STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00426983. Complaint IN00426983 - Federal/State deficiencies related to the allegations are cited at F693. Survey dates: February 11, 12, 13, 14, and 15, 2024 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Census Bed Type: SNF/NF: 85 SNF: 4 Total: 89 Census Payor Type: Medicare: 4 Medicaid: 67 Other: 18 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 19, 2024.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after March 7, 2024.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.			

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

Laura Burton | Executive Director | 03/02/2024

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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	§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure an Advanced Directive (code	F 0578	What corrective actions will be accomplished for those residents	03/07/2024

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	status) preference was documented accurately in the clinical record for 1 of 24 residents reviewed for Advanced Directives. (Resident 196) Finding includes: On 2/12/24 at 8:50 a.m., Resident 196's clinical record was reviewed. The Admission MDS (Minimum Data Set) assessment, dated 1/28/24, indicated Resident 196 was moderately cognitive impaired. The main screen tab portion of the electronic clinical record included an overview of Resident 196's vital information. A review of the tab indicated Resident 196's Advanced Directive (code status - decision regarding health care intervention) as DNR (Do Not Attempt Resuscitation - meaning no desire for life sustaining measures to be implemented). The Physician Orders, dated 1/24/24 and with no end date noted, indicated Resident 196 was a full code (desire for all life sustaining measures to be implemented). Resident 196's care plan, start date: 2/5/24 and valid through 6/27/24, indicated "...problem: Resident/legal representative has formulated an advanced directive: DNR...goal: preference in regard to advanced directives will be honored...approach: ensure the POST [Indiana Physician Orders for Scope of Treatment] form is completed fully and integrated in physician's orders..." On 2/13/24 at 10:35 a.m., the Director of Nursing Services (DNS) provided a copy of Resident 196's POST form. A review of the document indicated on 2/1/24 the POST form was completed, signed,		found to have been affected by the deficient practice? -Resident 196 code status has been corrected and is consistent throughout the clinical record. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? -All residents have potential to be affected by the alleged deficient practice. -A 1X audit will be conducted by clinical managers to ensure proper documentation of code status has been charted throughout the clinical record. -Staff education will be completed by the DNS/designee on or before March 7, 2024 with licensed nurses addressing code status accuracy throughout the clinical record. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -Staff education will be completed by DNS/designee on or before March 7, 2024 with licensed nurses addressing code status accuracy throughout the clinical record. -During the admission review, quarterly and sig change the IDT team will review code status to	

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	and dated by Resident 196's Power of Attorney and the attending Physician. A review of the document indicated the designated code status preference was "Do Not Attempt Resuscitation/DNR." No other POST form was provided. The POST form, dated 2/1/24, was provided to the facility on 2/2/24 and was uploaded into Resident 196's electronic clinical record on 2/13/24. Resident 196's clinical record was not consistent with the Resident's preferred DNR code status. Resident 196's preferred DNR code status was indicated by the POST form, dated 2/1/24, and by the care plan, dated 2/5/24. The DNR code status was not accurately reflected in the electronic clinical record until 2/13/24 when the updated physician's order was recorded. During an interview on 2/13/24 at 9:00 a.m., Licensed Practical Nurse (LPN) 4 indicated Resident 196's preferred code status was DNR as indicated by the POST form. The physician's orders indicated the resident was a full code. The clinical record was inconsistent. The Physician Orders should have been updated to reflect the preferred DNR code status. During an interview on 2/13/24 at 10:26 a.m., the DNS indicated the physician's orders should have been updated at the time the DNR POST form was received. During an interview on 2/13/24 at 3:15 p.m., Resident 196's representative indicated the Resident's preferred code status was that of a DNR. When the POST form was completed, it was provided to the facility.		ensure it is consistent throughout the clinical record; to include face sheet banner, order and care plan. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -To ensure compliance the DNS/designee will complete an Advanced Directives CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for five months by a nurse manager or designee. The Advanced Directive/Code Status CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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	On 2/13/24 at 10:35 a.m., the DNS provided a copy of the Advanced Directives (POST, DNR, Health Care Rep) policy, dated July 2023, and indicated it was the current policy in use by the facility. A review of the document indicated, "...it is the policy of this facility to provide information to resident/resident representative his/her rights to formulate advanced directives...if a resident has a valid Advanced Directive, the facility's care will reflect the resident's wishes as expressed in the Directive...the POST forms will be honored and executed...Physician's orders indicating the decisions made on the POST form will be added to the resident's admitting orders..." 3.1-4(f)(5)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for 1 of 2 residents reviewed for hospice. (Resident 32) Finding includes: On 2/12/24 at 1:46 p.m., the clinical record of Resident 32 was reviewed. The diagnosis included, but was not limited to, dementia. The Physician's Orders included, but were not limited, admit to hospice services due to dementia, initiated 3/27/23, with no end date was noted. Resident 32's care plan included, but was not limited to, "...start date 3/1/23 problem: Resident	F 0641	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? -Resident 32 MDS has been corrected and is consistent throughout the clinical record. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? -All residents have potential to be affected by the alleged deficient practice. -A 1X audit will be conducted by the MDS coord/designee to	03/07/2024

