 7/2/24 at 2:00 p.m. It indicated the following days and shifts the facility	R 0117	R_0117 Administration and Management- Noncompliance 1. Corrective action for those residents affected CPR/BLS certification classes held 7/9/2024 and again on 8/6/2024. Classes were mandatory for all QMA and LPN positions and optional for all other	08/06/2024

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	did not have a staff person each shift working that was CPR and First Aid certified: - Sunday, 6/23/24 - day, evening or night shift - no staff were CPR or First Aid certified, - Monday, 6/24/24 - day, evening or night shift - no staff were CPR or First Aid certified, - Tuesday, 6/25/24 - day and evening shift - no staff were First Aid certified, - Wednesday, 6/26/24 - day and evening shift - no staff were First Aid certified and night shift - no staff person was certified in CPR or First Aid, - Thursday, 6/27/24 - day and evening shift - no staff were First Aid certified, and night shift - no staff person was certified in CPR or First Aid, - Friday, 6/28/24 - day shift - no staff were First Aid certified, and night shift no staff person was certified in CPR or First Aid, and - Saturday, 6/29/24 - day, evening or night shift - no staff were CPR or First Aid certified. An interview was conducted with the Executive Director on 7/2/24 at 2:07 p.m. He indicated he was unable to provide documentation a staff person worked on 6/21/24 - 6/29/24 on each shift that was certified with CPR and First Aid.		staff. 1. measure to identify and correct this problem for residents with the potential of being affected: Documentation of completion of class given to Director of Resident Care and Business Office Manager to upload in "Workday" digital application. 2. Systematic Change: Director of Resident Care will maintain hard copies of certifications and Business Office Manager will upload documentation of completion in "Worday" digital application. 3. Monitoring: "Workday" Digital Application notifies Business Office Manager and Executive Director of any renewal needs 30 days prior to expiration. Director of Nursing will conduct a manual audit of hardcopies first working day of the month to identify any renewal needs of certification. Employee will be given notification of expiratiion minimum 30 days prior to expiration date to renew or not be allowed work until obtained.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention,			

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	safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on interview and record review, the facility failed to assure a staff member had Resident Rights and Dementia annual training for 1 of 5 staff members reviewed. Home Health Aide (HHA) 2 Findings include: The Employee Records form was provided by the	R 0120	R_0120 Personnel-Noncompliance 1. Corrective action for those residents affected Mandatory In-service scheduled for all staff	08/15/2024

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	Executive Director on 7/2/24 at 10:20 AM. The form indicated HHA 2 began working at the facility on 5/5/22. An interview was conducted with the Business Office Manager (BOM) on 7/2/24 at 1:55 PM. She indicated she was unable to provide verification of HHA 2's annual Residents Rights and Dementia training. The User Learning file for HHA 2 was reviewed on 7/2/24 at 1:55 PM. The record indicated the most recent resident rights training was completed 3/31/23 and the most recent dementia training was 5/31/23.		1. measure to identify and correct this problem for residents with the potential of being affected: Dementia specific training schedule each month to scheduled monthly town halls for minimum of 30- 45 mins/ month accumalating to minimyum of 8 hours per year 2. Systematic Change: All monthly staff mandatory in-services will contain a portion of meeting designated for dementia-specific training that equals a minimum of 8 hours annually to supplement assigned continuing education in each employee's digital file. 3. Monitoring: Attendance at these meetings wil be taken and the participation of receiving the education will be assured each direct supervisor. If an absence of this training is observed, the immediate supervisor will be responsible to educate the individual no later than end of month. Executive Director will monitor attendance first working day of following month for quality assurance. This will be done monthly.	
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			

