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	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOM AT GERMAN CHURCH	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00421227. Complaint IN00421227 - State deficiencies related to the allegations are cited at R0045. Survey dates: June 25 and 26, 2024 Facility number: 003916 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 1, 2024.	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 may be discussed in the response or plan of correction. In addition, preparation, and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Lingle	Executive Director	07/12/2024

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

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	known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the			

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	following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on interview and record review, the facility failed to ensure a resident who was transferred	R 0045	Deficiency ID: R 045 Completion Date: 7/24/24	07/24/2024

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	from the facility was provided, on a form prescribed by the department, of the transfer or discharge and the reasons for the move, in writing, nor was a copy of the completed notice placed in the residents' clinical record as soon as practicable for 2 of 2 closed records reviewed. (Residents B and D) Findings include: 1. The clinical record for Resident B was reviewed on 6/26/24 at 9:49 a.m. Resident B's diagnoses included, but not limited to, anxiety disorder and depression. A nursing note, dated 11/4/23 at 12:20 p.m., indicated the writer of the note sent an email to the local ombudsman to inform her of concerns regarding, Resident B Resident B was sent to a mental health facility for evaluation and treatment, on 10/25/23, for suicidal ideations and returned to the facility on 11/1/23. The writer was assured by the mental health facility that Resident B would be evaluated for safety to resume living at an assisted living facility prior to her discharge. Upon her return, the documents from the mental health facility stated, "return to skilled nursing facility". Resident B's medications had been changed and her behaviors quickly escalated. She was very confused and unable to sleep. On 11/3/23, she was determined to go to her credit union to get her money and stated her son was taking it, so she followed the staff around all day. At approximately 3 p.m., she stated, she might as well kill herself and that she would hang herself in her bathroom. Resident B was unable to be redirected and was transported to the local hospital's emergency room via ambulance. The clinical record for Resident B did not contain		Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** This RULE was not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident who was transferred from the facility was provided, on a form prescribed by the department, of the transfer or discharge and the reasons for the move, in writing, nor was a copy of the completed notice placed in the residents' clinical record as soon as practicable for 2 of 2 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:** All nursing staff and department heads educated on the discharge process. Appropriate forms are in place. Wellness Director has	

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	the 11/1/23 discharge paperwork from the mental health facility. In addition, Resident B's clinical record did not contain documentation to indicate the resident or the resident's representative was provided with the completed State's Transfer and Discharge form when sent to the mental health facility, on 10/25/23, nor the local hospital's emergency room on 11/3/23. 2. The clinical record for Resident D was reviewed on 6/26/24 at 11:06 a.m. Resident D's diagnosis included, but not limited to, Alzheimer's disease. Resident D was admitted to the facility, on 1/24/24, and discharged from the facility, on 2/16/24, to another assisted living facility. The clinical record did not contain evidence to indicate the resident/resident's representative was provided a completed State's Transfer and Discharge form when transferred to another assisted living facility on 2/16/24. An interview with Director of Nursing (DON) conducted, on 6/26/24 at 1:09 p.m., indicated she was unable to find evidence in Resident B's nor Resident D's clinical record of the form prescribed by the department, of the transfer or discharge and the reasons for the move, in writing, nor was a copy of the completed notice placed in the residents' clinical record. An Admission/Discharge Criteria policy received, on 6/26/24 at 10:00 a.m., from Executive Director (ED) indicated, "Discharge Notice...A resident being asked to relocate from the community will be given notice in accordance with the Admission Agreement." This citation relates to Complaint IN00421227.		made documentation changes to ensure correct discharge procedures are conducted. Wellness Director has educated all nursing staff and department heads on documentation changes that ensure correct transfer/discharge procedures are followed. **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:** Weekly audit of all discharges and transfers for 12 months has been implemented by Wellness Director. To be conducted by Wellness Director or designee.	

