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	04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT NORTHSIDE	1251 W 96TH ST INDIANAPOLIS, IN 46260

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00398798, IN00390967, IN00388371, IN00386777 and IN00384108. Complaint IN00398798 - No deficiencies related to the allegations are cited. Complaint IN00390967 - No deficiencies related to the allegations are cited. Complaint IN00388371 - No deficiencies related to the allegations are cited. Complaint IN00386777 - No deficiencies related to the allegations are cited. Complaint IN00384108 - No deficiencies ralated to the allegations are cited. Survey dates: April 18, 19, 20, 21 and 24, 2023 Facility number: 003282 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 28, 2023.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions,			

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

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	except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on interview and record review, the facility failed to conduct 3 of 12 fire drills reviewed for monthly fire drills. (12/22, 1/23, and 2/23) Finding includes: The facility's fire drill records for 12 months were reviewed on 04/19/23 10:31 a.m. The monthly fire drill documentation was missing fire drills for 12/22, 1/23, and 2/23. The missing fire drill documentation was requested of Maintenance Staff 4 on 04/19/23 at 10:59 a.m. During an interview, on 04/19/23 at 10:59 a.m., Maintenance Staff 4 indicated he was not employed at the facility during the time of the missing fire drills. The missing fire drill documentation was requested of the Senior Life-Style Counselor on 04/20/23 at 10:42 a.m.	R 0092	**Plan of Correction:** 1) Unable to resolve missing fire drills for December 2022, January 2023 & February 2023. 2) Current residents have the potential to be affected by this alleged deficient practice. 3) Director of Facilities responsible for fire drills is no longer employed with the company. 4) Executive Director educated new Director of Facilities regarding the Indiana State regulation for fire drills in a residential community. 5) Community is current for March 2023 and April 2023. 6) Director of Facilities is responsible for on-going compliance. Fire drills will be reviewed monthly by the Executive Director for three months. Fire Drill compliance will be monitored by	05/01/2023

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	During an interview, on 04/21/23 at 12: 21 p.m., the Assistant Executive Director indicated the facility was unable to find the documentation. A current policy, titled "FIRE DRILLS," dated as last reviewed on 10/01/22 and received from the Assistant Executive Director on 04/21/23 at 9:26 a.m., indicated "...The completed Fire Drill Report will be kept in a notebook, filed by date...."		the Safety Committee on an ongoing basis.	
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			

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	dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure the six (6) hours of dementia training was completed within six months of hire and three (3) hours of annual dementia training was completed annually thereafter for 1 of 9 employees reviewed for dementia training. (Cook 1) Finding includes: During a review of employee files, on 04/23/23, Cook 1 had a start date of 11/15/22. Cook 1 had attended the education, titled "Dementia Care: Normal Aging vs. Alzheimer's Dementia," on 01/13/23 and completed 0.5 hours of training. Cook 1 had attended the education, titled "Dementia Care: Understanding Alzheimer's Disease," on 01/13/23 and completed 0.5 hours of training. Cook 1 had attended the education, titled "(Name of Class) Brain Changes," on 04/23/23 and completed 0.25 hours of training. Cook 1 had attended the education, titled "(Name of Class) Dementia 101," on 04/23/23 and completed 0.25 hours of training.	R 0120	**Plan of Correction:** 1) Cook 1 received the remainder of the six hours of dementia related in-services on Relias Training on 5/10/23. The training has been filed in the employee training binder. Cook 1 was employed on 11/15/2023. The six-month requirement for training is 5/15/2023. 2) Current residents have the potential to be impacted by this alleged deficiency. 3) New hire files were audited by Executive Director on 5/11/2023. All new hires will be compliant with six hours of dementia training by 5/31/2023. 4) Business Office Manager was re-educated on the state requirement by Executive Director that new hires must have six hours of dementia training within six months of hire. 5) The Business Office Manager is responsible for sustained compliance. 6) The Executive Director or designee will audit the newly hired employee files monthly for three	05/31/2023

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	The training totaled 1.5 hours of dementia training. During an interview, on 04/24/23 at 11:50 a.m., the Assistant Executive Director indicated the facility followed the state regulations. A current policy, titled "Company In-Services & CEU Policy", undated and received from the Assistant Executive Director on 04/24/23 at 8:50 a.m., indicated "...In-Services and continuing education units should follow the local and state regulations for the state in which the community is licensed...."		consecutive months. Then quarterly thereafter for one quarter. The audit will be documented and reviewed at the QA meeting. The QA committee will continue with quarterly audits of dementia training for all new hires.	
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			

