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	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL OAKS PLACE	4200 WYNTREE DR NEWBURGH, IN 47630

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: November 25, 26, 2024 Facility number: 004903 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 1, 2024.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to attempt to told a fire and disaster drill in conjunction with the local fire department at least every six months. Finding includes: On 11/25/24 at 10:30 A.M., facility fire drills were reviewed. The most recent fire drill that indicated the fire department was notified was on 4/18/24. The fire department did attend that fire drill. On 11/25/24 at 12:46 P.M., the Administrator provided a current non-dated Fire Drill policy. The policy did not indicate how often the fire department should be invited to fire drills, but indicated facility policy was to notify the fire department annually (in the second quarter) and invite to attend. The policy did indicate the	R 0092	R 092 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	12/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
T.J. Bates	Executive Director	12/12/2024

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

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	facility would comply with regulations which included inviting the fire department at least every six months.		conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 On 12/6/2024, Executive Director (ED) conducted an audit of fire drills. No concerns identified. 2 On 12/6/2024, ED conducted an audit for inviting the local fire department to facility fire drills semi-annually. Identified concerns were corrected at time of findings. 3 ED provide in-service to staff on policy of fire drills and regulation including inviting the fire department at least every six months. 4 The Executive Director is responsible for sustained compliance. The ED, or designee, will review Fire Drills for proper regulatory requirements weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of	

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			compliance. Monitoring will be ongoing. 5 December 26th, 2024.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure a newly hired employee was screened for TB (tuberculosis) prior to resident contact for 1 of 2 newly hired employees. A new employee, unable to get the TB skin test due to an allergy, did not get a chest x-ray prior to having contact with the residents. (Care Manager 7) Finding includes: On 11/26/24 at 8:34 A.M., the employee records were reviewed and indicated Care Manager 7 was hired on 11/1/24. The file lacked documentation of a 2 step TB skin test or chest x-ray being completed prior to or upon hiring. During an interview on 11/26/24 at 11:53 A.M., the Administrator indicated Care Manager 7 required a chest x-ray and could not have a skin test done because of an allergy to the skin test procedure. At that time, he indicated Care Manager 7 had been in contact with residents. On 11/26/24 at 1:16 P.M., a current Staff TB Policy, dated 6/10/24, was provided by the Director of Nursing (DON) and indicated " ... Each newly hired care staff member will be screened regarding exposure to or symptoms of TB after an employment offer has been made and prior to the employee's duty assignments. TB test must be completed at the time of employment or within one (1) month prior to employment ... All employees who have a positive reaction to the skin test shall	R 0121	R 121 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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 On 12/2/2024, Executive Director (ED) conducted an	12/26/2024

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	be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis ... "		observational audit of employee TB screenings. Staff member identified was sent for chest x-ray on 12/4/24. No residents were affected. 2 On 12/6/2024, ED conducted an observational audit of all employee TB screenings. No concerns were identified. 3 ED provide in-service to DHW and Nursing staff on TB staff policy for each newly hired care staff member to be screened regarding exposure to or symptoms of TB after an employment offer has been made and prior to the employee's duty assignments. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will review new hire TB screenings weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on interview and record review, the facility failed to ensure as needed (prn) medications were administered by a Qualified Medication Aide	R 0246	R 246 Submission of this response and Plan of Correction is NOT a legal	12/26/2024