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	accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to keep kitchen equipment maintained and in good repair by not ensuring the ice machine was cleaned and sanitized at least every 6 months, having ice buildup along the door seals on the reach in freezer, and missing the protective, plastic handle guard for a reach in freezer. This had the potential to affect 61 of 61 residents who reside in the facility. (Facility) Findings include: A kitchen tour was conducted, on 7/1/24 at 9:55 a.m., with Dietary Manager (DM). During the tour, the following was observed: 1. The kitchen ice machine was found not to have a log of when it was cleaned and sanitized last. The DM indicated, at the same time as the observation, she had not cleaned and/or sanitized the ice machine as she was unaware of how to open the ice machine to perform the cleaning and sanitation. An interview with the Executive Director (ED) conducted, on 7/1/24 at 3:22 p.m., indicated they have not cleaned inside the ice machine. An Installation and User's Manual for the facility's ice machine was received on 7/1/24 at 1:18 p.m. The manual indicated, the frequency of cleaning and sanitizing the ice machine was "Recommended minimum time between cleanings is 6 months. To aid in determining if the machine has not been cleaned in 6 months, a Time To Clean light will glow after 6 months of power up time. Cleaning the machine with the following process will reset that light and the time that	R 0154	/p> 1. Corrective action for those residents affected Staff inservice scheduled 8/15/2024 for all Dining Staff. Daily and weekly cleaning checklist developed for signatures showing completion 7/9/24. Monthly Sanitation Audit 8/4 conducted and uploaded to TELS facility management application. Repairs needed to freezer (handle and seal) reported for repair 8/5. 1. measure to identify and correct this problem for residents with the potential of being affected: The above mentioned forms will be utilized by appropriate staff members to identify any current and/ or future findings needing resolution. 2. Systematic Change: Daily and weekly cleaning checklist developed for signatures showing completion 7/9/24. Monthly Sanitation Audit 8/4 conducted and uploaded to TELS facility management application. Repairs needed to freezer (handle and seal) reported for repair 8/5.	08/05/2024

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	controls it. More frequent cleanings may be required based on the mineral content of the water, run time and potential airborne contamination." 2. The kitchen's reach in freezer, near the dishwasher, had condensation build-up on the exterior of one of the doors and when the doors were opened, it was observed to have ice built up on the freezer's door seals at the top and bottom. 3. The reach in freezer's plastic, protective handle guard was missing exposing a sharp metal edge. A Food Safety in Receiving and Storage policy received, on 7/1/24 at 1:18 p.m., indicated "Cold Food Storage 1. The doors on the cold storage units are kept shut as much as possible. Door seals are checked periodically to confirm they are sealed properly."		3. Monitoring: daily audit conducted by server and cook and recorded on hard copy and filed. weekly audit of proper storage and kitchen sanitation completed per Food and Beverage Director and kept on hard file. Monthlly Sanitation Audit completed per Executive Director or designee and uploaded in TELS facility Management application. Audits continue in pertuity.	
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.			

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	(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure residents' service plans were signed by the resident and/or representatives for 5 of 6 residents' records reviewed. (Residents' 1, 22, 34, 62 and 73) Findings include: 1. The clinical record for Resident 1 was reviewed on 7/1/24 at 2:28 p.m. The diagnoses included, but were not limited to, heart failure and diabetes. Resident 1's clinical record contained a service plan, last updated 4/15/24. The service plan did not contain the signature of the resident or their representative. 2. The clinical record for Resident 22 was reviewed on 7/1/24 at 1:41 p.m. The resident's diagnoses included, but were not limited to, hypertension and chronic kidney disease. Resident 2's clinical record contained a service plan, last updated on 4/15/24. The service plan did not contain the signature of the resident or their representative.	R 0217	/p> 1. Corrective action for those residents affected Immediate audit and completion of all signed service plans from resident/ POA. 1. measure to identify and correct this problem for residents with the potential of being affected: Tracking of date for appropriate updates to existing service plan in PoinClickCare digital application. 2. Systematic Change: Resident and/ or POA to be contacted at time of establishment or change to service plan and invited to review. Once reviewed, record of agreement documented in	07/13/2024

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	During an interview, on 7/2/24 at 11:00 a.m., the DON (Director of Nursing) indicated there were no signed service plans for Resident 1 or Resident 22 prior to 7/1/24. 3. The clinical record for Resident 62 was reviewed on 7/1/24 at 2:05 p.m. The diagnosis included, but was not limited to, chronic kidney disease. Resident 62 was admitted to the facility on 2/13/22. A service plan, dated 3/25/22, for Resident 62 did not include the resident or representative signature. An interview was conducted with the DON on 7/2/24 at 10:25 a.m. She provided a signed copy of the Service Plan with date initiated, 2/27/22, and revision date of 3/25/22. She indicated Resident's 62's service plan had not been signed by resident or representative until 7/1/24. 4. The clinical record for Resident 34 was reviewed on 7/1/24 at 1:30 p.m. The diagnosis for Resident 34 included, but was not limited to, hypertension. The resident's service plan, revision date of 6/18/24, did not include a signature by the resident and/or representative. 5. The clinical record for Resident 73 was reviewed on 7/1/24 at 3:30 p.m. The diagnosis included, but was not limited to, dementia. The resident's service plan, dated 2/7/24, did not include a signature by the resident and/or representative. An interview was conducted with the DON on 7/2/24 at 9:55 a.m. She indicated Resident 34 and Resident 73's service plans were not signed by the residents nor their representatives.		PoinCLickCare digital application. 3. Monitoring: Regional Director of Health and Wellness will audit minimum of 1x/ week for any past due or incomplete service plans without digital or manual signature of receiving party. This regional review will be weekly in pertuity and notification will be communicated to Director of Resident Care and/ or Executive Director for obtainment of missing signature(s).	

