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	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WINDSOR RIDGE	2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 18 and 19, 2022 Facility number: 004001 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 28, 2022.	R 0000		
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights.			

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

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	(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure the completion of general and/or specific orientation for 3 of 8 staff reviewed. Findings include: The employee record reviewed, on 4/19/22 at 10:05 a.m., lacked the following documentation: -Maintenance 6 lacked documentation of a general and specific orientation. He was hired on 8/16//21. -Bookkeeper 5 lacked documentation of a specific orientation. She was hired on 3/21/22. -Cook 4 lacked documentation of a general and specific orientation. He was hired on 2/20/22. During an interview, on 4/19/22 at 12:43 p.m., the ED (Executive Director) indicated for the areas of staff orientation, the facility lacked the documentation. He could not locate a policy for employee record requirements. He just knew what the regulations required.	R 0119	Maintenance 6 received facility general and job specific orientation on 4/20/22. Bookkeeper 5 received specific job orientation on 4/20/22. Cook 4 received facility general and job specific orientation on 4/20/22. All employee charts were audited to ensure all required facility and job specific orientation had been completed and one other discrepancy was found and resolved. The facility will utilize a new employee check list to ensure all required employment documentation is completed. The Business Office Manager (Bookkeeper) was inserviced on facility and job specific orientations to ensure all are completed, documented, and copies to confirm compliance placed in the applicable employee file. Each new employee will have a	05/01/2022

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			check list completed prior to beginning employment and all employee files will be audited by the Administrator or designee to ensure all documentation is completed and current weekly x 4 weeks, then monthly x 5 months and will continue if 100% compliance is not achieved.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.			

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	(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure the completion of in-services for resident rights, dementia, and abuse for 5 of 8 staff reviewed. Findings include: The employee records were reviewed on 4/19/22 at 10:05 a.m. The records lacked the following documentation: -Maintenance 6 lacked documentation of in-services for resident rights and dementia. He was hired on 8/16//21. -Bookkeeper 5 lacked documentation of in-services for resident rights and abuse. She was hired on 3/21/22. -Cook 4 lacked documentation of in-services for resident rights and abuse. He was hired on 2/20/22. -CNA (Certified Nurse Aide) 7 lacked documentation of in-services for dementia and abuse. She was hired on 6/3/19. -CNA 8 lacked documentation of in-services for resident rights and dementia. She was hired on 7/27/21.	R 0120	Maintenance 6 received inservice education for Resident Rights on 4/20/22 and for Dementia training on 4/23/22. Bookkeeper 5 received inservice education on Resident Rights and abuse on 4/20/22. Cook 4 received inservice education on Resident Rights and abuse on 4/20/22. CNA 7 received inservice education on abuse on 4/20/22 and 6 hours Dementia Training on 4/23/22. CNA 8 received inservice education on Resident Rights on 4/20/22 and 6 hours Dementia Training on 4/23/22. All employee charts were audited to ensure all required in service education was up to date and no further findings were identified. The facility will implement "Individual Inservice Logs" to ensure compliance with 410 IAC 16.2-5-1.4(e)(1-3). The Business Office Manager (Bookkeeper) received inservice education on inservice requirements for employees in an effort to ensure ongoing monitoring and	05/01/2022

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	During an interview, on 4/19/22 at 12:43 p.m., the ED (Executive Director) indicated for the area of staff in-services related to resident rights, dementia and abuse, lacked the documentation of completion. He could not locate a policy for employee record requirements. He just knew what the regulations required.		compliance of required initial education, as well as ongoing education. The Administrator or designee will audit the "Individual Inservice Logs" to ensure that all employees are current on required inservices upon hire and thereafter weekly x 4 weeks, then monthly x 5 months and will continue if 100% compliance is not achieved.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation and interview, the facility failed to ensure hot water temperatures were maintained within safe limits for 5 of 5 rooms tested. (Rooms 112, 126, 128, 131, and 133) Findings include: During the environmental tour with the	R 0148	Upon being aware of the hot water reading 124-130 degrees F in resident rooms, the Maintenance Director and the Administrator immediately adjusted the hot water heater and all hot water was drained from the tank. In 1 hour, the hot water in resident	05/01/2022

