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	04/20/2023

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BLOOM AT GERMAN CHURCH	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00406175 and IN00406078. Complaint IN00406175 - State deficiencies related to the allegations are cited at R268, R406 Complaint IN00406078 - State deficiencies related to the allegations are cited at R268, R269, R273, and R272. Survey dates: April 17, 18, 19, and 20, 2023 Facility number: 003916 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 26, 2023	R 0000	Submission of this response and plan of correction is not a legal admission that the deficiency exists or that the statement of deficiencies was correctly cited and is not to be construed as an admission against any interest by the residents or any employees agents or other individuals who drafted or who maybe 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 the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Bloom Assisted Living respectfully requests a desk review of the attached Plan of Correction.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect residents from sexual and mental abuse by not determining their capacity to	R 0052	**What corrective actions will be accomplished for those residents found to have been**	05/16/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Lingle	Executive Director	06/02/2023

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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	consent to sexual activity and not developing a plan to address the sexual activity and subsequent psychological harassment for 2 of 2 residents reviewed for abuse. (Resident M and Resident N) Findings include: 1. The clinical record for Resident M was reviewed on 4/19/23 at 11:30 a.m. Resident M's diagnosis included, but was not limited to, brain aneurysm (bleed in brain). Resident M's Mini Mental State Examination (MMSE) dated 11/18/22 indicated the resident scored a 22. The scoring results indicated, "Score results of the Mini-Mental State Examination (MMSE) are used in the diagnosis of Alzheimer's disease. The scores indicate the areas of difficulty in a person presenting with cognitive problems such as memory, thinking, attention, reasoning, decision making and dealing with concepts. Scores indicating dementia: Scores of 27 and above are considered normal. Scores of between 23 and 26 indicate borderline condition. Scores of 22 and below are abnormal. Scoring and people with Alzheimer's disease: Scores of 20 to 26 equal to Mid-Alzheimer's disease. Scores of 10-19 equal to Moderate Alzheimer's disease. Scores below 10 indicate Severe Alzheimer's disease..." Resident M's Mini Mental State Examination (MMSE) dated 3/12/23 indicated the resident scored an 18. A service plan for Resident M dated 2/17/23 indicated, "...Awareness of own needs...Action: Difficulty understanding needs, but will cooperate with direction. Notes: [Resident M] continue to need verbal cues, gentle redirection, and		**affected by the deficient practice:** Resident M is no longer residing at Bloom at German Church. Resident N has been seen by Cheryl Ditltzer, NP, Tiffini Smith, NP, follow-up orders, care plan updated. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents who reside at the facility and who are at risk for sexual and mental abuse have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** All residents mini-mental scores to be reassessed by May 16, 2023, abuse risk to be noted. Service plans to be updated for all residents identified as scoring 22 and below. All residents and associates will be educated on abuse, and resident rights. The Administrator or her designee will ensure Mini-mental scores are assessed quarterly moving forward, more frequently in the event of a change in condition. Service plans to be audited quarterly, or more frequently in the event of a change in condition, to ensure vulnerabilities are identified and addressed, and appropriate	

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	assistance at times...Behavior:...Notes: [Resident M] has had words with other residents and becomes upset, but is easily redirected...Judgment:..Action: Experiences difficulty in decision making. Notes: [Resident M] continues to need verbal cues, gentle redirection, and assistance at times...Maintain cognitive function:...Action: Needs monitoring and guidance with orientation. Notes: [Resident M] may need verbal cues, gentle direction, and assistance at times. The resident's service plan does not address residents bullying him or his sexual relationship with a female resident. 2. The clinical record for Resident N was reviewed on 4/19/23 at 11:35 a.m. Resident N's diagnoses included, but not limited to, dementia with behavioral disturbance and major depressive disorder. Resident N's Mini-Mental State Examination (MMSE) dated 1/20/23 indicated the resident score was a 15. A service plan for Resident N dated 2/20/23 indicated "...Behavior:..Notes: [Resident N] does have episodes of attempting to manipulate other residents, staff, family, and situations...Judgment: Action: Experiences difficulty in decision making. Notes: Does require some verbal cues and redirections at times. Memory:...Action: Difficulty remembering and using information. Notes: Does require some verbal cues and redirections at times. [Resident N] will complain about other residents coming in her apartment that she does not want in there and will request that her door be locked at all times to keep these residents out, but then allow the same residents in her apartment...Receptive		care is provided. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** An actionable audit tool will be utilized to check mini-mental scores and care plans. An in-service Re: abuse and resident rights will be completed by May 16, 2023.	

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	Communication: Action: Communicate with some assistance....Use gentle touch to assure that [Resident N] knows she is being spoken to..." The resident's service plan does not address the resident's sexual interactions with a male resident. A nursing progress note for Resident N dated 1/6/23 indicated "Writer locked door of apartment after given resident am [a.m.] meds [medications] which male resident came to door and she let him in her room. CNA [Certified Nursing Assistant] later walked in the room on the 2 residents having intercourse and left out immediately and reported to nurse/DON [Director of Nursing] aware." A nursing progress note for Resident N dated 1/7/23 indicated "CNA reported both residents male/female without clothing when she entered residents room but male guest told her to hold on and come back at a later time. CNA report that female had her leg raised up while male guest was bent down." A psych visit for Resident M dated 1/20/23 indicated "...Spends lot times with peers in front lobby or female peer's rm [room]...mental status exam...Though process: Forgetful at times...Thought Content:...He has girlfriend here 'I call her my girlfriend', he goes to her apt [apartment] dly [daily], they eat chips/ice cream, watch tv, joke and laugh. He admits at times she can say something harsh, but he ignores it. He says they are having sexual relations...Orientation: Knows Jan [January], thinks spring, not know correct yr [year], not know exact name of place. Major Neuro cog [neurocognitive] d/o [disorder]..." A psych visit for Resident N dated 1/20/23			