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	requires hospice R/T [related to] progressing dementia...target date 2/27/24 goal: advanced directive wishes will be honored...approach: resident requires hospice R/T progressing dementia..." The Annual Minimum Data Set (MDS) assessment, dated 2/6/24, indicated Resident 32 was severely cognitive impaired and was not receiving hospice services. The Quarterly MDS assessment, dated 11/14/23, indicated Resident 32 was severely cognitive impaired and was not receiving hospice services. During an interview on 2/13/24 at 9:30 a.m., Licensed Practical Nurse (LPN) 4 indicated Resident 32 had been receiving hospice services since March of 2023. During an interview on 2/13/24 at 3:17 p.m., the MDS Coordinator indicated the MDS assessments dated 2/6/24 and 11/14/23 were coded incorrectly. Resident 32 had been receiving hospice services since March of 2023 and the MDS assessments should have reflected the same. On 2/14/24 at 9:40 a.m., the Director of Nursing Services provided a copy of the Resident Assessment (RAI) Medicare MDS Scheduling policy, dated April 2023, and indicated it was the current policy in use by the facility. A review of the document indicated, "...It is the policy...to assess the clinical condition of beneficiaries by completing MDS assessment..." 3.1-31(d)		ensure proper documentation of Hospice services has been charted throughout the MDS. -Staff education will be completed by the ED/Designee on or before March 7, 2024 with licensed nurses addressing the coding of Hospice in the MDS. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -The ED/designee will verify that when a hospice resident is in the facility that the MDS is coded correctly by reviewing the MDS prior to submission. How will the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -To ensure compliance the ED/designee will complete an MDS/Hospice CQI audit tool for six months with audits being completed monthly for six months. The CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this	

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			practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to provide services to ensure a gastrostomy site dressing was changed for a resident with a g-tube used for enteral feedings for 1 of 3 residents reviewed for gastrostomy services. (Resident B) Findings included:	F 0693	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? -Resident B's G-tube dressing was changed, dated and initialed. How other residents having the	03/07/2024