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	performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will 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 failed to perform the second test of a two-step Mantoux test (a tuberculosis skin test) for 1 of 5 new employees (Housekeeper 2) and failed to perform an annual Mantoux test or annual tuberculosis risk assessment on 1 of 5 established employee (the Dementia Care Coordinator) for 2 of 10 employees reviewed for Mantoux/tuberculosis skin testing/assessments. Findings include: A review of the employee records began on 04/23/23. 1. Housekeeper 2 had a start date of 02/08/23. The facility was unable to provide the two-step tuberculosis testing for the employee. 2. The Dementia Care Coordinator had a start date of 07/13/20. The facility was unable to provide the annual tuberculosis risk assessment or an annual	R 0121	**Plan of Correction:** 1) Housekeeper 2, received the first step of the two-step procedure skin test TB screening on May 11, 2023 and the second step will be given between one and three weeks following the first step. The two-step TB screening will be documented and filed in the employee record. 2) The Dementia Care Coordinator received an annual tuberculosis skin test on May 11th, 2023. 3) Current residents residing in the community have the potential to be affected by the alleged deficient practice. 4) An audit of the employee records is being completed by Corporate Business Officer Manager to identify employees that require the two-step	05/19/2023

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	tuberculosis skin test for the employee. During an interview, on 04/24/23 at 11:50 a.m., the Assistant Executive Director indicated the facility did not have the tuberculosis records for the employees. A current policy, titled "Employee Health Screen," dated as last reviewed 08/11/21 and received from the Assistant Executive Director on 04/24/23 at 3:30 p.m., indicated "...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...At the time of employment, or within one (1) month prior to employment, and at lease 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...."		procedure skin test for TB screening or an annual tuberculosis risk assessment/skin test. Any files found to be in non-compliance will be corrected by 5/19/22. 5) Executive Director re in-serviced the Business Office Manager on May 10, 2023 on scheduling the newly hired employees for health screening and TB screening prior to starting the work schedule. Director of Nursing was re in-serviced by Executive Director on 05/10/2023 on maintaining an annual tuberculosis risk assessment for all employees. 6) The Business Office Manager is responsible for sustained compliance. The Executive Director or designee will audit the newly hired employee files weekly for two consecutive months to ensure that both 1st step and 2nd step of TB have been completed and then monthly for two months thereafter to ensure compliance. The audit will be documented and reviewed at the QA meeting. The QA committee will continue to audit quarterly on an ongoing basis.	
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:			

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	(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 interview and record review, the facility failed to have the HVAC (heating and ventilation) system inspected on a yearly basis. Finding includes: The Heating, Ventilation and Cooling (HVAC) yearly inspection report was requested from Maintenance Staff 4 on 04/19/23 at 11:00 a.m. The HVAC yearly inspection report was requested from the Assistant Executive Director (AED) on 04/21/23 at 9:56 a.m. The HVAC inspection records were requested from the Maintenance Coordinator on 04/22/21 at 9:20 a.m., at that time he indicated the yearly HVAC inspection was not completed and he was not aware a yearly inspection needed to be done. During an interview, on 04/22/21 at 9:20 a.m., the Maintenance Coordinator indicated the facility did not have a policy addressing yearly inspections of the HVAC system. During an interview, on 04/24/23 at 10:19 a.m., the Assistant Executive Director (AED) indicated	R 0148	**Plan of Correction:** 1) HVAC Agreement will be signed through TELS Direct Supply Service. The agreement will be effective 6/01/2023. An annual inspection will be held in the month of June 2023. 2) Current residents have the potential to be affected by this alleged deficient practice. 3) Director of Facilities responsible for the HVAC Agreement is no longer employed with the company. 4) Executive Director educated new Director of Facilities regarding the Indiana State regulation for HVAC agreements and yearly inspections in a residential community. Community will be current by June 30, 2023. 5) HVAC agreement will be reviewed for compliance of yearly inspection report. Monthly QA meeting will review for compliance on an ongoing basis.	06/30/2023