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	indicated "...female who waffles (fail to make up mind) about her relationship with male peer here. She allows him in her rm almost dly. She denies he is her boyfriend, 'he calls me his girlfriend." Are having sexual relations...Pt seems embarrassed by it, denies it most of the time...Mental Status exam:...Thought Process:...Forgetful. Poor STM [short term memory]...Thought content: She denies [Resident M] is her boyfriend. She is adamant that they are not having sex. 'I did not come here to find a man'..Associations: poor..Insight: impaired. Judgement: She denies her relationship to us about [Resident M]...Major Neuro cog d/o vascular type with hx [history] here verbal harsh with peers...she has declined functionally, cog [cognitive]..." An interview was conducted with Resident M's Representative/Power of Attorney (POA) on 4/19/23 at 11:11 a.m. She indicated she had concerns with Resident M and Resident N having sexual interactions in Resident N's room regularly. It has been going on for months. Resident M was not cognitively intact to consent to sexual activity. She was told Resident N had Alzheimer's and was not cognitively intact either. She did not approve of the sexual activity, and the staff was not addressing. Resident N will allow Resident M in her apartment to have sex. She then in public settings will make statements to other residents that she does not like Resident M causing the other residents to "bully" him about her. She had observed, Resident M sitting in the lobby with other male and female residents, and they were "bullying" him about her (Resident N). Resident M was tearful at that time. As of today, she has come to visit and Resident M was in his bed lying in the dark. He reported to her that he did not want to come out of his room, due to "those people" will pick on him about Resident N.			

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	Resident M was normally very social and would be out of his room. She blames the bullying, for causing this change in his behavior. She indicated she was fearful of Resident N would some day accuse him of "rape" and was concerned about what Resident N's family thought about the sexual interactions between the two residents. She was concerned of their reaction due to the differences of race between Resident M and Resident N. An interview was conducted with License Practical Nurse (LPN) 1 and LPN 2 on 4/19/23 at 11:45 a.m. They indicated Resident M and Resident N do have sexual intercourse in Resident N's room routinely. LPN 2 indicated it has been going on for a while. The last time she was made aware of a sexual interaction between the two residents was about a month ago. Resident N "flips back and forth" if she wants to be in a relationship with Resident M. Resident N keeps her apartment door locked, but she will open the door and allow Resident M to come into her apartment. LPN 2 and other staff have walked in on Resident M and Resident N during their sexual activities. Staff at times, has had to assist Resident N off the floor after their sexual activities. Resident N has dementia and has had a cognitive decline. LPN 2 had been told that as long as the POAs of both residents are okay with the sexual relationship then it was okay for them to do the activity. She believed both resident's POAs were okay with it. She has had to call Resident N's POA and report the sexual activity between the two residents. Resident N's POA's response to the activity was, "I will talk to her." Resident N was embarrassed of the relationship she has with Resident M due to the residents are different in race. Resident N was "mean" to Resident M. In the privacy of her room, she likes Resident M, but in public settings she will tell			

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	other residents, she does not like him and denies their relationship. Resident M states Resident N was his girlfriend. This would cause the other residents to "bully" him making statements to him such as, "She doesn't like you." LPN 2 and LPN 1 had not provided education to either resident regarding the risks with engaging in sexual activities. An interview was conducted with the Executive Director (ED) on 4/19/23 at 1:42 p.m. She indicated she had been in the facility for 3 months. The sexual relationship between Resident N and Resident M had been going on prior to her arrival. Resident N was embarrassed with the relationship with Resident M, because of the race differences. She does not recognize him as her boyfriend in public. There are other residents in the facility that are in relationships, but she was unsure if they were sexual. The ED indicated the facility did not have policies and/or procedures related to residents engaging in sexual relationships. The former Executive Director had reported to her, he had educated Resident N regarding the consequences of sexual relations in the past, but had not documented the discussion in the resident's medical record. A documented list of female residents that staff indicated, "bully" Resident M was provided by the Executive Director on 4/19/23 at 1:46 p.m. The list included: Resident P, Resident Q, and Resident R. An interview was conducted with LPN 3 on 4/19/23 at 2:16 p.m. She indicated Resident N and Resident M are engaging in sexual interactions. Resident N has made statements to other residents that Resident M was "forcing" himself on her, but invites him to her apartment other			

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	times. Resident M would sit in the lobby and get picked on in group settings by other residents that were sitting in the lobby with him related to the relationship with Resident N. He would defend himself, but the other residents would continue to make jokes about him and make fun of him. An interview was conducted with Resident M on 4/19/23 at 2:42 p.m. He indicated he does have a sexual relationship with Resident N. "She is my girlfriend." An interview was conducted with Resident N on 4/19/23 at 2:52 p.m. She indicated she has not had any sexual interactions with Resident M. She hasn't seen him in days and does not want to. An interview was conducted with LPN 1 on 4/19/23 at 3:13 p.m. She indicated the medical provider had seen Resident M that day due to his decline. A medical provider visit dated 4/19/23 indicated "Acute concerns discussed today with patient and staff include: he has not been getting out of his room over the past week or so. He is not eating much and has been laying in his bed with the blinds drawn...Assessment: 1. Reactive depression. (symptoms of depression that occur in response to an external problem or stressor) 2. poor appetite...Added 15 mg [milligrams] Remeron..." An interview was conducted with Psych Nurse Practitioner 5 on 4/20/23 at 10:13 a.m. She indicated she does not conduct cognitive assessments on residents to determine the capacity to consent to sexual interactions. That would be determined by a judge. She planned to be in the facility on 4/21/23 to conducted a MOCA			

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	assessment on Resident N and Resident M which was a more in depth cognitive functional assessment. Resident N does deny the relationship with Resident M. She was unsure if the residents were actually engaging in sexual intercourse instead of just kissing and holding hands. An interview was conducted with the Director of Nursing (DON) on 4/20/23 at 11:45 a.m. She indicated Resident's N and M have engaged in sexual intercourse. The staff have walked in Resident N's room and observed the activity taking place. Resident N sleeps in a recliner, so she does not have a bed. The residents conduct their sexual activity on Resident N's floor. The staff have been called to the room to assist Resident N off the floor after the activity. At times, Resident N has voiced she does not want Resident M in her apartment and wants her door to her apartment to remain locked. The DON has observed Resident M and Resident N walking down the hallway together toward her apartment, and has attempted to redirect Resident M away from Resident N. At that time, Resident N indicated she wanted him to go into the apartment with her. She was unaware of Resident N making statements to other residents that Resident M was forcing himself on her. She would have liked LPN 3 to have reported that to her. The DON indicated some of the resident friend groups that reside in the facility act similar to the movie, "Mean Girls" (a movie based on teenagers bullying and harassing each other) regarding the bullying that goes on in the building. An abuse policy was provided by the Executive Director on 4/19/23 at 1:43 p.m. It indicated, "...Abuse-Physical abuse or psychological abuse. Physical Abuse - Intentionally inflicting or			