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	Maintenance Director on 4/19/22 at 11:25 a.m., the following rooms' hot water temperatures were measured at: - Room 112 = 130 degrees Fahrenheit - Room 126 = 128 degrees Fahrenheit - Room 128 = 128 degrees Fahrenheit - Room 131 = 128 degrees Fahrenheit - Room 133 = 124 degrees Fahrenheit While measuring these temperatures, the residents in Rooms 112, 128 and 133 indicated the water was very hot although they had never been scalded. The Maintenance Director indicated the temperatures were too warm and he would need to adjust them. It was a difficult and tricky process as it tended to go the opposite way and made the temperatures go cold. He followed the State guidelines for what the temperatures were supposed to be at. At 11:50 a.m., the temperatures were brought to the Executive Director's attention and a request was made for the water temperature logs for the past 4 months. At 1:08 p.m. the Executive Director indicated there were no records of the water temperatures being maintained. At 1:20 p.m., a re-check of the hot water temperatures measured at the 97 degree Fahrenheit mark in each of the 5 rooms. The Maintenance Director said he would have to go and re-check the settings and adjust again.		apartments measured 97 degrees F. The Maintenance Director made an adjustment on the hot water heater and the temperature was brought to 108 degrees F, which is within the appropriated range of 100-120 degrees F. All zones of the facility were within the appropriate range. The Maintenance Director received inservice education regarding 410 IAC 16.2-5-1.6(k) regarding acceptable temperatures for hot water in all resident bathing and hand washing facilities. He was also inserviced on facility policy regarding facility Preventative Maintenance Policy, including routine checks of resident hot water on 4/20/22. As a means to ensure ongoing compliance, the Maintenance Director shall be responsible to follow the preventative maintenance schedule conducting routine checks of hot water temps and provide those logs to the Administrator. The Hot Water Temp Logs will be audited by the Administrator or designee to ensure checks are completed and within acceptable range weekly x 4 weeks, then monthly x 5 months and will continue if 100% compliance is not achieved.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the			

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	facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure a Resident Service Plan on a newly admitted resident was developed and discussed with the resident with a signature after review. This deficient practice affected 1 of 7 residents reviewed for Service Plans. (Resident 1) Finding included: The clinical record was reviewed on 4/18/22 at 10:00 a.m. Diagnoses included, but were not	R 0217	The Director of Nursing completed a Service Plan for the affected resident on 4/20/22. All resident charts were audited with no other resident lacking a current Service Plan. The Director of Nursing received inservice training regarding Service Plans being completed prior to admission and semi-annually and upon any known substantial	04/20/2022

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	limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus, schizophrenia, bipolar disorder, and major depressive disorder. She was admitted to the facility on 4/1/22. On 4/18/22 at 1:30 p.m., a request was made to the Executive Director for a copy of the resident's Service Plan as it was not in the clinical record. He indicated he would look for it. On 4/19/22 at 9:30 a.m., the Executive Director and the Director of Nursing were unable to locate a completed Service plan for the resident. On 4/19/22 at 1:15 p.m., the Executive Director presented the facility's current policy titled "Policy on Residential Admittance and Continued Stay at Residential Level." which he indicated covered about the Service Plans being developed. Review of this policy included, but was not limited to, "...8. An evaluation of individual needs conducted by a licensed nurse shall be initiated prior to admission and shall be updated at least semi-annually and upon a known substantial change in a resident's condition..."		change in resident condition. The DON or designee will audit all resident charts to ensure all service plans are current weekly x 4 weeks, then monthly x 5 months and will continue if 100% compliance is not achieved.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, record review and interview, the facility failed to notify the physician of an error and obtain a change in dose (as requested by the resident) for the resident's insulin dosage for 1 of 5 residents observed for medication administration. (Resident 2)	R 0247	The affected resident had no adverse effects from the medication error. The facility “Medication Error Policy” was followed, including notifying the physician and family	05/01/2022

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	Findings include: During an observation of insulin administration on 4/18/22 at 9:27 a.m., for Resident 2, QMA (Qualified Medication Aide) 3 completed an accu check on the resident with a reading of 285. She obtained the Humalog flexpen and the lantus flexpen. She dialed the Lantus to 40 units and dialed the Humalog to 7 units. The resident did not request an increased amount of insulin. The physician's order indicated 5 units of Humalog to be administered. The clinical record for Resident 2 was reviewed on 4/18/22 at 12:35 p.m. The diagnosis included, but was not limited to Diabetes Mellitus type 1. The April 2022 Physician's Orders indicated the resident was to receive the following medications: -Humalog 100 unit/mL (milliliters) kwik insulin Lispro prime and inject subcutaneously every per sliding scale for the diagnosis of diabetes mellitus. The start date was 9/21/21. -Humalog sliding scale: if the resident's blood sugar was 151 to 200 give 3 units, 201 to 250 give 4 units, 251 to 300 give 5 units, 301 to 350 give 6 units, greater than 351 give 7 units. The start date was 5/3/21. -Lantus Solostar 100 units/mL prime and inject 40 units subcutaneously every morning for the diagnoses of diabetes mellitus. The start date was 7/29/21. The clinical record lacked documentation of a physician's order for honoring the resident's preference of the increased units of insulin.		of the error. The Administrator met with the resident on 4/19/22 to discuss his insulin orders. The orders were printed boldly and reviewed and left with the resident for reference. The resident states that he wants to follow the MD orders as they are written. The resident was also instructed that if he should request that his insulin be administered in any amount that differs from the order, the facility licensed nurse would be required to notify the MD of his request. The QMA was also inserviced on this and also the necessity to prime the insulin pen as directed by the manufacturer. An audit was completed on all residents who receive insulin injections and no further discrepancies were identified. All nurses and QMA's received inservice education on the Physician's Orders Policy as well as procedures for administration of Humalog insulin pens as indicated on Humalog.com on 4/23/22. The DON or designee will audit by conducting random observations of nursing staff during administration of insulin pens and for compliance with adherence to insulin/sliding scale orders weekly x 6 months and will continue if 100% compliance has not been achieved.	