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	(Name of Company) did the HVAC inspection, but she did not have the report. At that time, she provided the phone number. A call was placed to (Name of Company) on 04/24/23 at 12:15 p.m. Employee 4 of (Name of Company) indicated services were provided, on 02/23/23, but it was a repair not an inspection of the system. The only other services provided by the company were for plumbing. The facility was unable to provide documentation relating to an HVAC yearly inspection by the exit date of 04/24/23. A current policy, titled "Maintenance," dated as last reviewed on 02/01/22 and received from the Assistant Executive Director on 04/24/23 at 1:30 p.m., indicated "...Develop and adhere to a schedule for routine maintenance and inspections for the building/property and equipment, which may include but not be limited to...Heating/Cooling systems...."			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the kitchen and equipment was kept in a sanitary manner. This deficient practice had the potential to affect 80 of 80 residents residing in the facility. Findings include: During an observation of the kitchen with the	R 0154	**Plan of Correction:** 1) The kitchen was cleaned and sanitized on 5/25/2023 and all food and beverages in the kitchen were inspected for proper labeling and dating. New carts for the dining room and for bussing were purchased to replace the ones that were previously used in the	04/25/2023

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	Dietary Manager (DM) in attendance, on 04/18/23 beginning at 9:11 a.m., the following observations were made: 1. The food preparation counter on each side of the kitchen was found to have debris upon it. The smaller preparation counter had clear drops of liquid on it. 2. The cleaning bucket containing water and a disinfectant called Sink and Surface cleaner did not register on the strips to check the chemical concentrations. During an interview, on 04/18/23 at 9:20 a.m., the DM indicated the strips used to check the concentration were not available. 3. The dining cart, which held cups, glasses, and a container of cream, sugar and napkins was found to have small pieces of trash on the top and was stained. 4. The table bussing cart had a dark brown substance all along the bottom shelf. The substance was able to be chipped off. During an interview, on 04/18/23 at 9:24 a.m., the DM indicated the cart was hard to clean, and was as clean as it would get. 5. In the front refrigerator, a 1/4 stick of butter was found on the shelf and open to air, and a 10-ounce bottle of sugar free green tea was found with the seal of the cap broken (open) without a label to indicated who it belonged to or when it was opened. During an interview, on 04/18/23 at 9:33 a.m., the DM indicated she thought the tea should be		kitchen. 2) Current residents have the potential to be affected by this alleged deficient practice. 3) Executive Director re-educated the Executive Chef on proper sanitation and the need to follow policy for labeling and dating food and beverages. The dietary team was re-educated on proper sanitation and the need to follow policy for labeling and dating food and beverages. 4) The Executive Chef is responsible for continued compliance. The Executive Director or designee will audit the cleaning schedules and inspect food and beverages for correct labeling and dating five days a week for one month, then weekly for two month and at QA meetings on an ongoing basis.	

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	labeled. A current policy, titled "FOOD SERVICE SANITATION," dated as effective on 1/2020 and received from the Assistant Executive Director on 04/22/23 at 9:26 a.m., indicated "...All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter...All utensils, countertops, shelves and equipment shall be kept clean, maintained in good repair and shall be free from dust, grease, dirt...chemical concentrations shall be measured...." A current policy, titled "Labeling," dated as last reviewed 05/10 (effective date 2020) and received from the Assistant Executive Director on 04/24/23 at 9:20 a.m., indicated "...Any food items...must have a date...before putting in any storage (dry, refrigerator, freezer, pantry)...."			
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 assess a resident to ensure the resident was capable of self-administration and able to	R 0216	**Plan of Correction:** 1) Resident 104 was assessed using the Self-Administration	05/12/2023

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	secure their medications for 1 of 5 residents reviewed for self-administration of medications. (Resident 104) Finding includes: During an observation and interview, on 04/21/23 at 10:34 a.m., Resident 104 indicated she did take one medication. She then walked over to the unsecured drawer of the nightstand and removed a box labeled alendronate (a medication for osteoporosis). She indicated she took it weekly. The record for Resident 104 was reviewed on 04/21/23. Diagnoses included, but were not limited to, osteoporosis, impaired mobility, and impaired activity of daily living. A physician's order, dated 01/06/23, indicated alendronate 70 mg once a week. A physician's admission order, dated 12/22/23, indicated "Self-Administration...Is resident able to understand medication name, purpose, frequency, route. Resident will be given self-administration competency to ensure ability...." The service plan for Resident 104, dated 02/20/23, indicated "Self Administration of medication status...Requires employees assist/administer medications up to 3 x per day with more than 4 medications per pass...." During an interview, on 04/21/23 at 11:03 a.m., the Assistant Executive Director indicated the admission order for Resident 104 (related to self-administration) was the self-administration assessment. A current policy, titled "Self Administering		Medication Assessment. Resident was able to identify the medication name, purpose, frequency and route of her medication. 2) Residents who self-administer medications could be affected by this practice. 3) Regional nurse performed an audit of all residents who self-administer medications on 05/08/2023. Director of Nursing performed a new Self-Administration Medication assessment on all residents who self-administer their own medications by 05/12/2023. 4) Director of Nursing purchased lock boxes to ensure residents who self-administer medication have a secure place to safely store those medications in their apartment. 5) Regional nurse re-educated Director of Nursing on May 10, 2023 on the policy for Self-Administration of Medications. 6) The Director of Nursing is responsible for sustained compliance. The Executive Director or designee will audit assessments for those who self-administer medications for completion of the Self-Administration Medication Assessment prior to a resident being able to self-administer their own medications. 7) Executive Director or designee will audit new residents' Clinical	