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	allowing injury on a vulnerable adult by an act or failure to act. Physical abuse includes, but is not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery...Physical abuse does not include altercations or acts of assault between vulnerable adults. Psychological Abuse - Deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress..." A Bill of Rights policy was provided by the Executive Director on 4/19/23 at 1:46 p.m. It indicated "...In accordance with this right to dignity and respect...5. Personal Treatment. Every Resident Shall have the Right to:..B. Courteous treatment in address and handling..."			
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 develop an abuse policy that clearly states the assurance of all residents that reside in the facility are free of abuse. This had a potential to affect 57 of 57 residents that resident in the facility.	R 0091	Deficiency ID: R 091 Completion Date: Plan of Correction Text:	05/16/2023

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	Findings include: An abuse policy was provided by the Executive Director on 4/19/23 at 1:43 p.m. It indicated, "...Abuse-Physical abuse or psychological abuse. Physical Abuse - Intentionally inflicting or allowing injury on a vulnerable adult by an act or failure to act. Physical abuse includes, but is not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery...Physical abuse does not include altercations or acts of assault between vulnerable adults..." An interview was conducted with the Executive Director on 4/20/23 at 11:18 p.m. She indicated after review of the abuse policy the statement, "physical abuse does not include altercations or acts of assault between vulnerable adults," was poorly written. That was written based on if cognitive impaired residents "bumped" into each other accidentally the staff did not need to report incident. It was not worded clearly. The corporate office was correcting the statement and rewording to indicate the meaning of that statement.		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** All residents living in the community had the potential to be affected. The facility failed to develop an abuse policy that clearly states the assurance of all residents that live in the facility are free of abuse. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Policy on *Abuse and Neglect* has been updated to reflect that all residents that reside in community are free from abuse. All residents residing at community have been educated on Resident Rights, Abuse and Neglect. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** The policy regarding abuse has been reviewed and modified. All staff to be re-educated by 5/8/2023 to ensure immediate intervention and appropriate reporting. **How the corrective actions will be monitored to ensure the**	

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			deficient practice will not recur i.e. what quality assurance program will be put in place: Identified concerns will be immediately addressed and reported to the administrator for trending. QA will be performed by administrator or designee monthly to ensure residents understand their right to live in a community free from abuse and neglect.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will			

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	depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on interview and record review the facility did not assure a 2 step tuberculin skin test was completed for 2 of 5 employee records reviewed. (Facility) Findings include: 1. The employee record for QMA (Qualified Medication Assistant) 11 was reviewed on 4/19/23 at 4:49 p.m. a.m. The date of hire for QMA 11 was 11/29/21. The employee record for QMA 11 did not contain documentation of a 2 step tuberculin skin test. During an interview on 4/19/23 at 5:26 p.m., the WD (Wellness Director) indicated, she was unable to find QMA 11's 2 step tuberculin skin test documentation. 2. The employee record for LPN (Licensed Practical Nurse) 12 was reviewed on 4/19/23 at 4:49 p.m. a.m. The date of hire for LPN 12 was 2/8/23.	R 0121	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** All residents living in the community had the potential to be affected. None were affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Wellness Director to test all staff by May 16, 2023. Moving forward, all staff to be tested in May. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** The facility policy and protocols on new hire and existing staff were	05/16/2023

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	The employee record for LPN 12 contained documentation of the first step of a 2 step tuberculin skin test. The first step was completed on 1/9/23. During an interview on 4/19/23 at 5:26 p.m., the WD (Wellness Director) indicated, she was unable to find LPN 12's second step of a 2 step tuberculin skin test documentation.		reviewed. New employee files to be reviewed by Administrator or designee for 2-step Mantoux test compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Testing all staff in May, regardless of hire date, will ensure compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure an evaluation of an individual's needs assessment included a resident's semiannual weights for 1 of 5 residents reviewed for their evaluation of needs. (Resident D) Findings include:	R 0216	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to ensure an evaluation of an individual's needs assessment	05/16/2023

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	The clinical record for Resident D was reviewed on 4/18/23 at 10:18 a.m. Resident D's diagnoses included, but not limited to, diabetes type II, chronic obstruction pulmonary disease, and cerebral vascular accident (CVA, stroke). A review of Resident D's progress notes did not indicate Resident D's semi-annual weight. Resident D's Service Plan dated 10/14/22 did not indicate her semi-annual weight. An interview with DON (Director of Nursing) on 4/18/23 at 10:23 a.m. indicated, she did not have Resident D's semi-annual weights documented. She further indicated, the resident's Service Plan is what she considers as an evaluation of needs assessment. A Service Plan policy was received on 4/19/23 @ 11:05 a.m. from DON. The policy indicated, "A Resident Service Plan should be developed, implemented and maintained for each resident...2. The Resident Service Plan should be reviewed and revised as necessary by the community care team...minimally every quarter."		included a resident's semiannual weights for 1 of 5 residents viewed for their evaluation of needs. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents living in the community have the potential to be affected. All residents to be weighed by May 16, 2023. Moving forward, all residents will be weighed monthly. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** All residents to be weighed upon admission and monthly thereafter. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Wellness Director or designee will monitor that all resident's weights completed upon admission, monthly, and when there is a change in condition.	
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			

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	members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (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 revise a resident's service plan as their needs changed related to frequent falls for 1 of 5 resident's service plans. (Resident F) Findings include: The clinical record for Resident F was reviewed on 4/18/23 at 11:41 a.m. Resident F's diagnoses included, but not limited to, arthritis, macular degeneration (an eye disease which causes vision loss), and cerebral vascular accident (CVA,	R 0217	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A Fall Risk assessment for Resident F dated 8/8/22 indicated Resident F was a moderate risk for falls. A Fall Risk assessment completed on 2/17/23 indicated that Resident F was now a high risk for falls. A Service Plan review would have indicated the	05/16/2023