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	During an interview on 2/12/24 at 10:48 a.m., Resident B indicated the facility had not changed his gastrostomy tube (g-tube) dressing recently. Resident B indicated the facility had not changed the dressing daily "like they are supposed to". During an observation on 2/11/24 at 1:00 p.m., observed Resident B's g-tube dressing to be undated. During an observation on 2/12/24 at 10:30 a.m., observed Resident B's g-tube dressing to be undated. During an observation on 2/13/24 at 11:00 a.m., observed Resident B's g-tube dressing to be undated. During an interview on 2/13/24 at 11:15 a.m., LPN 3 indicated Resident B's g-tube dressing should have been dated after each dressing change. On 2/11/24 at 11:00 a.m., the clinical record of Resident B was reviewed. The diagnosis included, but was not limited to, dysphasia. A care plan, dated 1/8/24 and current through 4/8/24 indicated Resident B was at risk for complications related to g-tube feeding. The interventions included, but were not limited to, cleanse around site as ordered and observe the site for signs of infection; redness, warmth, and malodorous drainage. A physicians order, dated 1/6/24 with no end date, indicated: Cleanse G-Tube site with soap and water, pat dry and apply gauze every shift. On 2/13/24 at 10:24 a.m., the Director of Nursing		potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? -All residents with a G-tube have the potential to be affected by the alleged deficient practice. -A 1X audit has been conducted to ensure proper G-tube dressing changes are being completed as ordered with date and initials. -Staff education will be completed by the DNS/designee on or before March 7, 2024 with licensed nurses addressing changing of G-tube dressings with date and initials. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -Staff education will be completed by DNS/designee on or before March 7, 2024 with licensed nurses addressing the changing of G-tube dressings with date and initials. -DNS/Designee will conduct observational rounds at least 3X a week to ensure residents with G-tubes are getting dressings changed per MD order with dates and initials. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	

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	provided a policy titled Dressing Change Clean Technique (incision or wound), dated November 2011, and indicated it was the current policy being used by the facility. A review of the policy indicated to date and initial new dressings. This citation relates to Complaint IN00426983. 3.1-44(a)(2)		put into place? -To ensure compliance the DNS/designee will complete an audit tool labeled MD orders CQI for six months with audits being completed once weekly for one month and then monthly for five months by a nurse manager or designee. The MD orders CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.			

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	(iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to ensure the posted nurse staffing included the actual worked by nursing hours and was updated daily for 3 of 5 days observed during the survey. Findings included. On 2/11/24 at 8:45 a.m., the Staff Posting Report, dated 2/9/24, was observed in the front lobby. The posted Staff Nursing Hours were observed to not indicate the actual hours worked and was not observed to be updated to the current date (2/11/24). On 2/12/24 at 8:30 a.m., the Staff Posting Report was observed to not indicate the actual hours	F 0732	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? -No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? -Staff education will be completed by the DNS/designee on or before March 7, 2024 with Nursing managers addressing the	03/07/2024

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	worked. On 2/13/24 at 10:33 a.m., the Staff Posting Report was observed to not indicate the actual hours worked. During an interview at that time RN 2 indicated the only posted nursing hours were kept in the front of the facility in the main lobby. During an interview on 2/13/24 at 10:45 a.m., the Director of Nursing indicated she was not aware the actual worked hours were to be listed on the posted Staff Nursing Hours. On 2/13/24 at 11:00 a.m., the Director of Nursing provided a policy titled Posted Nurse Staffing Data, dated July 2019 and indicated it was the current policy being used by the facility. A review of the policy indicated, "Procedure: ...1. d. The total number of actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered nurses ii. Licensed nurses iii. Certified nurse aides."		appropriate posting of nursing staffing. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -Staff education will be completed by DNS/designee on or before March 7, 2024 with Nursing managers addressing the appropriate posting of nursing staffing. -The DNS/designee will review the daily staff posting 5X a week to ensure the appropriate documentation and information is present. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -To ensure compliance the DNS/designee will review the daily staffing posting 5X a week for one month and then weekly for three months. If a 95% threshold is not achieved as reviewed in the CQI Committee an action plan will be developed.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility			

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	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were labeled with an open date for 1 of 3 medication carts observed. (Moving Forward/Split Cart) Finding includes: On 2/13/24 at 8:50 a.m., the Moving Forward/Split Cart was observed. In the cart, three opened vials of Insulin Lispro (a short acting medication to treat Diabetes Mellitus) 100 units/ml (milliliter) and one opened Insulin Glargine (a long acting medication to treat Diabetes Mellitus) Flex Pen 100	F 0761	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? -No resident identified has been affected by this practice. -The medications with no open date were immediately removed from the medication cart. How other residents having the potential to be affected by the same deficient practice will be	03/07/2024