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	(QMA) only upon authorization by a licensed nurse for 2 of 7 resident records reviewed. (Resident 5, Resident 7) Findings include: 1. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease. Current physician orders included, but were not limited to: acetaminophen 325mg (milligrams) every six hours as needed. hydroxyzine 25mg every six hours as needed. ondansetron 4mg three times a day as needed. loperamide 2mg every six hours as needed. Resident 5's MAR (Medication Administration Record) for October and November 2024 included, but were not limited to, the following prn medications administered by a QMA without prior authorization from a licensed nurse: acetaminophen 325mg given on 10/2/24 at 9:59 A.M., 10/15/24 at 12:10 P.M., and 10/18/24 at 10:36 A.M. hydroxyzine 25mg given on 10/2/24 at 10:00 A.M., and 10/18/24 at 10:36 A.M. ondansetron 4mg given on 10/15/24 at 12:10 P.M. loperamide 2mg given on 11/17/24 at 12:51 P.M. 2. On 11/26/24 at 10:00 A.M., Resident 7's closed clinical record was reviewed. Diagnosis included, but were not limited to, osteoporosis.		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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 Resident 5 and Resident 7 suffered no negative effects related to these findings. QMA's and Nurses to be in-serviced on obtaining appropriate authorization for each PRN administration and proper documentation of PRN administration in the nursing notes indicating the time and date on 12/13/24 2 On 12/10/2024, Director of Health and Wellness (DHW)	

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	Physician orders included, but were not limited to: acetaminophen 1000mg every eight hours as needed. Resident 7's MAR from April 2024 through July 2024 included the following dates/times acetaminophen as needed was administered by a QMA without prior authorization from a licensed nurse: 4/19/24 at 8:00 P.M. 4/22/24 at 8:00 P.M. 4/28/24 at 8:00 P.M. 5/12/24 at 8:00 P.M. 5/26/24 at 8:00 P.M. 6/4/24 at 8:00 P.M. 6/7/24 at 8:00 P.M. 6/8/24 at 8:00 P.M. 6/9/24 at 8:00 P.M. 6/18/24 at 8:00 P.M. 6/23/24 at 8:00 P.M. 6/25/24 at 8:00 P.M. 7/2/24 at 8:00 P.M. 7/5/24 at 8:00 P.M. 7/6/24 at 8:00 P.M. 7/7/24 at 8:00 P.M. 7/12/24 at 8:00 P.M. 7/15/24 at 8:00 P.M. 7/18/24 at 8:00 P.M. 7/25/24 at 8:00 P.M. On 11/26/24 at 12:35 P.M., QMA 3 indicated when administering a prn medication, QMAs should obtain prior authorization from a licensed nurse and document that authorization in the MAR. On 11/26/24 at 1:05 P.M., the Administrator provided a current Qualified Medication Aide policy, dated 6/10/24, that indicated "PRN medications can be administered by a QMA only		conducted an audit on Medication Administration Records of current residents receiving PRN medications in past 60 days to ensure PRN medication was administered by a QMA after receiving appropriate authorization and properly documenting in the residents' nurses' notes. Results of the audit were reviewed by the ED. 3 By 12/19/2024, current QMA's will be re-educated by DHW on receiving appropriate authorization for each administration of a PRN medication and documenting in the nursing notes indicating the time and date of the contact. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will audit 5 resident records receiving PRN medication to ensure appropriate authorization was obtained and documented in the nurses notes weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	

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	upon authorization by a licensed nurse of physician ... The QMA must receive appropriate authorization for each administration of a PRN medication"			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to maintain all food preparation and public serving areas in accordance with state and local sanitation and safe food handling standards for 3 of 3 kitchen observations, and 1 of 2 dining observations. Findings include: 1. During an observation of the kitchen on 11/25/24 at 9:00 A.M., the following were observed: An open gallon of milk was not dated in the drink cooler. The lid to the sugar bin was off and lying on top of the flour bin in the dry storage area. A dented can of pizza sauce Three cans of peaches with dents, two of of which had dents along the rim of the can. During an observation on 11/25/24 at 12:34 P.M., the lid to the flour bin was off and lying on the sugar bin. At that time, the Executive Chef indicated all the bins should have been covered at all times. She further indicated she was unaware of what the policy was for dented cans. Since the cans were not leaking she would have used them unless the food looked or smelled bad, at which	R 0273	R 273 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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 On 11/29/24, ED and Chef	12/26/2024