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	stroke). A Fall Risk assessment for Resident F dated 8/8/22 indicated, Resident F was a moderate risk for falls. A Fall Risk assessment completed on 2/17/23 indicated, Resident F was now a high risk for falls. A nursing progress note dated 1/13/23 at 8:30 p.m. indicated, Resident F was observed on the floor in a sitting position in her apartment by the bathroom door with her walker beside her. Resident F stated, "I think I lost my balance and fell". A nursing progress note dated 1/15/23 at 7:45 a.m. indicated, Resident F was observed sitting on the floor in the bathroom. Resident F stated, "I fell". A nursing progress note dated 3/31/23 at 3 p.m. indicated, a CNA (Certified Nursing Assistant) reported to the nurse that Resident F was on the floor in her bathroom. Resident F had indicated to the nurse that she had slipped. A nursing progress note dated 4/2/23 at 9:25 a.m. indicated a CNA reported to the nurse that Resident F was sitting on her bottom by her bed. Resident F was encouraged not to get up alone. An incident report dated 1/13/23 was received on 4/18/23 at 2:28 p.m. from DON. The report indicated, Resident F was observed on the floor in a sitting position in her apartment by her bathroom door with her walker by her on the floor. The action taken as indicated by the box being checked next to them was: Care Plan update and Therapy screen. Resident F's Service Plan dated 2/17/23 was		need for interventions. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents living in the community have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** All resident fall assessments reviewed by May 12, 2023. When a fall assessment indicates a higher risk of falling a physicians order for PT, OT evaluation and treatment will be obtained and a referral to a therapy provider will be made. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Wellness Director or designee will monitor fall assessments weekly for changes.	

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	received on 4/18/23 at 2:28 p.m. from DON (Director of Nursing). The service plan included, but not limited to, the following: Mobility- "No assistance with mobility. Uses a walker for mobility" Night Checks- "Provide no night checks" Nighttime preparation- "Provide no nighttime preparation assistance" Toileting/Incontinence- "No assistance with toileting..." Transfers- "No assistance with transfers" The Service Plan did not address Resident F's falls, fall risk, or therapy needs. An interview with DON conducted on 4/18/23 at 12:13 p.m. indicated, Resident F's service plan did not address her frequent falls, increased fall risk, nor needs to help prevent future falls. A Resident Serve Plan policy received on 4/19/23 at 11:05 a.m. from DON indicated, "The Resident Service Plan should be reviewed and revised as necessary...A. Following a change in the condition of the resident that results in altered care needs over a period of greater than two weeks...3. The Resident Service Plan should include: A. Specific and individualized needs of the resident. B. Specific and individualized approaches for the care of the resident based on their needs."			
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 observation, interview and record review, the facility failed to ensure a resident was assessed to self administer medications for 1 of 5 residents reviewed. (Resident B)	R 0240	**What corrective actions will be accomplished for those residents found to have been affected by the deficient**	05/16/2023

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	Findings include: The clinical record for Resident B was reviewed on 4/17/23 at 9:00 a.m. Resident B's diagnosis included, but was not limited to, COVID. An observation was made of Resident B in her room on 4/17/23 at 10:42 a.m. The resident's bedside table was observed with a cup full of whole pill medications sitting on a bedside table next to Resident B. There was no staff present in the room at that time. The resident indicated, the medication was her morning medications. She had told the nursing staff she would take the medications "in a minute." The nursing staff do not always stay in the room while she takes her medications. During the interview, Resident B has had some swallowing issues. Resident B's clinical record did not include a self medication administration assessment indicating the resident was able to take her medications without the assistance of the nursing staff presence. A negotiated risk assessment for Resident B was provided by the Executive Director on 4/17/23 at 1:18 p.m. It indicated "Resident has had some swallowing issues. If she chokes, injury or death could occur. Resident prefers to eat and drink in her room..." An interview was conducted with the Director of Nursing (DON) on 4/17/23 at 12:45 p.m. She indicated the medications should not have been left at bedside for Resident B to take without nurse presence.		**practice:** The facility failed to ensure a resident was assessed to self-administer medications for 1 of 5 residents reviewed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents who are incapable of self-administration of medication who live in the community are at risk of being affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** All nursing staff will be educated regarding medication administration. This will be conducted by May 8, 2023. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Residents who may be capable of self-administration will be evaluated to confirm whether they are capable or not. This will be completed by May 15, 2023.	

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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 as needed (PRN) medications administered by Qualified Medication Assistants (QMA) were authorized by licensed nursing personnel for 2 of 5 residents reviewed. (Residents H and D) Findings include: 1. The clinical record for Resident H was reviewed on 4/17/23 at 12:00 p.m. Resident H's diagnosis included, but was not limited to, giant cell arteritis. A physician order dated 3/29/23 indicated Resident H was to receive 5/325 milligrams of hydrocodone every 6 hours as needed. A physician order dated 2/10/23 indicated Resident H was to receive 4 milligrams of tizanidine every 6 hours as needed. The April 2023 Medication Administration Record (MAR) indicated Resident H had received the 5/325 milligrams of hydrocodone on the following days and times by QMA 10: 4/5/23 at 3:22 a.m., 4/9/23 at 12:37 a.m.,	R 0246	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to ensure as needed (PRN) medications administered by Qualified Medication Assistants (QMA) were authorized by licensed nursing personnel for 2 of 5 residents reviewed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents receiving as needed medications have the potential to be affected. Prior to administering as needed medications, the QMA will notify the licensed nurse for authorization to administer the medication. After receiving the authorization, the QMA will document all actions taken on the MAR. In the event there is no licensed nurse on the premises,	05/16/2023