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R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to maintain hot water temperatures between 100 degrees and 120 degrees Fahrenheit at point of use for 3 of 3 rooms observed (Resident 8, 25, and 46). Findings include: On 6/25/24 at 3:04 p.m., an environmental tour of the facility was conducted with the DPO (Director of Plant Operations). Resident 46's kitchen sink was observed. The hot water temperature was obtained from the kitchen sink by the DPO at 131 degrees Fahrenheit (F). The DPO indicated that the hot water temperature was "way to high". Resident 25's kitchen sink had a hot water temperature, obtained by the DPO, at 124 degrees F. Resident 8's kitchen sink hot water temperature was obtained at 128 degrees F. The facility mixing valves were observed with the DPO on 6/25/24 at 3:20 p.m. The thermometers present on the mixing valves read 133 degrees F. The DPO indicated that was the actual hot water temperature at the point of the mixing valves. The DPO had adjusted the hot water heater temperature due to the kitchen dish machine not meeting temperature. On 6/26/24 at 1:45 p.m., the Executive Director	R 0187	Deficiency ID: R 187 Completion Date: 7/24/24 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The RULE is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain hot water temperatures between 100 degrees and 120 degrees Fahrenheit at point of use for 3 of 3 rooms observed. **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**	07/24/2024

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	indicated the facility did not have a policy for hot water temperature.		**practice does not recur:** Maintenance Director will be re-educated on monitoring water temperatures and maintaining those temperatures from 100 degrees to 120 degrees, according to the Indiana Administrative Code, Physical Plant Standards. **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:** A daily audit of 20% of resident room water temperatures will be conducted 1 time per day, daily, for 30 days, by Maintenance Director or designee. A weekly audit of 25% of resident room water temperatures will be conducted weekly moving forward.	
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 the facility kitchen food preparation and serving areas were free of personal staff items, hair nets were utilized while staff were in the kitchen, food was dated with open dates, expired food disposed of, the dish machine was at appropriate temperatures,	R 0273	Deficiency ID: R 273 Completion Date: 7/24/24 Plan of Correction Text: **What corrective actions will be**	07/24/2024

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	and the kitchen was maintained, clean, and sanitary. This had the potential to effect 54 of 54 residents who reside at the facility. Findings include: A tour of the kitchen and main dining room was conducted, on 6/25/24 at 9:50 a.m., with DM (Dietary Manager). The following was noted: A personal water bottle was observed next to sink at the cook station. DM removed the personal water bottle. DM indicated the personal water bottle should not have been there. DPO (Director of Plant Operations) came into the kitchen without donning a hair or beard net covering. The DM informed the DPO that hair nets and beard covers were required to be used in the kitchen The food storage area contained 1 open and 5 unopened packages of English muffins with a use by date of 6/10/24, 1 unopened package of bagels with a use by date of 6/19/24, 6 cans of evaporated milk with a use by date of 11/23/23, and an open brownie mix with use by date of 6/13/24. DM took all the English muffins, bagels, cans of milk, and brownie mix and placed in waste receptacle. Observed 2 unopened packages of hamburger buns, 12 unopened packages of wheat bread, 2 unopened packages of white bread, and 3 unopened packages of hot dog buns, all with no received by date or use by date. The hot dog buns stated, "keep frozen until use". There were 2 unopened packages of hoagie type rolls with green mold on the rolls. The DM removed such items and placed in the trash receptacle. A dented can of fruit cocktail was removed from shelf by DM and placed in the area for return to supplier.		**accomplished for those residents found to have been affected by the deficient practice:** This RULE is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the facility kitchen food preparation and serving areas were free of personal staff items, hair nets were utilized while staff were in the kitchen, food was dated with open dates, expired food disposed of, the dish machine was at appropriate temperatures, and the kitchen was maintained, clean, and sanitary. **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:** All staff will be educated on personal items appropriate storage, and use of hair nets. In addition, all Dietary staff will be educated on proper dating of food, disposal of expired food, proper dish machine temperature, cleanliness and sanitation for all areas of the	