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	A service plan policy was provided by the Executive Director on 7/2/24 at 9:35 a.m. It indicated, "...I. Policy Statement. This policy provides guidelines on documenting, via individualized service plans, the services required and provided to individual residents, including Activities of Daily Living ("ADLs"), Instrumental Activities of Daily Living ("IADLs"), medication assistance and other personal care needs...IV. Provision(s) and Procedure(s)...B. The resident (and family/caregiver if desired by the resident) is involved in all aspects of the assessment and service planning process. A meeting is held with the resident (family/caregiver) to review and sign the service plan. Community team members are involved in the review process as appropriate..."			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to administer insulin, as ordered by the physician, for 1 of 5 records reviewed for medication administration. (Resident 1) Findings include: The clinical record for Resident 1 was reviewed on 7/1/24 at 2:28 p.m. The diagnoses included, but were not limited to, heart failure and diabetes. A service plan, initiated 10/17/23, indicated that Resident 1 needed staff assistance for medication administration. The goal was for him to receive his medications safely and as prescribed. The interventions were for staff to monitor the	R 0240	Immediate Action: Review and education to staff of policy CL-AL-PRO-8000 and audit of MARs for descrepancies and nursing schedule if discrepancy is found for individual re-training. ="" p <="" p1.="" corrective="" action="" for="" those="" residents="" affected<="" pimmediate="" review="" and="" education="" of="" "diabetes,="" insulin="" blood="" glucose="" management"="" policy="" with="" all="" qma's="" lpns="" certified.<="" measure="" to="" identify="" correct="" this="" problem="" the="" potential=""	07/12/2024

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	medications for effectiveness, side effects, and interactions, initiated 10/17/23, and that staff administered medications for him, initiated on 10/17/23. A physician's order, dated 5/30/24, indicated Resident 1 was to receive Novolin 70-30, 30 units injected subcutaneously, each evening. The June 2024 MAR (Medication Administration Record) did not contain documentation that the Novolin 70-30 was administered, at 4:00 p.m., on the following days: 6/1, 6/2, 6/4, 6/13, 6/14, and 6/27/24. During an interview, on 7/2/24 at 10:40 a.m., the DON (Director of Nursing) indicated the staff should sign the MAR when medication has been administered.		being="" affected: ="" individual="" above="" listed="" appropriate="" staff="" live="" observation="" administration="" documentation="" from="" director="" resident="" care.<="" p2.="" systematic="" change:="" care="" will="" observe="" any="" member="" administering="" upon="" hire="" at="" time="" annual="" merit="" approved="" skill="" set.<="" p3.="" monitoring:="" monitor="" weekly =" x="" 4weeks,="" biweekly="" 4="" weeks,="" monthly="" 2="" months. ="" set="" check="" off="" be="" conducted="" annually="" hire.<="" p="">1. measure to identify and correct this problem for residents with the potential of being affected: In-service of all related staff of policy CL-AL-PRO-8000 and demonstration of administration of insulin with supervision of Director of Resident Care. 2. systematic change: All pertinant staff will be required to succesfully demonstrate the administration and documentation of insulin administration including MAR and Blood Glucose Record to Director of Resident Care using the tool, Duty Area 2.1 (a)Evaluation (CL-AL-PRO-1002.App A.F1) Any new hire will also be required to successfully demonstrate proficiency in documentation and	

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FIVE STAR RESIDENCES OF CLEARWATER	4519 EAST 82ND STREET INDIANAPOLIS, IN 46250