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	4/13/23 at 3:35 a.m., and 4/15/23 at 3:22 a.m. The MAR indicated the following days and times Resident H had received the as needed 5 milligrams of tizanidine by QMA 10: 4/5/23 at 3:22 a.m., 4/13/23 at 3:35 a.m., and 4/15/23 at 3:22 a.m. The resident's clinical record did not include a license nurse authorization for QMA 10 to administer the hydrocodone or the tizanidine to Resident H on 4/5/23, 4/9/23, 4/13/23, and 4/15/23. 2. The clinical record for Resident D was reviewed on 4/18/23 at 10:18 a.m. Resident D's diagnoses included, but not limited to, anxiety disorder, atrial fibrillation, chronic obstructive pulmonary disease, diabetes type II, and COVID-19. A physician's order for Resident D placed on 1/27/23 indicated, to give 10 ml (milliliters) of chest congestion relief DM liquid every 4 hours as needed for cough. A physician's order for Resident D placed on 1/27/23 indicated, to give two tablets of acetaminophen 325 mg tablets every 4 hours as needed for discomfort and/or fever greater than 100 degrees Fahrenheit. A physician's order for Resident D placed on 4/1/23 indicated, to give two tablets of acetaminophen 325 mg every 4 hours as needed for discomfort. The April 2023 MAR indicated, Resident D received 10 ml of chest congestions relief DM liquid by QMA 10 on the following dates and		the Wellness Director will be contacted for approval.**What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** Each QMA employed at the facility has been re-educated, concerning the appropriate way to administer as needed medications. Prior to administering as needed medications, the QMA will notify the Licensed Nurse. After receiving the authorization from a Licensed Nurse, the QMA will document all actions taken on the MAR. In the event there is no licensed nurse on the premises the Wellness Director will be contacted for approval.**How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Wellness Director or designee will review all as needed medication given the prior 24 hours daily for 4 weeks, and then weekly for 3 quarters.	

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	times: 4/8/23 at 12:18 p.m. 4/8/23 at 9:07 p.m. 4/9/23 at 12:08 a.m. 4/9/23 at 9:10 p.m. 4/10/23 at 2:35 a.m. The April 2023 MAR indicated, Resident D received two tablets of acetaminophen 325 mg for discomfort and/or fever by QMA 10 on the following dates and times: 4/8/23 at 9:07 p.m. 4/9/23 at 12:08 a.m. 4/9/23 at 9:10 p.m. 4/10/23 at 2:25 a.m. The resident's clinical record did not include a licensed nurse authorization for QMA 10 to administer the chest congestion relief liquid or acetaminophen on the following dates: 4/8/23, 4/9/23, or 4/10/23. An interview with DON (Director of Nursing) conducted on 4/18/23 at 11:23 a.m. indicated the QMA's are to get approval for administration of PRN medication from the licensed nurse prior to administering it to the residents. She indicated, the licensed nursing authorization for PRN medications is usually documented on the MAR or in progress notes. An interview with DON conducted on 4/18/23 at 1:39 p.m. indicated, QMA 10 believed only narcotic PRN medications needed prior authorization from the licensed nurse prior to the administration of PRN medications. A Medication Charting Documentation policy received on 4/18/23 at 1:39 p.m. from DON indicated, "The community follows specific			

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	protocol procedures for charting documentation for medication...PRN sheet It is important to note date, time, drug, purpose and signature. If medication is given at the end of the shift, the next shift should chart the results."			
R 0268 Bldg. 00	410 IAC 16.2-5-5.1(a) Food and Nutritional Services - Deficiency (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. Based on interview, observation, and record review, the facility failed to ensure it provided meals that provided a balanced distribution of the daily nutritional requirements for 57 of 57 residents who reside in the facility. (Facility) Findings include: A weekly lunch and dinner entree menu was provided by the Dietary Manager (DM) on 4/18/23 at 10:06 a.m. An observation of lunch service was conducted on 4/17/23 at 12:07 p.m. The menu for lunch on that day was herb crusted chicken breast, mixed vegetables, rice pilaf, and a dinner roll. During the lunch service, KS (kitchen staff) 2 prepared a puree consistency meal for one resident. KS 2 placed a chicken breast into a blender, added an unmeasured amount of hot water from the faucet and blended the two ingredients. KS 2 did the same with the mixed vegetables but did not attempt to puree the rice. That resident's meal consisted of puree chicken breast and mixed vegetables. An interview with DM conducted on 4/19/23 at	R 0268	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to ensure it provided meals that provided a balanced distribution of the daily nutritional requirements for 57 of 57 residents who reside in the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents residing in the community had the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** The facility has switched to Grove menus, approved by a registered dietician. Dietary Director	05/16/2023

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	3:01 p.m. indicated, she was unaware of who created the current menus the facility is following nor does she believe the menus were reviewed for distribution of daily nutritional requirements.. To her knowledge, the menu's are not approved by a RD (Registered Dietician). The menus do not contain a signature of a Registered Dietician. She indicated, there aren't recipes for her to follow for the items on the menu's nor did she have a recipe to follow for the pureed food served to one resident. When asked how she knows how to make the menu items without a recipe, she indicated, she had either made it before or will Google a recipe. She stated, the facility just started using the Gordon's Food Menu generator but was unsure how to use the site to generate a menu, account for substitutions, find puree version of recipes or ensure nutritional daily requirements had been met. This state tag relates to complaints IN00406175 and IN00406078.		educated about having a registered dietician sign off on any substitutions. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Dietary Director will monitor meals for substitutions and compliance.	
R 0269 Bldg. 00	410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. Based on interview and record review, the facility failed to ensure meals and/or substitutions were approved by a registered dietician for 57 of 57 residents who reside in the facility. (Facility) Findings include: A weekly lunch and dinner entree menu was provided by the Dietary Manager (DM) on 4/18/23 at 10:06 a.m.	R 0269	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to ensure meals and/or substitutions were approved by a registered dietician for 57 of 57 residents who reside in the facility. **How the facility will identify other residents having the**	05/16/2023

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	An interview with DM conducted on 4/19/23 at 3:01 p.m. indicated, she was unaware of who created the current menus the facility was following nor does she believe the menus were approved by a RD (Registered Dietician). The menus do not contain a signature of a Registered Dietician. She indicated, there aren't recipes for her to follow for the items on the menu's nor did she have a recipe to follow for the pureed food served to one resident. She stated, the facility just started using the Gordon's Food Menu generator but was unsure how to use the site to generate a menu, account for substitutions, or find puree version of recipes. A Food Preparation policy received on 4/18/23 at 11 a.m. from DM indicated, "Production Records A. All kitchen associates are to produce foods according to specified recipes and amounts indicated on the Food Production Sheet." This state tag relates to complaint IN00406078.		**potential to be affected by the same deficient practice and what corrective action will be taken:** 57 of 57 residents living in the community have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** The facility has change menu provider to Grove. Dietary Director educated to ensure substitutions are approved by a registered dietician. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Dietary Director will monitor meals for substitutions and compliance.	
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview, and record review, the facility failed to ensure food was served at a safe and appropriate temperatures for 9 residents who received room trays (Facility) and one resident with a puree consistency diet (Resident S). Findings include:	R 0272	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to ensure food was served at safe and appropriate temperatures for 9 residents who received room trays	05/16/2023