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	A brown paper wrapping was observed on floor under the storage rack. The DM indicated the floor is swept daily and as needed. A hair net was observed hanging/stuck to the bread rack. The DM notified to visualize the net for removal. The facility dishwasher was observed with a wash temperature of 116 degrees Fahrenheit (F) and a rinse cycle temperature of 119 degrees F. The information plate located on the dishwasher unit was observed with the DM. DM indicated the temperature of the wash and rinse cycles should be no lower than 120 degrees F. Rolled up black mats were observed under the sink in dishwashing area. KA (Kitchen Aide) 2 indicated that the black mats were anti-slip mats and were too soiled to use. The drink dispenser in main dining room was observed to have visible soil at area where spigots are attached to unit. The interview with DM indicated they should not look that way. Juice and tea containers in drink dispenser observed to have no received date or use by date. Ice machine was observed to have a black substance accumulating on both sides internally where ice is housed. DM indicated there should not be black substance growing in the ice machine. Refrigerator/freezer unit in main dining room observed to have unopened containers of 7 units of juice (3 white cranberry, 1 sweet tea, 2 fruit punch, 1 orange juice for use in drink dispenser) with no received on or use by date. Popsicles observed in freezer with no received on or use by date. No log for temperature available on unit and no thermometer in refrigerator or freezer was		kitchen. **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:** A daily audit of personal staff items, hair net usage, all food dated with open dates, expired food disposed of, dish machine temperatures, the kitchen clean and sanitary, will be conducted 1 time per day daily x 30 days, and 1 time weekly thereafter for 11 months by Dietary Director or designee.	

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	observed. DM indicated they will place a temperature log on refrigerator and a thermometer in each the refrigerator and freezer. On 6/25/24 at 11:55 a.m., lunch service was observed in the main kitchen. The KC (kitchen cook) was observed using a gloved hand to touch utensils for serving, then touching food directly, picking up roll and placing on plate, cutting potato to plate and using utensils again. KC picked up serving utensil from area next to kitchen for serving creamed corn. DM retrieved a clean utensil for creamed corn, removing and replacing the utensil KC put in creamed corn.			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure a resident, who required the use of an antibiotic, received the prescribed medication in a timely manner for 1 of 5 resident records reviewed. (Resident 42) Findings include: The clinical record for Resident 42 was reviewed on 6/25/24 at 3:12 p.m. Resident 42's clinical record indicated, on 4/8/24, a urine sample was collected and sent for analysis with culture and sensitivity. A laboratory report, dated 4/12/24, indicated Resident 42's urine had greater than 100,000 cfu/ml	R 0297	Deficiency ID: R 297 Completion Date: 7/24/24 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The RULE is not met as evidenced by 1 of 5 residents records reviewed indicated that the facility failed to ensure a resident who required the use of an antibiotic received the prescribed medication in a timely manner. 1of	07/24/2024

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	(colony forming units per milliliter) of gram-negative rods which indicated, he had a urinary tract infection. A physician's order, dated 4/13/24, indicated for Resident 42 to receive Bactrim (a combination of two antibiotics) 400 mg-80 mg (milligram) tablets twice daily for 7 days. A nursing note, dated 4/13/24 at 11:45 a.m., indicated after reviewing Resident 42's lab results for the urinalysis, his Nurse Practitioner placed a new order for Bactrim 400 mg-80 mg tablets twice daily for 7 days. A nursing note, dated 4/13/24 at 11:00 p.m., indicated Resident 42 was not given the Bactrim that shift because the pharmacy had not delivered it yet. A nursing note, dated 4/14/24 at 3:00 p.m., indicated Resident 42's Bactrim was not available and the facility was still waiting for the pharmacy to deliver the medication. A nursing note, dated 4/15/24 at 7:00 a.m., indicated, Resident 42's Bactrim was "still" not available. Resident 42's, April of 2024, medication administration record (MAR) indicated Resident 42 did not receive the Bactrim on the following dates and times: 4/13/24 - 8 p.m. dose 4/14/24 - 8 a.m. dose 4/14/24 - 8 p.m. dose 4/15/24 - 8 a.m. dose 4/15/24 - 8 p.m. dose		5 residents reviewed received the prescribed medication 4/16/24. **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:** All nursing staff will be educated on new physician orders, and pharmacy policy for medications not immediately available or in the EDK. Additionally, an audit of all current resident orders will be conducted to ensure residents are receiving prescribed medications in a timely manner. **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:** A daily audit of new orders will be conducted 1 time per day daily x 30 days, and 1 time weekly thereafter for 11 months by Wellness Director or designee.	