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	units/ml were observed. The vials and Flex Pen were not labeled to indicate the date the medication was opened. During an interview at that time, LPN 8 indicated the vials should have been dated at the time they were opened. On 2/13/24 at 10:24 a.m., the Director of Nursing provided a policy titled, Storage and Expiration Dating of Medications, Biologicals, dated January 2002, and indicated it was the current policy being used by the facility. A review of the policy indicated "....5. Once any medication or biological package is opened; Facility should follow manufacturer or supplier guidelines with respect to expirations dates for open medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened." 3.1-25(k)		identified and what corrective actions will be taken? -All residents taking insulin have the potential to be affected by the alleged practice. -a 1X audit will be completed by the DNS/designee to ensure all applicable open medications were labeled with open dates. -Staff education will be completed by the DNS/designee on or before March 7, 2024 with licensed nurses on medication labeling with open dates as applicable. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -Staff education will be completed by the DNS/designee on or before March 7, 2024 with licensed nurses on medication labeling with open dates as applicable. -Medication carts will be audited 5X a week by nurse managers/designee to ensure all open medications are labeled with open dates as applicable. Any concerns will be addressed immediately. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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			-To ensure compliance the DNS/Designee will complete the Medication Storage Review CQI audit tool for six months with audits being completed once weekly for one month and then monthly for 5 months by a nurse manager/designee. The Medication Storage Review CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility			

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	gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 3 of 4 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Cook 5, Dietary Staff 6) Findings include: 1. During the initial kitchen observation on 2/11/24 from 9:35 a.m. to 9:45 a.m., observed Cook 5 walking throughout the kitchen area. Cook 5 had hair pulled from the front to the back of the head and hair in front of and behind the ears. The hair was observed to not be covered. 2. During a follow up kitchen observation on 2/11/24 from 12:20 p.m. to 12:30 p.m., the following was observed: - Cook 5 was working at the steam table where the noon meal was being held. Cook 5 was observed obtaining the noon meal starting temperatures. Cook 5's hair was pulled from the front to the back of the head and hair in front of and behind the ears. The hair was not observed to be covered. - Dietary Aide 6 was observed walking throughout the kitchen area and at the steam table	F 0812	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? -Cook 5 utilizes a hair net to cover all hair when in the kitchen. -Dietary aide 6 utilizes a hair net to cover all hair when in the kitchen. -No residents have been affected by this practice. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? -All residents have the potential to be affected by the alleged deficient practice. -Dietary staff will be educated by the ED/Designee on or before March 7, 2024 on utilizing hair covers correctly while in the kitchen. What measures will be put into place or what systemic changes	03/07/2024

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	where the noon meal was being held. Dietary Aide 6 was observed to have bangs, approximately 2 inches in length, hanging over the forehead area. The bangs were observed to not be covered. 3. During a follow up kitchen observation on 2/11/24 from 1:20 p.m. to 1:25 p.m., the following was observed: - Cook 5 was at the steam table the noon meal was being held and was observed plating the noon meal. Cook 5's hair was pulled from the front to the back of the head and hair in front of and behind the ears. The hair was not observed to be covered - Dietary Aide 6 was observed at the steam table area where the noon meal was being held and being plated. Dietary Aide 6 was observed to have bangs, approximately 2 inches in length, hanging over the forehead area. The bangs were observed to not be covered. During an interview at that time, the Dietary Manager (DM) indicated all hair was to be covered while in the kitchen. On 2/12/24 at 2:19 p.m., the DM provided a copy of the Culinary Personnel Hygiene policy, dated May 2023, and indicated it was the current policy in use by the facility. A review of the document indicated, "...Employees will maintain good personal hygiene to prevent food contamination...all employees working in the culinary department must wear a clean hair restraint which effectively covers all hair..." On 2/12/24 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements,		will be made to ensure that the deficient practice does not recur? -Dietary staff will be educated by the ED/Designee on or before March 7, 2024 on utilizing hair covers correctly while in the kitchen. -The Culinary Manager/Designee will complete a hair net audit daily to ensure hair is properly restrained. How Will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -The Culinary Manager/Designee will be responsible for the completion of the Short Sanitation QA tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;			