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	1. An observation of the lunch service was conducted on 4/17/23 at 12:07 p.m. Residents in the dining room were served lunch first. Once the dining room was served, KS (kitchen Staff) 2 began to prepare the room trays. As each room tray was made, they were placed onto a three shelved cart until all 9 of the room trays plus one test tray had been prepared. The room tray service began at 12:48 p.m. with HHA (Home Health Aide) 17. After 7 of the 9 room trays had been delivered, CNA (Certified Nursing Assistant) 2 took the food temperature readings of the test tray. The temperature readings were as follows: Herbed chicken breast: 109.6 degrees Fahrenheit Rice pilaf: 123 degrees Fahrenheit Mixed vegetables: 113 degrees Fahrenheit An interview with DM (Dietary Manager) was conducted immediately following the room tray observation. DM indicated, the service temperature of the test room tray was too cool. She indicated, they need something to help keep the room trays warmer. A Food Preparation policy was received on 4/18/23 at 11 a.m. from DM. The policy indicated, "Maintenance of Food Temperatures A. After food is produced according to the recipe and the correct amount, it is maintained as follows. Acceptable minimum temperatures are: 1. Broths, 180 Degrees F. 2. Creams Soups, 165-170 Degrees F. 3. Entrees, 145 Degrees F. 4. Starches, 160 Degrees F. 5. Vegetables, 145 Degrees F... B. If temperatures are inadequate, food is returned to the cooks to modify the temperatures to the correct degree. Temperatures are checked		(Facility) and one resident with a puree consistency diet. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents receiving room trays had the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** Dome plate covers ordered to maintain proper temperatures for room trays. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Dietary Director will monitor room tray temps daily.	

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	half-way through service and at the end of service." 2. An observation of lunch service was conducted on 4/17/23 at 12:07 p.m. During the lunch service, KS (kitchen staff) 2 prepared a puree consistency meal for Resident S. KS 2 placed a chicken breast into a blender, added an unmeasured amount of hot water from the faucet and blended the two ingredients. KS 2 did the same with the mixed vegetables. Once Resident S's meal was pureed, KS 2 placed the food items into a Styrofoam container, closed it up, and placed it on the service table for delivery. When asked to check the temperature of Resident S's meal, KS 2 indicated, she "forgot" she wanted to check the temperature as well. Resident S's meal temps were as follows: Puree chicken - 92.3 degrees Fahrenheit Mixed vegetables - 113.6 degrees Fahrenheit. An interview with KS 2 immediately following the testing of Resident S's food temperatures indicated, the food needed to be reheated to the appropriate temperature. This state tag relates to complaint IN00406078.			
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, interview, and record review, the facility failed to ensure kitchen equipment was maintained in good working order by the reach in freezer's condenser unit leaking onto foods stored below, not having expired food	R 0273	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to	05/16/2023

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	items, not properly labeling and dating of opened food items, and kitchen staff not wearing beard/mustache restraints in the kitchen for 57 of 57 residents who eat meals from the facility kitchen. (Facility) Findings include: A kitchen tour was conducted with KS (kitchen staff) 2 on 4/17/23 at 9:29 a.m. During the kitchen tour, the following was observed: In the reach in refrigerator were: - A pitcher containing a red liquid, identified as cranberry juice by KS 2, had no label or date. - A pitcher containing an orange liquid, identified as orange juice by KS 2, had no label or date. - Two large pitchers containing a brown liquid, identified as tea by KS 2, had no labels or dates. - A pitcher containing a pink liquid, identified as fruit punch by KS 2, had no label or date. - An unopened gallon of milk with an expiration date of 4/16/23. - Three, previously opened gallons of milk without opened dates. - A large container of cottage cheese with an expiration date of 3/20/23. - Six, small, plastic ramekins, 3 of them containing a white substance, identified as ranch dressing by KS 2 and 3 of them containing a reddish substance, identified as french dressing by KS 2, had no labels or dates. - An opened package of sliced deli ham with an expiration date of 4/7/23. In the reach in Freezer: - A metal pan containing ice was located under the freezer's condenser unit. An interview with KS 2 conducted at the same time as the observation indicated, the condenser had been leaking for a few weeks and they put the pan there		ensure kitchen equipment was maintained in good working order by the reach in freezer's condenser unit leaking onto foods stored below, not having expired food items, not properly labeling and dating of opened food items, and kitchen staff not wearing beard/mustache restraints in the kitchen for 57 of 57 residents who eat meals from the facility kitchen. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents living in the community have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** All staff working in the affected area will be educated by May 8, 2023, on labeling of food and drinks and food handling standards. The refrigerator has been repaired. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** All resident residents residing at the facility and utilizing the dining services have the potential to be affected.	

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	to catch the leaking water in the mean time. A repair person had come out a few weeks back but did not complete the repair as it was too late in his day to do it. KS 2 indicated, the repair person said they would be back but had never returned. - A five gallon, cardboard container of ice cream located below the condenser unit had ice built up on the top of the container as well as drips of frozen water down the sides of the ice cream container possibly contaminating the contents of the container and the ice cream had no opened date. - An opened box of frozen broccoli was located under the condenser unit and had ice built up on the top of the opened box. Inside the box, the bag of broccoli was left open to air and possibly was contaminated by the leaking condenser unit. An observation made during lunch service on 4/17/23 at 12:09 p.m. was made of Kitchen staff (KS) 22. He was observed in the kitchen without a beard restraint over his beard and mustache while placing cake slices onto plates. KS 22's beard and/or mustache was longer than 1/4" in length. An interview with DM conducted at the same time as the observation indicated, they currently did not have any beard/mustache restraints in the facility. An Infection Control - Food Storage policy was received on 4/18/23 at 11 a.m. from DM (Dietary Manager). The policy indicated, "It is the policy of the Dining Services Department that food storage occurs in a strictly defined manner...to prevent the transmission of disease carrying organisms...5. Meats, poultry, seafood should be stored in the same areas and boxes...and labeled as to when the items is scheduled for use." A Food Preparation policy was received on		All food and drinks in the freezer and refrigerator have been dated and labeled with open dates and discard dates. Staff was educated on sanitation and safe food handling standards. Beard/mustache restraints have been purchased and are being used.	