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	An interview with Director of Nursing (DON) conducted, on 6/25/24 at 3:55 p.m., indicated the facility's pharmacy had been out of Bactrim and/or it would be in the next delivery. She further indicated; Bactrim was not available in their emergency medication kit. An interview with the facility's pharmacy conducted, on 6/27/24 at 11:37 a.m., indicated Resident 42's Bactrim order was received, on 4/13/24, late in the day and missed the Saturday cut off time for same day delivery and the pharmacy does not deliver on Sundays. The facility's pharmacy indicated the Bactrim was delivered, on 4/15/24, and was signed for by a nurse at the facility. The facility's pharmacy provided an Ordering and Receiving Medication policy on 6/26/24 at 2:52 p.m. The policy indicated, "Medications and related products are received from the pharmacy in a timely manner. The facility maintains accurate records of medication ordered and received...New medications, except for emergency or 'stat' [sic, immediate] medications, are ordered as follows: i. If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery..."			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident.			

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		A. BUILDING 00 B. WING	06/26/2024

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	(2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to document the disposition of any released, returned, or destroyed medications in the resident's clinical record for 1 of 2 residents reviewed for closed records. (Resident D) Findings include: The clinical record for Resident D was reviewed on 6/26/24 at 11:06 a.m. Resident D's diagnosis included, but were not limited to, Alzheimer's disease. Resident D was admitted to the facility, on 1/24/24, and discharged from the facility, on 2/16/24, to another assisted living facility. At the time of discharge, Resident D had current physician orders for the following medications that were to be continued at the new facility: - Dapsone (an antibiotic and anti-inflammatory medication) 25 mg (milligrams) tablet, take 2 tablets by mouth daily, - divalproex (an anticonvulsant medication) 125 mg capsule, twice daily by mouth, - famotidine (an acid reducing medication) 40 mg tablet, twice daily by mouth, - fexofenadine (an antihistamine) 180 mg tablet, take two tablets twice daily by mouth, - fluoxetine (antidepressant medication) 40 mg tablet, once daily by mouth,	R 0306	Deficiency ID: R 306 Completion Date: 7/24/24 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** This rule is not met as evidenced by: Based on interview and record review, the facility failed to document the disposition of any released, returned, or destroyed medications in the resident's clinical record for 1 of 2 residents reviewed for closed records. **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**	07/24/2024

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	- Singulair 10 mg tablet, once daily by mouth, - Miralax 17 grams daily, dissolve in 8 ounces of water or juice, - rosuvastatin 20 mg tablet, by mouth daily at bedtime, & - epinephrine 0.3 ml (milliliters) auto-inject pen as needed for severe allergic reaction, may keep at bedside. Resident D's clinical record did not contain a disposition of medications. A nursing note, dated 2/26/24 at 4:00 p.m., indicated, all belongings and medications were sent with Resident D's family. An interview with Director of Nursing (DON) conducted, on 6/26/24 at 1:09 p.m., indicated she was unable to locate a disposition of medications form for the medications which were released to Resident D's family. A Medication Disposition for Absence from the Community policy received, on 6/26/24 at 2:37 p.m., from Executive Director (ED) indicated, "Procedure...2. Each medication released to the resident or his guardian shall be listed on the Medication Release When Resident is Absent from Community form. Included in this listing shall be the name, strength and quantity of each medicine released. The form must be signed by the person receiving the medications and by the Wellness Director, Nurse or designee, releasing them."		**changes the facility will make to ensure that the deficient practice does not recur:** Nursing staff re-educated on the correct process of releasing, returning, or destroying medications. Appropriate forms are in place. **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:** Weekly audit of all dispositions of medications moving forward to be implemented by Wellness Director. To be conducted by Wellness Director or designee.	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution.			