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	time she would have disposed of them. During an observation on 11/26/24 at 12:24 P.M., an open gallon of milk was not dated in the drink cooler. At that time, the Executive Chef indicated she was unaware that the milk needed to be dated when opened. 2. During an interview on 11/25/24 at 10:47 A.M., the Executive Chef indicated she was not familiar with the process of running the dishwasher since the aides were the ones who ran the dishwasher. At that time, she took a strip from a bottle of chlorine test strips and dipped it into the water in the dishwasher. The strip did not turn colors. She indicated she was unsure why the strip did not turn any colors. At that time, there were no available CNAs (Certified Nurse Aides) to run the dishwasher. During an interview on 11/25/24 at 12:25 P.M., the Executive Chef indicated the chlorine test strips should have tested 50 to 100 ppm (parts per million). On 11/25/24 at 1:01 P.M., the Administrator was observed to test the dishwasher with a Hydrion QT-40 pH test strip. He placed the strip in the water in the dishwasher and it tested 400. At that time, he indicated it should test between 400-500. He indicated they could use either the chlorine or Hydrion test strips for the dishwasher since they were both provided by the company that serviced the dishwasher. At that time, a large plastic container of chlorine was observed under the counter next to the dishwasher. During an interview on 11/25/24 at 1:01 P.M., the Executive Chef indicated she believed the chlorine test strips were outdated and lacked an expiration		discarded identified opened unlabeled and/or undated food. Storage bins were closed and sealed appropriately. All dented cans were pulled from storage racks to be sent back to food supplier. On 12/6/24 ice scoop holder was ordered for drink cart in the dining room. On 12/5/24 staff were educated to not were open-toed shoes in the kitchen. On 12/10/24 staff were educated on proper hand hygiene. 2 Observational audit was conducted on 12/11/24 by ED of current staff to ensure any items shipped were not damaged, of if they were, that they were pulled to be sent back. Checked for properly sealed storage bins, labeling and dating, and that ice scoop containers were being used. Also, that no open-toed shoes were being worn. DHW completed audit on 12/12/24 for appropriate hand hygiene. 3 By 12/9/24, current staff will be re-educated by ED on labeling/dating, food storage policy, dented can policy, open toed shoes, ice scoop policy and hand hygiene. 4 The Executive Director is responsible for sustained compliance. The Dietary Manager, or designee, will conduct an audit of labeled/dated food, dented cans, food storage, proper ice scoop storage and open toed shoes weekly for four weeks,	

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	date on the bottle. On 11/26/24 at 11:48 A.M., Cook 17 provided a copy of the November Low Temperature Dish Washer log with the following bleach readings: Day 17 Breakfast Bleach 55, Lunch Bleach 53, Dinner Bleach 55 Day 18 Breakfast Bleach 51, Lunch Bleach 52, Dinner Bleach 51 Day 19 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 51 Day 20 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach 51 Day 21 Breakfast Bleach 53, Lunch Bleach 53, Dinner Bleach 53 Day 22 Breakfast Bleach 51, Lunch Bleach 50, Dinner Bleach 52 Day 23 Breakfast Bleach 50, Lunch Bleach 51, Dinner Bleach 51 Day 24 Breakfast Bleach 53, Lunch Bleach 55 At that time, the chlorine test trip bottle was observed the the following key for result readings: 10 p.p.m. (parts per million), 50 p.p.m., 100 p.p.m., 200 p.p.m. During an interview on 11/26/24 at 12:01 P.M., the Executive Chef indicated the company that serviced the dishwasher came on 11/25/24. A report from that visit was requested and not received. 3. During an observation on 11/26/24 at 1:13 P.M., CNA 11 was observed coming out of the kitchen carrying a plate wearing soft shoes with several holes in the top and going back into the kitchen. 4. On 11/25/24 from 12:00 P.M. through 12:15 P.M., lunch service was observed in the main dining room.		biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. DHW will conduct an audit of hand hygiene weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	