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			administration of insuling using these same tools listed above. 3. monitoring: Director of Resident Care, or designated personell will audit each resident MAR and Glucose Record weekly for 3 months, monthly for the next 3 months, and PRN thereafter. Education and Corrective Action will be utilized if any discrepancy is found after re-assessing any affected resident.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure appropriate authorization for administration of PRN (as needed) medication by a Qualified Medication Aide (QMA) for 1 of 6 records reviewed. (resident 62) Findings include: The clinical record for Resident 62 was reviewed on 7/1/24 at 10:55 AM. The diagnosis included, but was not limited to, chronic kidney disease. A physicians' order, dated 2/27/23, was written for "Clonidine HCL [hydrochloride] [blood pressure medication] 0.1 mg [milligrams] tablet. Give 1 tablet	R 0246	Immediate Action: Review and education to staff of policy Medication Administration Guidelines and audit of MARs for descrepancies and nursing schedule if discrepancy is found for individual re-training. ="" p <="" p1.="" corrective="" action="" for="" those="" residents="" affected<="" pimmediate="" review="" and="" education="" of="" "diabetes,="" insulin="" blood="" glucose="" management"="" policy="" with="" all="" qma's="" lpns=""	07/12/2024

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	by mouth every 8 hours as needed for SBP >170 [systolic blood pressure greater than] or DBP > 100 [diastolic blood pressure greater than]." The May 2024, MAR (Medication Administration Record), indicated a dose of Clonidine 0.1 mg was administered, on 5/14/24, by QMA 3 for SBP 181 without a nurse authorization or assessment. The back side of the MAR had no markings or writing, dated 5/14/24, that indicated a dose had been administered by date/hour, dosage/route, reason, results/response, and hour/nurse signature. The May 2024, MAR, indicated a dose of Clonidine 0.1 mg was administered, on 5/24/24, by QMA 5 for SBP 182 without a nurse authorization or assessment. The back side of the MAR had no markings or writing, dated 5/24/24, that indicated a dose had been administered by date/hour, dosage/route, reason, results/response, and hour/nurse signature. The June 2024, MAR, indicated a dose of Clonidine 0.1 mg was administered, on 6/28/24, by QMA 3 for an unknown blood pressure documented on the front side of the MAR without a nurse authorization or assessment. The back side of the MAR had no markings or writings, dated 6/28/24, that indicated a dose had been administered by date/hour, dosage/route, reason, results/response, and hour/nurse signature. On 7/2/24 at 3:27 PM, the Blood Pressure (B/P) log dated, May 2024 and June 2024, was provided by the Executive Director (ED). The B/P's logged for the dose of Clonidine 0.1 mg administered by QMA 3, on 5/14/24, indicated B/P for AM (morning) was 191/95, 2:00 PM B/P was scribbled out and illegible, PM (evening) B/P was 151/69. The B/P's logged for the dose of Clonidine 0.1 mg		certified.<="" measure="" to="" identify="" correct="" this="" problem="" the="" potential="" being="" affected: =" individual="" above="" listed="" appropriate="" staff="" live="" observation="" administration="" documentation="" from="" director="" resident="" care.<="" p2.="" systematic="" change:="" care="" will="" observe="" any="" member="" administering="" upon="" hire="" at="" time="" annual="" merit="" approved="" skill="" set.<="" p3.="" monitoring:="" monitor="" weekly =" x="" 4weeks,="" biweekly="" 4="" weeks,="" monthly="" 2="" months. ="" set="" check="" off="" be="" conducted="" annually="" hire.<="" p="">"> 1. measure to identify and correct this problem for residents with the potential of being affected: In-service of all related staff of policy Medication Administration Guidelines. 2. systematic change: All Qualifed Medication Aides have been educated since survey to notify Director of Resident Care or appointed designee prior to the administration of any PRN medication. Director of Resident Care or appointed designee will audit documentation from QMA that approval was granted for administraion upon the next worked shift.	