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	(3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure a transfer form included the necessary information for a resident who was transferred to another facility for 2 of 2 residents reviewed for closed records. (Residents B and D) Findings include: 1. The clinical record for Resident B was reviewed on 6/26/24 at 9:49 a.m. Resident B's diagnoses included, but not limited to, anxiety disorder and depression. Resident B was transferred from the facility, on 11/3/23, to a local hospital's emergency room for suicidal ideation. A nursing note, dated 11/3/23 at 3:35 p.m., indicated Resident B stated she might as well kill herself and get it over with. Resident B then stated she wanted to hang herself in the bathroom. Resident B's Nurse Practitioner was notified and gave an order for Resident B to be sent to the local hospital's emergency room for suicidal ideation. Resident B left the facility with emergency medical services (EMS) transport. Resident B's son was notified, and report was given to the ER (emergency room).	R 0354	Deficiency ID: R 354 Completion Date: 7/24/24 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** This rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a transfer form included the necessary information for a resident who was transferred to another facility for 2 of 2 residents reviewed for closed records. **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	07/24/2024

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	The clinical record for Resident B did not contain a transfer form for the 11/3/23 transfer to the local emergency room which indicated the following information: - Name of the receiving institution and date of transfer. - Resident's personal property when transferred to an acute care facility. - Nurses' notes relating to the resident's: functional abilities and physical limitations; nursing care and treatment; current diet and condition on transfer; and date of chest x-ray and skin test for tuberculosis. 2. The clinical record for Resident D was reviewed on 6/26/24 at 11:06 a.m. Resident D's diagnosis included, but not limited to, Alzheimer's disease. Resident D was admitted to the facility, on 1/24/24, and discharged from the facility, on 2/16/24, to another assisted living facility. The clinical record for Resident D did not contain a transfer form for the 2/16/24 transfer to another health care facility which indicated the following information: - Name of the receiving institution and date of transfer. - Resident's personal property when transferred to an acute care facility. - Nurses' notes relating to the resident's: functional abilities and physical limitations; nursing care and treatment; current diet and condition on transfer; and date of chest x-ray and skin test for tuberculosis. An interview with Director of Nursing (DON) conducted, on 6/26/24 at 1:09 p.m., indicated the		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:** Wellness Director has implemented documentation to ensure necessary information is conveyed along with proper forms. An audit of resident transfers moving forward will be conducted to ensure all necessary information is conveyed. All nursing staff educated on information to be conveyed at the time of transfer. **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:** Weekly audit of all discharges moving forward has been implemented by Wellness Director. To be conducted by Wellness Director or designee.	

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	facility does not have a specific transfer form they utilize for transfers, but usually she sends a copy of the resident information sheet (which contains emergency contacts, physician's information and preferred hospital), current physician's orders, and the Indiana bed hold/ transfer/discharge form when transferring a resident. DON was unable to provide evidence confirming the required information was sent to the receiving providers for Residents B or D. A blank copy of an Indiana Transfer/Discharge form was provided by Executive Director (ED) on 6/26/24 at 2:39 p.m. ED indicated, neither Resident B nor Resident D's clinical record contained the completed Indiana Transfer/Discharge forms in their clinical record for their respective transfers. She also indicated, they were unable to produce a Transfer/Discharge procedure and/or policy instead the Admission/Transfer/Discharge Criteria policy was provided.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to ensure used insulin needles were not recapped for 2 of 2 injections	R 0407	Deficiency ID: R 407 Completion Date: 7/24/24	07/24/2024