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	Two ice containers were observed filled with ice on a rolling cart by the kitchen door with an ice scoop sticking out of one of them. Care Manager 7 was observed to use the ice scoop to scoop ice from the container to serve drinks to residents, then place the ice scoop back into the ice container. Care Manager 7 was observed to wash hands in between passing trays to residents with a two second lather, and the rest of the hand wash was performed with her hands under the water. QMA (Qualified Medication Aide) 9 was observed to wash hands in between passing trays to residents with a three second lather, and the rest of the hand wash was performed with her hands under the water. On 11/25/24 at 12:15 P.M., QMA 9 indicated there was a separate container for the ice scoop in the kitchen, but not on the rolling cart in the dining room. On 11/25/24 at 12:24 P.M., the Kitchen Manager indicated hands should be washed with soap and water during meal service lathering hands long enough to sing the Happy Birthday song twice slowly. On 11/25/24 at 1:13 P.M., the Administrator provided a current non-dated Ice Scoop policy that indicated "The ice scoop is stored in a clean container that allows water to drain" On 11/26/24 at 8:31 A.M., the Administrator provided a current Hand Hygiene policy, dated 6/10/24, that indicated "Wet hand with water and apply soap ... Rub hands together for at least			

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	twenty (20) seconds ... Rinse ..." During an interview on 11/25/24 at 1:11 P.M., the Administrator indicated he did not have a policy for the dishwasher. On 11/26/24 at 10:10 A.M., the Administrator provided an undated Food Storage Guidelines policy which indicated "All food items must be labeled...Prepared foods must be stored in an appropriated container with an airtight lid." On 11/26/24 10:37 A.M., the Administrator indicated the same was true for bins of sugar and flour. On 11/26/24 at 2:14 P.M., the Administrator provided an undated Food Storage Guidelines policy which indicated " 2. Receiving Food Orders: ...Reject if:...packaging is damaged." At that time, the Administrator indicated this was the same for dented cans. On 11/26/24 at 2:14 P.M., the Administrator provided an undated Personal Appearance policy which indicated "Sandals, flip flops or any type of open toed shoes is not allowed with the uniform."			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency Based on observation and interview the facility failed to store a schedule II (narcotic) medication under a double lock for 1 of 5 medication observations. A resident's narcotic medication was in a clear medicine cup in the top drawer of the medication cart. (Resident 14) Finding includes: During an observation of medication administration 11/25/24 at 12:15 P.M., LPN	R 0304	R 304 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	12/26/2024

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	(Licensed Practical Nurse) 28 opened the top drawer of a medication cart and obtained a clear, unlabeled medication cup with 3 tablets in it. At that time, LPN 28 indicated Resident 14 refused her medication prior to eating lunch so the 2 sodium chloride 1 gram tablets and 1 oxycodone--acetaminophen 7.5mg (milligrams/ 325mg tablet was placed in the top of the medication cart until Resident 14 finished lunch. During an interview on 11/26/24 at 10:08 A.M., the DON (Director of Nursing) indicated if a resident refused to take a narcotic medication, the medication should be destroyed, and the narcotic should be obtained from the double locked box at the time of administration. On 11/26/24 at 8:31 A.M., a current Medication Storage--Centrally Stored Medications policy, dated 6/10/24 indicated, "...All Schedule II drugs administered by the facility shall be kept in individual containers under double lock..."		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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 Resident 14 suffered no negative effects related to findings. LPN 28 educated on proper labeling and storage of narcotic medication. 12/5/24 2 Director of Health and Wellness (DHW) conducted on audit of medication carts on 12/3/24 to ensure all narcotic medications are in double locked drawers. No findings at time of audit. 3 By 12/19/24, current Nurses and QMA's will be re-educated proper labeling and storing of narcotic medication in individual containers and double locked. 4 The Executive Director is responsible for sustained compliance. The DHW, or	