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	administered by QMA 5, on 5/24/24, indicated B/P for AM (morning) was 182/78, patient was out of facility for 2:00 PM (afternoon) B/P, PM (evening) B/P was 141/84. The B/P's logged for the dose of Clonidine 0.1 mg administered by QMA 3, on 6/26/24, indicated B/P was 186/84, patient was out of facility for 2:00 PM (afternoon) B/P, and the log for the PM (evening) B/P was blank. On 7/2/24 at 2:29 PM, an interview was conducted with the Director of Nursing (DON). She indicated that a nurse should have authorized and assessed Resident 62 prior to administration of the PRN medication. She provided a policy titled "Medication Management Guidelines", that indicated the following, "PRN medication is administered by a QMA upon authorization by a licensed nurse. The nurse's authorization is documented on the back of the MAR. If the authorization is provided by a licensed nurse who is not on the premises (by telephone), the authorization is also documented in the nurses notes to include the time and date of the contact/authorization".		3. monitoring: Director of Resident Care, or designated personell will audit each affected resident's documentation after approving administration of PRN on the following worked shift for 3 months, monthly for the next 3 months, and PRN thereafter. Education and Corrective Action will be utilized if any discrepancy is found after re-assessing any affected resident. ="" p <="" p1.="" corrective="" action="" for="" those="" residents="" affected<="" pimmediate="" review="" and="" education="" of="" "="" medication="" administration"="" policy="" with="" all="" qma's="" lpns="" .<="" measure="" to="" identify="" correct="" this="" problem="" the="" potential="" being="" affected: ="" individual="" above="" listed="" appropriate="" staff ="" from="" director="" resident="" care.<="" p2.="" systematic="" change:="" care="" will="" designate="" a="" lpn="" "on="" call"="" position="" when="" drc="" is="" not="" available="" receive="" calls="" needing="" permission="" prn="" administration="" medications.<="" p3.="" monitoring:="" monitor="" documentation="" weekly ="" x="" 4weeks,="" biweekly="" 4="" weeks,="" monthly="" 2="" months. <="" p="">	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to, an unclean meat slicer, unlabeled food, opened items without opened dates in the coolers and freezer, improper stacking of clean trays and bowls, food left open to air, and the general cleanliness of the kitchen. This had the potential to affect 61 of 61 residents who consumed food from the kitchen. (Facility) Findings include: A kitchen tour was conducted, on 7/1/24 at 9:55 a.m., with Dietary Manager (DM). During the tour, the following was observed: In the general Kitchen: -Trash containers not in use did not have lids tightly affixed and a trash can with an automatic lid was stuck in the open position related to overflowing trash. - Glass bowls and stacks of plastic trays were stored facing upwards allowing dust and/or debris to collect on inside/upright surfaces. - Floors were sticky and dirty with debris under racks and equipment. - The meat slicer which had been covered by a plastic bag still had dried debris and crumbs on and around it. - Opened containers of spices did not have opened dates and the onion powder, crushed red pepper flakes, ground cumin and garlic & herb	R 0273	1. Corrective action for those residents affected Staff inservice scheduled 8/15/2024 for all Dining Staff. Daily and weekly cleaning checklist developed for signatures showing completion 7/9/24. Monthly Sanitation Audit 8/4 conducted and uploaded to TELS facility management application. Repairs needed to freezer (handle and seal) reported for repair 8/5. 1. measure to identify and correct this problem for residents with the potential of being affected: The above mentioned forms will be utilized by appropriate staff members to identify any current and/ or future findings needing resolution.2. Systematic Change: Daily and weekly cleaning checklist developed for signatures showing completion 7/9/24. Monthly Sanitation Audit 8/4 conducted and uploaded to TELS facility management application. Repairs needed to freezer (handle and seal) reported for repair 8/5.3. Monitoring: daily audit conducted by server and cook and recorded on hard copy and filed. weekly audit of proper storage and kitchen sanitation completed per Food and Beverage	08/15/2024

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	containers were left open to air. - The stove hood had dust stuck to it and appeared fuzzy. - A lemon juice bottle on the shelf by the spices was previously opened but did not have an opened date and was left out after its last use. The warm lemon juice bottle indicated, "Refrigerate after opening". - A container of sliced tomatoes on the counter was left open to air and was not in use at the time. - A container of wilted lettuce on the counter was left open to air and was not in use at the time. In the mini fridge: - Two stacks of what appeared to be previously opened cheese slices did not have labels or open dates. - The inside of the mini fridge had food debris smeared in it. - An opened bottle of salad dressing had no label or open date. - An opened bottle of chocolate sauce had no label or open date. In the reach in cooler near the dishwasher: - Two opened containers of liquid whole eggs did not have open dates. - A small piece of what was identified by DM as banana bread was wrapped in clear plastic wrap and did not have a label affixed or a use by date. - An open container of chicken base had no open date. - A black container with what was identified as tuna salad by DM had a use by date, of 6/27, written on a sticker. The sticker did not list the name of its contents. - A cardboard box containing strips of uncooked bacon did not have an open date on it.		Director and kept on hard file. Monthlly Sanitation Audit completed per Executive Director or designee and uploaded in TELS facility Management application. Audits continue in pertuity.	