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	Medication," dated as effective 2020 and received from the Assistant Executive Director on 04/24/23 at 11:39 a.m., indicated "...Residents who...self administer...medications, may do so, after the Care Services Manager or designee completes a Self-Medication evaluation...This evaluation will determine if the resident is capable of self-administration, maintaining security of medications...."		File within 3 days of the resident admitting to the community to ensure that anyone who is identified as being capable of self-administering medications has a Self-Administration Medication Assessment in their file for three months. All residents who self-administer medications will be reviewed at QA meetings on an ongoing basis to ensure that residents who self-administer medications have current and updated Self-Administration Medication Assessments.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (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			

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	services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans (an agreed upon plan of services which would be provided by the facility to the resident) were signed by the resident or resident's representative for 5 of 9 residents reviewed for service plan agreements. (Residents 101, 102, 103, 104 and 107) Findings include: 1. The record for Resident 101 was reviewed on 04/20/23. Diagnoses included, but were not limited to, rheumatoid arthritis, bladder incontinence, and hypertension. There was no signed service plan found in the record and the facility was unable to provide a service plan signature sheet. 2. The record for Resident 102 was reviewed on 04/20/23. Diagnoses included, but were not limited to, osteoporosis, muscle weakness, and glaucoma. There was no signed service plan found in the record and the facility was unable to provide a service plan signature sheet. 3. The record for Resident 103 was reviewed on 04/20/23. Diagnoses included, but were not limited to, restless leg syndrome, post-traumatic stress disorder, and insomnia.	R 0217	**Plan of Correction:** 1) Newly hired Director of Nursing was educated on the Resident Service Plan Policy. 2) Regional nurse and Director of Nursing audited the files of residents who reside in the community on 05/11/2023. 3) Residents have signed their most current service plans or the resident's representative has been invited to a care plan meeting to sign residents most recent service plan on residents behalf. Resident Service Plans will all be signed by 5/31/2023. 4) Current residents have the potential to be affected by this alleged deficient practice. 5) The Director of Nursing is responsible for sustained compliance. 6) The Executive Director or designee will audit the service plans for ten residents weekly for a month to ensure compliance, then bi-weekly for two months. Service Plans will be reviewed at QA meetings on an ongoing basis to ensure that residents or a resident's representative have signed the most current resident	05/31/2023

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	There was no signed service plan found in the record and the facility was unable to provide a service plan signature sheet. 4. The record for Resident 104 was reviewed on 04/21/23. Diagnoses included, but were not limited to, osteoporosis, impaired mobility, and impaired activity of daily living. There was no signed service plan found in the record and the facility was unable to provide a service plan signature sheet. 5. The record for Resident 107 was reviewed on 04/21/23. Diagnoses included, but were not limited to, dementia, hypertension, and chronic bronchitis. There was no signed service plan found in the record and the facility was unable to provide a service plan signature sheet. During an interview, on 04/24/23 at 9:22 a.m., the Assistant Executive Director indicated the facility did have the services plans but they were not signed by the resident or the resident's representative. A current policy, titled "Resident Service Plan," dated as last reviewed 08/11/21 and received from the Assistant Executive Director on 04/24/23 at 3:30 p.m., indicated "...will adhere to the State Regulations pertaining to Resident service plans...."		service plan.	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment			