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	randomly observed. (Resident 11 and Resident 46) Findings include: On 6/26/24 at 11:08 a.m., QMA (Qualified Medication Aide) 4 was observed administering insulin to Resident 11. QMA 4 performed hand hygiene, prepared the insulin pen for injection, and donned gloves. QMA 4 then took the insulin pen into the room, removed the cap from the needle, and administered the insulin to Resident 11. QMA 4 returned to the medication cart and while removing the needle from the insulin pen, the cap was observed to be on the needle. QMA 4 then moved her medication cart to the hallway outside of Resident 46's room. She prepared the insulin injection by withdrawing insulin into an insulin syringe from a vial. She put the cap back on the unused insulin syringe and took the medication into Resident 46's room. QMA 4 administered the insulin injection to Resident 46 and then used the insulin syringe to scoop up the cap with her right hand and then used her left hand to put the cap firmly on the used needle on top of the syringe. During an interview, on 6/26/24 at 11:25 a.m., QMA 4 indicated that she routinely recapped used insulin needles after she administered the medication. The types of needles that were sent from the pharmacy did not have any sort of safety devices for them and in order to remove the needles from the pens she needed to recap them. The insulin syringes also did not have safety devices to cover the needle after use, so she recapped the syringes as well. She was not sure why the pharmacy did not send needles and syringes with safety features so that recapping would not be needed.		Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** This RULE is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure used insulin needles were not recapped for 2 of 2 injections randomly observed. **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 insulin injections 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:** Insulin Safety Pens are now being used in the facility for insulin administration. Nursing staff educated regarding the use of the new pens. **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:** Insulin Safety Pens will be the	

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	During an interview, on 6/26/24 at 11:30 a.m., the DON (Director of Nursing) indicated that used needles should not be recapped. The article, "Hazards that can be eliminated by modifying work practices include injuries due to recapping, failing to dispose of a needle device properly " dated November 1999, was retrieved on 6/27/24 from the Centers of Disease Control (CDC) website at https://www.cdc.gov > niosh > docs > pdfs. The guidance included: "...Activities Associated with Needlestick Injuries Whenever a needle or other sharp device is exposed, injuries can occur. Data from NaSH [sic] show that approximately ...42% occur after use and before disposal. The circumstances leading to a needle stick injury depend partly on the type and design of the device used...In addition to risks related to device characteristics, needlestick injuries have been related to certain work practices such as recapping...Past studies of needlestick injuries have shown that 10% to 25% occurred when recapping a used needle .... Although recapping by hand has been discouraged for some time and is prohibited under the OSHA [Occupational Safety and Health Administration] bloodborne pathogens standard..."		only administration procedure available moving forward. Monitoring tool weekly to ensure all staff and residents are using safety pens. To be administered by Wellness Director or designee.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12)			

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	months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure tuberculin skin tests were administered prior to or at the time of admission for 1 of 5 records reviewed. (Resident C) Finding includes: The clinical record for Resident 45 was reviewed on 6/25/24 at 11:27 a.m. The resident was admitted to the facility on 3/19/24. The clinical record did not contain evidence that tuberculin (TB) skin tests completed for Resident C prior to or upon admission to the facility. An interview with Director of Nursing (DON) conducted, on 6/25/24 at 2:03 p.m., indicated she was unable to find evidence of a completed TB (tuberculosis) test prior to move-in for Resident C nor was there any indication that Resident C had a documented history of a significant Mantoux test (a PPD reactor). A Resident TB testing policy received, on 6/26/24 at 1:29 p.m., from Executive Director (ED) indicated, "Residents will be asked to provide proof of a negative TB test prior to move-in...Procedure: 1. The required tuberculosis	R 0410	Deficiency ID: R 410 Completion Date: 7/24/24 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure tuberculin skin tests were administered prior to or at the time of admission for 1 of 5 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**	07/24/2024

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	test shall include the two-step Mantoux test for tuberculosis using five tuberculin units of purified protein derivative (PPD); or, if the individual has a documented history of a significant Mantoux test, PPD reactor, a chest x-ray."		**changes the facility will make to ensure that the deficient practice does not recur:** Residents will have a TB test administered prior to move in or at time of move in, or if the individual has a documented history of a significant Mantoux test, PPD reactor, a chest x-ray obtained prior to move in. **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 audit tool of all new admissions moving forward has been implemented by the Wellness Director. To be conducted by the Wellness Director or designee.	