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	In the reach in freezer near the dishwasher: - A previously opened bag of frozen biscuits had no open date or identification label affixed. - An opened box containing a frozen cheesecake was found to have the plastic wrap around the cheesecake ripped opened and one piece was missing. The cheesecake was left open to air. - A previously opened plastic bag of fajita vegetables did not have an open date. - A previously opened plastic bag of chicken patties did not have an open date. - Two large metal trays with frozen mini pizzas on them had no label or use by date. - A previously opened bag of waffle fries had no label or open date. In the dry storage area: - A bulk container of flour did not have a use by date. - The bulk container lids for the flour and sugar were dirty with food debris on them. In the food prep fridge: - A bag with what was identified as an employee's lunch was located under two large bags of shredded cheese. - A bag of mint leaves was found to be left open to air. A Food Safety in Receiving and Storage policy received, on 7/1/24 at 1:18 p.m., indicated "Storage...Food is stored in its original packaging as long as the packaging is clean, dry and intact. 3. Food that is repackaged is placed in a leak proof, pest proof, non absorbent, sanitary container with a tight fitting lid. The container is			

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	labeled with name of the contents and dated with the date it was transferred to the new container...Dry Storage...Open packages are resealed tightly to prevent contamination and dated with the open date...All food storage bins or container are maintained in clean condition and labeled with the contents...All canned and packaged goods have a one year expiration after delivery..." 410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure a transfer form was sent for a resident being transferred to an acute care hospital for 1 of 2 residents reviewed for discharge. (Resident 61). Findings include: The clinical record for Resident 61 was reviewed 7/2/24 at 1:30 p.m. The resident's diagnoses	R 0354	R-0354 Clinical Records-noncompliance 1. Corrective action for those residents affected: the community has implemented the following two forms to be completed at any time a resident shall transfer or discharge from community: State Form 49669 "Notice of Transfer or Discharge" and also in-house form	08/15/2024
R 0354 Bldg. 00				

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	included, but were not limited to, hypertension and diabetes. A progress note, dated 6/3/24 at 10:50 a.m., indicated that Resident 61 was found on the floor with her legs out in front of her. Emergency services were called, and Resident 61 was sent to an acute care hospital. The clinical record did not contain information that a transfer form was sent with Resident 61 to the acute care hospital. During an interview, on 7/2/24 at 2:10 p.m., QMA (Qualified Medication Aide) 1 indicated that a transfer form, a copy of the face sheet, medication administration records, and labs should have been sent with Resident 61 when she was transferred to the hospital. During an interview, on 7/2/24 at 3:38 p.m., the DON (Director of Nursing) indicated that the facility did not have a policy regarding transfer forms, but that a transfer form should be sent with residents who are sent to the hospital.		"Transfer Form" wich collects the following information: Identification Data, Name of Resident, Name of Tranferring institution name of receiveing institution date of transfer, Resident's personal property when transferred to an acute care facility, nurse's notes will accompany these two forms stating the following: Functional abilities and physical limitations, nursing care, medications, treatment, current diet and condition to transfer. A diagnosis and date of chest xray and skin test for tuberculosis will also accompany this information. 1. Measures to identify and correct this problem for residents with the potential of being affected: the above listed inforation contained in the above mentioned forms will be accompanied with a note in the resident chart that states that these forms were completed and that the resident was provided with such forms. 2. Systemic Change: These forms will be provided to each resident upon any transfer or discharge with notation in nursing notes of such forms being given. 3. Monitoring:A quality improvement revidw will be conducted by the Director of Resident Care to designee to insure that this new method of documenting forms were provided the two discharge/ transfer to any resident discharging or transferring from the	