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	The diabetes center physician's note, dated 2/8/21 indicated per MD (medical doctor's) orders there were no changes in insulin. If the patient had any more low blood sugars, fax the physician. The RN Assessment for Delegation of Insulin Administration, dated 11/9/20, indicated QMA 3 was assessed for the review of physician's orders for clarity to ensure the QMA could follow the orders. She was also assessed for the review and completion of the resident-specific insulin administration decision tree. The QMA acknowledged understanding of the tool and mandatory compliance. During an interview, on 4/18/22 at 1:50 p.m., QMA 3 indicated based on the resident's blood sugar and his food intake, he would tell her what he wanted as a dosage of insulin. The doctor hadn't changed the orders. She felt comfortable giving the resident the insulin, he wanted. It was strange at first. The physician had not made a note for administration per the resident's request. When administration of the flexpen she would clean the tip of the pen, apply a safety needle, dial up the pen to the correct dosage. She would clean the area of the administration site and holding the pen level, she would administer the insulin. She did not prime the needle for Resident 2 because she was nervous. She should have primed the needle by dialing up 3 units and applying the button. During an interview, on 4/19/22 at 9:33 a.m., the ED (Executive Director) indicated he could not locate any nurse's note of the physician being notified of the resident's wishes for more insulin than ordered. He informed the resident he would have to follow the physician's order and if he felt he needed more insulin, then the physician would			

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	have to be notified. During an interview, on 4/19/22 at 12:13 p.m., the DON (Director of Nursing) indicated the QMA should follow doctor's orders for medication administration and prime the insulin flexpen prior to administration. The Physician's Orders policy, dated October, 2014, was provided by the ED on 4/19/21 at 9:34 a.m., included, but was not limited to, "Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe... the licensed nurse will attempt to contact the prescribing physician to obtain a clarification of any order in question..." The Insulin Administration by a Qualified Medication Aide policy, dated January 2021, was provided by the ED (Executive Director) on 4/19/22 at 9:34 a.m. The policy included, but was not limited to, "... Should the QMA observe fluctuating blood sugar, the QMA shall notify the facility licensed nurse on site or on call for initial instructions. The licensed nurse will determine the need for further resident assessment and/or physician notification. Should resident condition be such to warrant significant revision(s) in insulin orders, the RN shall be contacted to ensure a reassessment for the Resident is conducted and any resulting revision reviewed with the QMA..." The Humalog company website,copyrighted in 2020, https://pi.lilly.com/us/humalog-kwikpen-um.pdf titled Instruction for Use HUMALOG Kwikpen included, but was not limited to, "... Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may			

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	collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units... Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle..."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure every resident had a current Emergency File which contained a photo, hospital preference, physician's information, emergency contacts name and number, and a copy of Advanced Directives. This deficient practice affected 1 of 8 Emergency Files reviewed.	R 0356	The Emergency File for Resident 1 was completed/updated on 4/20/22. All resident charts were audited to ensure emergency files were up to date with no further discrepancy found.	05/01/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WINDSOR RIDGE	2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Resident 1) Finding included: The clinical record was reviewed on 4/18/22 at 10:00 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus, schizophrenia, bipolar disorder, and major depressive disorder. On 4/18/22 at 1:30 p.m., a request was made to the Executive Director for a copy of the resident's Emergency File as it was not in the clinical record. He indicated he would look for it. On 4/19/22 at 9:30 a.m., the Executive Director and the Director of Nursing were unable to locate an Emergency File for the resident. On 4/19/22 at 1:00 p.m., the Executive Director indicated he did not have a policy on Emergency Files.		All staff received inservice education on ensuring an Emergency File is completed on admission and maintained with current information. The administrator or designee will audit all resident Emergency Files to ensure all are completed and updated/current weekly x 4 weeks, then monthly x 5 months and will continue if 100% compliance is not achieved.	