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	(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	What corrective actions will be	03/07/2024

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	Based on observation, interview, and record review, the facility failed to accurately and completely document services provided for 1 of 2 residents reviewed for catheter care. (Resident 88) Findings include: On 2/11/24 at 1:20 p.m., Resident 88 was observed resting in bed. An indwelling urinary catheter (a medical device that helps drain urine from the bladder) was connected to the catheter tubing which was connected to the catheter drainage bag (a medical bag that held urine) was observed. On 2/14/24 at 9:22 a.m. Resident 88's clinical record was reviewed. The diagnoses included, but were not limited to, malignant neoplasm of prostate (prostate cancer); neuromuscular dysfunction of bladder (urinary condition where people lack bladder control); and urine retention (difficulty urinating and completely emptying the bladder). The Admission Minimum Data Set (MDS) assessment, dated 1/25/24, indicated Resident 88 was moderately cognitively intact and had an indwelling urinary catheter. Resident 88's care plan indicated "...Problem start date: 11/20/23...Resident requires an indwelling urinary catheter...Goal target date: 4/18/24...Resident will have catheter care managed appropriately as evidenced by: not exhibiting signs or urinary tract infection or urethral trauma...Approach: start date: 11/20/23...change catheter per MD order..." Physician orders included, but were not limited to, "cath [catheter] orders: change foley catheter and urinary drainage bag monthly; once a day on the 8th of the month...start date: 1/8/24 and no end		accomplished for those residents found to have been affected by the deficient practice? -Nurse providing catheter care to resident 88 has been educated on appropriate documentation when carrying out an MD order. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? -All residents with catheters have the potential to be affected by the alleged deficient practice. -Licensed nurses will be educated by the DNS/Designee on or before March 7, 2024 on documentation after carrying out MD orders for catheter changes in the clinical record. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -Licensed nurses will be educated by the DNS/Designee on or before March 7, 2024 on documentation after carrying out MD orders for catheter changes in the clinical record. -The DNS/designee will review the administration history report 5X a week for residents with catheters to ensure appropriate documentation of catheter changes per MD orders.	

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	date noted..." The January 2024 Treatment Administration Record (TAR) lacked facility staff's initials that indicated the urinary catheter and urinary drainage bag was changed. The February 2024 TAR lacked facility staff's initials that indicated the urinary catheter and urinary drainage bag was changed. During an interview on 2/14/24 at 11:00 a.m., Resident 88 indicated the catheter had not been changed since prior to his admission "about 3 months ago." During an interview on 2/14/24 at 11:58 a.m., LPN 8 indicated on 2/8/24 Resident 88's catheter and drainage bag was changed. However, the TAR document had not been signed off and no other documentation was available that would indicate the physician's order had been followed. During an interview on 2/14/24 at 3:42 p.m., the Director of Nursing Services (DNS) indicated the facility lacked documentation that the catheter and drainage bag had been changed in accordance with the physician's order for January and February of 2024. Staff were to follow the physician's order. On 2/15/24 at 8:53 a.m., the DNS provided a copy of the Indwelling Urinary Catheter policy, dated December 2012, and indicated it was the current policy in use by the facility. A review of the document indicated, "...confirm physician orders...including catheters..." On 2/15/24 at 3:00 p.m., a review of Basic Healthcare Documentation Standards indicated		How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -To ensure compliance the DNS/Designee will complete the Missed Administrations CQI audit tool for six months with audits being completed once weekly for one month and then monthly for five months by a nurse manager or designee. The Missed Administrations CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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	"...entries are dated and authenticated by the author. Documentation is made at the time service is provided..." 3.1-50(a)(1)			