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	4/18/23 at 11 a.m. from DM. The policy indicated, "Food Handling A. The dietary Service Director is responsible to maintain safe food handling practices by all kitchen associates by providing the following tools and instruction in use...4. Hats/caps/hairnets for protective covering...6. Food labeling materials for labeling and dating..." The Indiana Retail Food Establishment Sanitation Requirements effective on November 14, 2004 indicated, "Date Marking and Disposition 410 IAC 7-24-191 Ready-to-eat, potentially hazardous food; date marking Sec. 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day one (1): (1) Forty-one (41) degrees Fahrenheit or less for a maximum of seven (7) days. (2) Forty-five (45) degrees Fahrenheit or between forty-one (41) degrees Fahrenheit and forty-five (45) degrees Fahrenheit for a maximum of four (4) days in existing refrigeration equipment that is not capable of maintaining the food at forty-one (41) degrees Fahrenheit or less if: (A) the equipment is in place and in use in the food establishment, and (B) the equipment is upgraded or replaced to maintain food at a temperature of forty-one (41) degrees Fahrenheit or less as specified in section 187(a)(2)(B)(ii) of this rule. (b) Except as specified in (d) and (e) of this			

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	section, refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a retail food establishment and if the food is held for more than twenty-four (24) hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in subsection (a) and: (1) the day the original container is opened in the retail food establishment shall be counted as day one (1); and (2) the day or date marked by the retail food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (c) A refrigerated, ready-to-eat potentially hazardous food that is frequently" This state tag relates to complaint IN00406078.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure a resident's medical record was complete that included the emergency contant information for 1 of 5 residents reviewed.	R 0349	**What corrective actions will be accomplished for those residents found to have been affected by the deficient**	05/16/2023

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	(Resident H) Findings include: The clinical record for Resident H was reviewed on 4/17/23 at 12:00 p.m. Resident H's diagnosis included, but was not limited to, giant cell arteritis. The resident's medical record did not include a face sheet with the emergency contact information. An interview was conducted with the Director of Nursing on 4/17/23 at 1:29 p.m. She indicated after reviewing Resident H's medical record; she was unable to locate the emergency face sheet for Resident H that contained the emergency information. It should not be removed from the chart.		**practice:** The facility failed to ensure a resident's medical record was complete that included the emergency contact information for 1 of 5 residents reviewed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents residing at the facility have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** An audit of all charts will be conducted to ensure that up-to-date face sheets are included. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Wellness Director or designee will review all charts quarterly, to ensure that face sheets are in charts	
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family,			

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	responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure the information regarding a resident's death included the notification of the physician for 1 of 2 closed records reviewed. (Resident K) Findings include: The clinical record for Resident K was reviewed on 4/18/23 at 3:40 p.m. Resident K's diagnoses included, but not limited to, dementia and depressive disorder. A nursing progress note dated 1/1/23 at 7:30 p.m. indicated, a CNA (Certified Nursing Assistant) had informed the nurse that Resident K had passed away. The nursing note stated, "Hospice notified" but did not indicate the resident's physician had been notified of Resident K's death. An interview with DON (Director of Nursing) conducted on 4/18/23 at 4:39 p.m. indicated, she was unable to find where the physician was notified of Resident K's death in the clinical record.	R 0357	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to ensure the information regarding a resident's death included the notification of the physician for 1 of 2 closed records reviewed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents residing in the facility have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** Moving forward when a hospice resident passes, facility will notify Physician as well as hospice. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Wellness Director will monitor for compliance.	05/16/2023

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R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to ensure a resident's comprehensive care plan was developed in cooperation with their mental health service provider for 1 of 5 residents reviewed for care plans. (Resident D) Findings include: The clinical record for Resident D was reviewed on 4/18/23 at 10:18 a.m. Resident D's diagnoses included, but not limited to, diabetes type II, chronic obstruction pulmonary disease,cerebral vascular accident (CVA, stroke), and major depressive disorder. Resident D's psychological evaluation dated 3/9/22 indicated, "Chart records diagnosis of major depressive disorder and anxiety disorder. She does report a history of 'a little counseling' in	R 0383	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to ensure a resident's comprehensive care plan was developed in cooperation with their mental health service provider for 1 of 5 residents reviewed for care plans. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents residing in the community who suffer from major mental health issues have the potential to be affected.	05/16/2023

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	the past. She currently reports her mood is 'not great' due in part to significant pain symptoms. She reports poor appetite and mild to moderate anxiety...Recommendations: 1. In view of continued depressive symptoms with pain complex, you may wish to consider the medical appropriateness of increasing Cymbalta to 90 mg qd [sic, milligrams per day] for better control of depression with pain complex. 2. Will schedule patient for 4-6 sessions of cognitive-behavioral and insight oriented psychotherapy in view of depressive symptoms including anxiety, rumination, and. [sic] Treatment is medically necessary at this time in view of current severity of symptoms. Goal therapy is to decrease severity of target symptoms to a mild range b y increasing insight into maladaptive thought processes and by facilitating more efficient problem-solving skills." A psychotherapy progress note for Resident D dated 3/31/22 indicated, "Patient stated physical health is worsening her mental health symptoms causing more anxiety and depressive symptoms. Facilitated discussion aimed at developing behavioral strategies for pain management." Treatment goal and plan: 1. Reduce target symptoms...by increasing insight into maladaptive thought processes and by facilitating more efficient problem-solving skill...Continue present management. A psychotherapy progress note for Resident D dated 3/1/23 indicated, "Patient reports an increase in depressive symptoms due to cold, cloudy weather. Patient reports she has been going on more outings and trying to keep herself busy by participating in activities and seeing family and friends...Separation for psychotherapy does not appear appropriate at this time in view of		**What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** Residents suffering from major mental health issues will have care plans developed in cooperation with mental health professionals. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Wellness Director will audit to ensure compliance.	