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			designee, will conduct an audit of medication carts to make sure all narcotic medications are labeled properly and stored in double locked drawers weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance Based on observation and interview, the facility failed to ensure the proper disposal of medications in 1 of 1 medication rooms, and the facility failed to document the temperature of the medication refrigerator for 1 of 1 medication refrigerator's. Numerous medications in clear packets and multiple pill bottles were observed in the medication room. Findings include: On 11/25/24 at 9:00 A.M., the medication room was observed. A blue gallon size medication bin overflowed with clear packets that was too numerous to count and were filled with medications, and the following medications were observed in pill bottles on the counter in the medication room: Resident 9: terazosin 10mg (milligrams)-- 1 bottle	R 0306	R 306 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	12/26/2024

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	mirtazapine 15mg-- 1 bottle simvastatin 40mg-- 1 bottle quetiapine 50mg-- 1 bottle carbidopa / levodopa 25mg/100mg-- 2 bottles Resident 10: metformin 850mg-- 1 bottle trazodone 100mg-- 1 bottle montelukast 10mg-- 1 bottle isosorbide mononitrate 30mg-- 1 bottle pentoxifylline 400mg-- 1 bottle warfarin 5mg-- 1 bottle nortriptyline 25mg-- 1 bottle atorvastatin 10mg-- 1 bottle metoprolol 25mg-- 1 bottle Resident 11: levothyroxine 100mcg (micrograms)-- 1 bottle Myrbetriq ER (extended release) 50mg-- 1 bottle esomeprazole 40mg--1 bottle metoprolol 25mg-- 1 bottle lamotrigine 100mg-- 2 bottles trazodone 150mg-- 1 bottle atorvastatin 20mcg-- 1 bottle Resident 12: stimulant laxative 8.6/50mg--1 bottle Aspirin 81mg-- 1 bottle sulfamethoxazole trimethoprim 800/160mg-- 1 bottle A review of the November temperature log lacked a temperature recorded for the AM and PM on the medication refrigerator: November 1 November 4--5 November 7 November 9--10 November 13--15 November 18--19		allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 All medications identified were destroyed on 11/28/24. 2 On 11/29/24 an audit of the medication room was completed for all medications to be destroyed. Any identified medications were destroyed. An audit of the fridge log was also completed, and staff were educated on 12/2/24 of the policy of Daily Refrigerator Temp Control Log. 3 By 12/19/24, current Nurses and QMA's will be re-educated proper destruction of medication policy and refrigerator temp control log. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will conduct an audit of medication fridge log for temps and medication destruction log and any medications to be destroyed weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI	

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	November 23--24 During an interview on 11/25/24 at 9:10 A.M., the DON (Director of Nursing) indicated all medications in the blue bin and on the counter should have been destroyed as the medications were brought into the medication room. At that time, she further indicated the temperature of the refrigerator should be documented daily. On 11/26/24 at 8:31 A.M., a current Medication Storage-- Centrally Stored Medications policy, dated 6/10/24 indicated, "...Medications will be stored in a manner that ensures the maintenance of the medication's integrity and safety of all residents residing in the Community...The refrigerator temperature is checked daily and documented on the Daily Refrigerator Temperature Control Log..."		committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on observation, record review, and interview, the facility failed to accurately document in the resident's clinical record for 5 of 7 residents reviewed. Resident's had an order for an annual health statement, but the facility failed to provide a Tuberculin (TB) skin test or Risk Assessment. (Resident 2, Resident 3, Resident 4, Resident 5, Resident 8) Findings include: 1. On 11/25/24 at 9:50 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, high blood and diabetes mellitus. Resident 4 was admitted to the facility on 12/20/23.	R 0349	R 349 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	12/26/2024