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			community with notation in nursing notes is in compliance and gfollowed. This review will be conducted weekly for four weeks, biweekly for 4 weeks, monthly for 2 months.	
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 maintain an infection control program by not changing gloves after touching potentially contaminated surfaces, and then touching food with the same gloved hands, during a kitchen observation for food service. This had the potential to affect 61 of 61 residents who eat food from the kitchen. (Facility) Findings include: An observation of food service was conducted on 7/1/24 at 11:07 a.m. Kitchen staff (KS) 4 was observed to have donned (put on) a pair of gloves, touched the food prep fridge's handle as she opened and closed the fridge, reached into a bag of onions and took an onion out and placed it on a cutting board. KS 4 sliced some of the onion	R 0407	1. Corrective action for those residents affected Staff inservice scheduled 8/15/2024 for all Dining Staff. Daily and weekly cleaning checklist developed for signatures showing completion 7/9/24. Monthly Sanitation Audit 8/4 conducted and uploaded to TELS facility management application. Repairs needed to freezer (handle and seal) reported for repair 8/5. 1. measure to identify and correct this problem for residents with the potential of being affected: The above mentioned forms will be utilized by appropriate staff members to identify any current and/ or future findings needing	08/15/2024

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	and tomato, with the same gloved hands, and then reached into a bag of buns to remove a bun. KS 4 then went over towards a container of hamburger patties and picked up the spatula to place a hamburger on the grill. With the same gloves, KS 4 went to the mini fridge and opened it, grabbed a stack of cheese slices, opened and removed a cheese slice from the stack and placed the cheese on top of the patty on the grill. KS 4 with the same gloves on, then went over to the steam table and made a lunch plate for another resident. After touching the handles of the scoops used to make the lunch meal from the steam table, KS 4 then picked up a slice of onion and tomato and placed them with the top of the bun into a Styrofoam container. KS 4 did not change their gloves after touching potentially contaminated surfaces and then touching food items. The Indiana Retail Food Establishment Sanitation Requirements indicated, "Sec. 100. "Utensil" means a food-contact implement or container used in the storage, preparation, transportation, dispensing, sale, or service of food, such as the following...Gloves used in contact with food...Duties of the person-in-charge Sec. 119. (a) When applicable, the person-in-charge of the retail food establishment shall ensure the following...Employees are effectively cleaning their hands, by routinely monitoring the employees ' hand washing...(11) Employees are preventing cross-contamination of ready-to-eat food from unwashed hands and are properly using suitable utensils...When to wash hands Sec. 129. (a) Food employees shall clean their hands and exposed portions of their arms as specified under section 128 of this rule immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use		resolution.2. Systematic Change: Daily and weekly cleaning checklist developed for signatures showing completion 7/9/24. Monthly Sanitation Audit 8/4 conducted and uploaded to TELS facility management application. Repairs needed to freezer (handle and seal) reported for repair 8/5.3. Monitoring: daily audit conducted by server and cook and recorded on hard copy and filed. weekly audit of proper storage and kitchen sanitation completed per Food and Beverage Director and kept on hard file. Monthlly Sanitation Audit completed per Executive Director or designee and uploaded in TELS facility Management application. Audits continue in pertuity.	

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FIVE STAR RESIDENCES OF CLEARWATER	4519 EAST 82ND STREET INDIANAPOLIS, IN 46250

(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
	articles and the following...6) After handling soiled surfaces, equipment, or utensils. (7) During food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks...(9) Before touching food or food-contact surfaces. (10) Before placing gloves on hands. (11) After engaging in other activities that contaminate the hands...Gloves...If used, single-use gloves shall be: (1) used for only one (1) task, such as working with ready-to-eat food or with raw animal food; (2) used for no other purpose; and (3) discarded when: (A) damaged or soiled; or (B) interruptions occur in the operation."			
R 9999 Bldg. 00	Based on interview and record review, the facility failed to maintain new hire employee records for 1 of 3 staff members reviewed. ((Director of Nursing (DON)) An interview was conducted with the Business Office Manager (BOM) on 7/2/24 at 1:55 PM. She indicated she could not provide the missing general and specific orientation, references, or job description for the DON. She indicated that "orientation is done by corporate". "This is all I could find".	R 9999	1. Corrective Action: Records of Director of Nursing on-boarding missing documentation requested from corporate office. 2. Measure to identify and correct prn: Any newly hired Director of Nursing or Executive Director will ask for a copy of their on-boarding, orientation (specific) paperwork to give to Business Office for employee file. 3. Monitoring: Audit of DRC and ED paperwork completed with collection of missing paperwork r/t being conducted at corporate level.	08/13/2024