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		A. BUILDING 00 B. WING	04/20/2023

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	exacerbation of depressive symptoms. Will create new treatment plan at next encounter. A psychotherapy progress note for Resident D dated 3/8/23 indicated, treatment plan changes are "Will schedule patient for 4-6 sessions of cognitive-behavioral and insight oriented psychotherapy in view of depressive symptoms including anxiety, rumination, and depression. Resident D's Service most current service plan dated 10/14/22 included, but not limited to, the following needs and actions: - Adaptation to change: Independently adjust to changes. Notes: May require verbal cues at times. Will continue to monitor and adjust plans of care as needed. - Behavior: No assistance with attitude, habits and behavior. Notes: Resident does seek medical attention due to numerous complaints and request to be sent to ER (emergency room) rather than allowing some tests to be completed in house. - Expressive Communication: Provide no assistance with communication. Resident D's service plan did not address her major depressive disorder, anxiety, and rumination nor did it contain actions the facility should take to help alleviate the signs/symptoms she was experiencing. An interview with DON (Director of Nursing) conducted on 4/18/23 at 10:23 a.m. indicated, Resident D's service plan should have included the recommendations from the mental health provider. A Service Plan policy received on 4/19/23 at 11:05 a.m. from DON indicated, "The Resident Service Plan should be reviewed and revised as necessary...			

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	A. Following a change in condition of the resident that results in altered care needs over a period of greater than two weeks. B. Minimally every quarter. 3. The Resident Service Plan should include: A. Specific and individualized needs of the resident. B. Specific and individualized approaches for the care of the resident based on their needs."			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview and record review, the facility failed to properly prevent and/or contain COVID-19, and ensure infection control was maintained by staff not donning of doffing the appropriate personnel protective equipment (PPE) that was required to enter/exit a resident's room that was in droplet transmission with COVID-19 for 1 of 2 residents reviewed for infection control (Resident B) and for not performing hand hygiene between each resident's lunch tray delivery for 1 of 9 room trays observed (Resident T). Findings include: 1. The clinical record for Resident B was reviewed on 4/17/23 at 9:00 a.m. Resident B's diagnosis included, but was not limited to, COVID. The resident tested positive for COVID-19 on 4/13/23. An observation was made of Resident B's apartment on 4/17/23 at 10:26 a.m. A droplet	R 0406	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to properly prevent and/or contain COVID-19, and ensure infection control was maintained by staff not donning or doffing the appropriate personal protective equipment (PPE) that was required to enter/exit a resident's room that was in droplet transmission with COVID-19 for 1 of 2 residents reviewed for infection control and for not performing had hygiene between each resident's lunch tray delivery for 1 or 9 room trays observed. **How the facility will identify**	05/16/2023

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	transmission sign was observed on the resident's door and a PPE cart was sitting in the hallway next to the door. The sign indicated the apartment was in transmission based precautions. The following PPE was required to enter the resident's apartment: N95 respirator, faceshield/goggles, gown, and gloves. Certified Nursing Assistant (CNA) 2 with a surgical mask on her face was observed walking out of the resident's apartment. An interview was conducted with CNA 2 at that time. She indicated the required PPE equipment to enter the resident's apartment was a surgical mask, gown and gloves. The staff did not have to wear face shields. During that time, the PPE cart was observed with no gowns and no face shields. At 10:30 a.m., an observation was made of License Practical Nurse (LPN) 4 with a surgical mask on her face coming out of Resident B's apartment. LPN 4 indicated the required PPE was surgical mask, gown and gloves. She did not have to wear a face shield. An interview was conducted with Resident B on 4/17/23 at 10:42 a.m. She indicated some staff wear face shields and other staff do not while in her apartment. LPN 4 had administered an inhaler and obtained her blood sugar while she was in her apartment. During the interview, CNA 2 had entered the resident's room and was observed at that time with a gown, gloves and surgical mask. CNA 2 was not observed with an N95 nor face shield. An interview was conducted with the Executive Director at 11:00 a.m. She indicated the staff are to wear N95 and face shields in resident's rooms that are in isolation with COVID-19. 2. An observation of the lunch tray delivery was conducted 4/17/23 at 12:48 p.m. with HHA (Home Health Aide) 17. HHA 17 knocked on R's door then entered the		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents residing in the community have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** Re-education was provided to staff on proper infection control practices including hand washing, proper PPE, including face shields, donning and doffing PPE by April 19, 2023. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** When isolation is in place, Wellness Director or designee will conduct daily audits of isolation carts to ensure all PPE is available.	

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	room with her lunch tray. Resident T was still in her bed. HHA 17 set the lunch containers down on a chair and she proceeded to call to Resident T's name. HHA 17 then walked over to Resident T in bed and placed her hands on Resident T and gently shook her by her shoulder to wake the resident. When Resident T woke up, she told HHA 17 she did not want her lunch at this time so HHA picked up the containers, walked out of the room, and set the containers back on the cart holding other resident's lunch. HHA 17 then proceeded to Resident B's room. HHA 17 had not performed hand hygiene after touching Resident T and Resident T's chair. 3. Continuing the lunch tray observation with HHA 17, she approached Resident B's room. Resident B was on droplet isolation related to an active COVID-19 infection. HHA 17 donned the necessary PPE (personal protective equipment), prepared a black plastic trash bag and left it on the ground in front of Resident B's room, grabbed Resident B's lunch and entered the room. Upon exiting Resident B's room, she came out into the hallway with her full PPE still on. HHA 17 doffed (sic, removed) the gloves first, followed by the eye shield, the N95 mask, then the gown. She placed all the PPE items into the trash bag lying on the ground and tied the bag up. HHA 17 then performed hand hygiene and grabbed the bag by the area she had just tired with contaminated hands and took it to trash room. She also wore the surgical mask underneath the N95 mask. An interview with DON (Director of Nursing) conducted on 4/17/23 at 2:47 p.m. indicated, staff need to perform hand hygiene in between each resident when delivering food. She also indicated, when removing PPE from a COVID-19 positive room, it should have been removed prior to exiting			

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	the resident's room and in a way which prevents cross contamination. The CDC's (Centers for Diseases and Control) website at cdc.gov/coronavirus, last accessed on 4/24/23 at 2:41 p.m., "Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19" indicated, "Doffing (taking off the gear)... 1. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak). 2. Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle. 3. HCP [sic, healthcare provider] may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles. 6. Remove and discard respirator (or facemask if used instead of respirator). Do not touch the front of the respirator or facemask. - Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator. - Facemask: Carefully untie (or unhook from the ears) and pull away from face without touching the front.			

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	7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse." This state tag relates to complaints IN00406175.			