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	A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated, 2/29/24 . Resident 4's clinical record lacked an annual TB skin test or any other test to support the health statement. 2. On 11/26/24 at 8:50 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but was not limited to, woundcare and mobility. Resident 8 was admitted to the facility on 2/28/2020. A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated, 8/3/23 . Resident 8's clinical record lacked documentation of a yearly TB test or Risk Assessment support the health statement. 3. On 11/25/24 at 8:45 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limited to, hypertension, status post CVA (cerebrovascular accident), and prediabetic. Admission date was 2/3/24. A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated 2/3/24. Resident 3's clinical record lacked an admission TB skin test or any other test to support the health statement. 4. On 11/25/24 at 9:30 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and atrial fibrillation. Admission date was 1/27/23.		facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 Resident 4 was corrected on 11/26/24. Resident 2 and 3 corrected on 12/9/24. No residents were harmed during this finding. 2 On 12/11/24 Director of Health and Wellness (DHW) completed an observational audit of the resident TB's for accuracy of completion. Any identified issues were corrected. 3 By 12/19/24, current Nurses will be re-educated proper Resident Record policy and documenting clinical records on each resident. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will conduct an audit of resident records to make sure all documentation is completed at admission and annually for each resident weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during	

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	A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated 4/2/24. Resident 2's clinical record lacked an annual TB skin test or any other test to support the health statement. 5. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. Admission date was 11/4/23. A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated 3/2/24. Resident 2's clinical record lacked an annual TB skin test or any other test to support the health statement. During an interview on 11/26/24 at 10:30 A.M., the DON indicated the facility was unable to find TB results for Resident 2, Resident 3, Resident 4, Resident 5, and Resident 8 and TB tests should be completed on admission and then a Risk Assessment or a TB test should be done annually. At that time, she indicated the annual health statement should be updated for the resident when the TB tests or Risk Assessments are completed. On 11/26/24 at 1:05 P.M., the Administrator provided a current Resident Record policy, dated 6/10/24, that indicated the facility must maintain accurately documented clinical records on each resident.		monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	

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R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on interview, observation, and record review, the facility failed to ensure a tuberculin (TB) skin test or risk assessment was completed for 5 of 7 residents reviewed. Residents lacked admission and yearly TB test and/or risk assessment. (Resident 2, Resident 3, Resident 4, Resident 5, Resident 8) Findings include: 1. On 11/25/24 at 9:50 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, high blood and diabetes mellitus. Resident 4 was admitted to the facility on 12/20/23. Resident 4's clinical record lacked an annual TB skin test or any other test to indicate active TB. 2. On 11/26/24 at 8:50 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but was not limited to, woundcare and mobility. Resident 8 was admitted to the facility on 2/28/2020. Resident 8's clinical record lacked documentation of a yearly TB test or risk assessment. 3. On 11/25/24 at 8:45 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limitied to, hypertension, status post CVA (cerebrovascular accident), and prediabetic. Admission date was 2/3/24. Resident 3's clinical record lacked an admission TB skin test or any other test to indicate active TB. 4. On 11/25/24 at 9:30 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but	R 0410	R 410 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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/26/2024. The facility will ensure this requirement is met through the following corrective measures: 1 Resident 4 was corrected on 11/26/24. Resident 2, 3 and 5 corrected on 12/9/24. No residents were harmed during this finding. 2 On 12/11/24 Director of Health and Wellness (DHW)	12/26/2024

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	were not limited to, dementia and atrial fibrillation. Admission date was 1/27/23. Resident 2's clinical record lacked an annual TB skin test, risk assessment, or any other test to indicate active TB. 5. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. Admission date was 11/4/23. Resident 2's clinical record lacked an annual TB skin test, risk assessment, or any other test to indicate active TB. During an interview on 11/26/24 at 10:30 A.M., the DON indicated the facility was unable to find TB results for Resident 2, Resident 4, Resident 5, and Resident 8 and TB tests should be completed on admission and then a Risk Assessment or a TB test should be done annually. On 11/26/24 at 10:10 A.M., the Administrator provided a current Resident Tuberculosis policy, dated 6/10/24, that indicated "The Community will screen all residents for TB infection and disease upon admission or readmission. Additionally, residents will be screened annually per Indiana regulations"		completed an observational audit of the resident TB's for accuracy of completion. Any identified issues were corrected. 3 By 12/19/24, current Nurses will be re-educated resident TB's upon admission and annual screening. 4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will conduct an audit of resident records to make sure all resident TB's are completed at admission and annually for each resident weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 December 26th, 2024.	