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	records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to document the administration of a medications on the Medication/Treatment Administration Record (MAR/TAR) for 1 of 6 residents reviewed. (Resident 107) Finding includes: The record for Resident 107 was reviewed on 04/21/23. Diagnoses included, but were not limited to, dementia, hypertension, and chronic bronchitis. A physician's order, dated 07/15/22, indicated to give Trazadone (an antidepressant medication) 50 milligrams twice a day. The July 2022 MAR/TAR was missing documentation, on 7/15, 7/19, 7/20 and 7/21/22 for the 5:00 p.m., administration time. During an interview, on 04/24/23 at 2:31 p.m., QMA 6 indicated the MAR/TAR needed to be signed off as you go, it was supposed to be signed off. During an interview, on 04/24/23 at 2: 33 p.m., the Assistant Executive Director indicated the MAR/TAR was to be signed when the service (medications or treatments) was completed/performed. A current policy, titled "Medication Record," undated and received from the Assistant	R 0243	**Plan of Correction:** 1) Unable to correct the missing documentation from July 2022. 2) Current residents residing in the community have the potential to be affected by the alleged deficient practice. 3) Regional nurse re-educated the Director of Nursing on May 10, 2023 on the policy titled "Medication Record" and the need to document all medications at time it was given. 5) The Director of Nursing is responsible for sustained compliance. The Director of Nursing has scheduled an in-service for nurses and QMA's the week of 5/15/2023 to re-educate nurses and QMAs on proper medication record procedures and policy . 6) The Director of Nursing will audit the MAR/TAR daily for a three residents daily on each shift for a month. The Executive Director will go over the audits with Director of Nursing. Compliance will be reviewed thereafter at the QA meetings.	05/19/2023

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	Executive Director on 04/24/23 at 3:39 p.m., indicated "...Once medication is given to the resident, documentation will include...Date and time of medication administration...Name and initials of the staff person administering the medication...."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure a yearly tuberculosis test or screening was completed for 2 of 9 residents and failed to ensure a two-step tuberculosis test was administered to 3 of 9 residents reviewed for tuberculosis screening. (Residents 101, 102, 103, 106 and 107) Findings include: 1. The record for Resident 101 was reviewed on 04/20/23. Diagnoses included, but were not limited to, rheumatoid arthritis, bladder incontinence, and hypertension. The resident admitted to the facility on 06/03/22. There was no two-step tuberculosis testing in the record. 2. The record for Resident 102 was reviewed on 04/20/23. Diagnoses included, but were not limited to, osteoporosis, muscle weakness, and glaucoma.	R 0409	**Plan of Correction:** 1) Newly hired Director of Nursing was educated on the Tuberculosis Assessment & Testing Policy. 2) Regional nurse and Director of Nursing audited the files of all residents who have reside in the community on 05/11/2023. 3) Residents who require a two-step TB skin test, an annual TB skin test or resident TB risk assessment will all receive such on 5/1/52023. The skin tests will be read on 05/17/2023 and those who need a two-step TB skin test will receive the second step one to three weeks later. 4) Prior to admission each resident will have a health assessment to include TB requirements. Residents will have a health assessment to include TB requirements annually	05/17/2023

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	The resident admitted to the facility on 10/28/22. There was no two-step tuberculosis testing in the record. 3. The record for Resident 103 was reviewed on 04/20/23. Diagnoses included, but were not limited to, restless leg syndrome, post-traumatic stress disorder, and insomnia. The resident admitted to the facility on 10/30/21. There was no annual tuberculosis test or screening assessment in the record. 4. The record for Resident 106 was reviewed on 04/21/23. Diagnoses included, but were not limited to, insomnia, altered mental status, and hypertension. The resident admitted to the facility on 07/25/21. There was no annual tuberculosis test or screening assessment in the record. 5. The record for Resident 107 was reviewed on 04/21/23. Diagnoses included, but were not limited to, dementia, hypertension, and chronic bronchitis. The resident admitted to the facility on 04/22/22. There was no two-step tuberculosis testing in the record. During an interview, on 04/24/23 at 11:50 a.m., the Assistant Executive Director indicated the facility followed the state regulations. A current policy, titled "Tuberculosis Assessment		thereafter. 5) The Director of Nursing is responsible for sustained compliance. The Executive Director or designee will audit the files of new resident within 3 days of admission for the first month. The audit will be documented and reviewed at the QA meeting. The QA committee will continue to audit on an ongoing basis.	

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	& Testing," dated as last reviewed 08/11/2021 and received from the Assistant Executive Director on 04/24/23 at 12:07 p.m., indicated "...A tuberculin skin test must be completed within three months prior to admission or upon admission...."			