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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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 IN00397134. Complaint IN00397134 - Substantiated. State deficiencies related to the allegations are cited at R0027. Survey dates: December 15, 16, 19 and 20, 2022 Facility number: 013347 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 22, 2022	R 0000		
R 0027 Bldg. 00	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on interview and record review, the facility failed to maintain a dignified existence for 3 of 12 residents reviewed for dignity. (Residents B and L) Findings include: 1. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. The diagnoses for	R 0027	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R027 **1. What Corrective action(s) will be accomplished for those residents found to have been**	02/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Harrison	RDO	01/10/2023

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	Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The 9/30/22 Level of Service Assessment/Evaluation indicated Resident B was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed, but may miss some part or intent of the message. 2. The clinical record for Resident L was reviewed on 12/20/22 at 2:00 p.m. The diagnoses for Resident L included, but were not limited to, anxiety. She was admitted to the facility on 7/1/22. The 10/5/22 Level of Service Assessment/Evaluation indicated Resident L was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed without difficulty. On 12/19/22 at 9:19 a.m. the IED (Interim Executive Director) provided an 8/2/22 statement from the DM (Dietary Manager) regarding a staff altercation between CNA (Certified Nursing Assistant) 6 and Cook 8. The statement read, "When I arrived at work this morning, I pulled [name of Cook 8] into my office to talk about Sunday Breakfast. I also showed her a picture that someone sent me of her sleeping at my desk during lunch service. She asked me who sent the picture and I stated I didn't know. Someone told her [name of Kitchen Staff 7] took the picture, so she confronted her about it at the point an argument broke out. [Names of CNA 10 and CNA		**affected by the deficient practice** Staff members were terminated immediately following incident. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. b. c. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	

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	5] and myself were trying to stop them when [Name of CNA 6] came charging at [name of Cook 8.] They went back and forth and [name of CNA 6] threw whatever she had in her cup on [name of Cook 8's] face and swung and hit [name of CNA 5] on the shoulder. [Name of Kitchen Staff 11] had to physically remove [name of CNA 6] from the kitchen." An interview was conducted with the DM on 12/20/22 at 11:15 a.m. She indicated Kitchen Staff 7 sent her a picture of Cook 8 sitting at her desk, thinking she was asleep. The DM spoke with Cook 8 about it the following Monday. One of the previous cooks informed Cook 8 that Kitchen Staff 7 took the picture. Cook 8 and Kitchen Staff 7 were discussing the picture and one thing led to another. CNA 6 was by the ice machine in the kitchen, when Kitchen Staff 7 told Cook 8 to talk to CNA 6. Then CNA 6 was like a "raging bull" and threw a cup of ice at Cook 8. The DM, CNA 5, and CNA 10, Kitchen Staff 11 were trying to hold CNA 6 back. CNA 6 hit CNA 5 in the shoulder, left a bruise, and was slightly bleeding. They got CNA 6 out of the kitchen. CNA 5 reported that CNA 6 hit her. There were no residents in the dining room at the time, but there were 3 or 4 in the hallway, just outside of the dining room, and the dining room doors were open. The DM was unsure which residents were in the hallway at the time. She indicated, "of course" residents could hear the altercation. An interview was conducted with Resident B on 12/16/22 at 11:23 a.m. She indicated there was a fight in the kitchen between 2 staff members. She did not see them fighting, but she was sitting in the hallway, waiting to go to lunch, and heard them cussing, "what somebody was gonna do to somebody."			

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	She heard commotion, stuff moving around, and saw other staff running to break it up. "I was like wow! Is this the type of place I'm living in? You think you're moving somewhere you don't have to deal with that, but evidently you do." It made her feel unsafe, because "in a situation like that you could get hurt whether involved or not." They could have picked something up, thrown it, then gotten hit herself. It made her uncomfortable, as she was a newer resident at the time. She stated, "I didn't like that." An anonymous interview was conducted with a resident. They indicated they were in the activity room. The dining room doors were open and she heard staff "cussing and carrying on." It scared her and still scared her. They stated, "I can't live scared." They don't socialize as much anymore or eat in the dining room anymore, because "it's always something in the dining room." The dining room staff were rude and won't let you sit where you choose, if they've already wiped the table. "It's the attitudes and way things are conducted. It's really, really bad." They just don't want to be in "this environment anymore. It's very hostile." They witnessed CNA 5 in the hallway outside of the dining room embarrass and talk down to Resident C for having an "accident" on himself. CNA 5 was saying, "You know better. Why are you doing that? You're being lazy." They used to go to activities regularly, now only go sporadically. It didn't have to be this way, but there were certain CNAs that made it hard, like CNA 13 and CNA 10. CNA 13 would get in "an uproar," was loud, obnoxious, rude, and discussed other residents' personal information. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated the kitchen staff and CNAs at the facility have "attitude			

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	problems," and you can't ask them for anything. The previous Friday, one of the agency staff told her she didn't like her tone. An interview was conducted with Resident B on 12/16/22 at 8:57 a.m. She indicated some staff were respectful and others were not. CNA 5 spoke to her like a child and was rude. The Resident's Personal Rights Policy and Procedure was provided by the IED on 12/15/22 at 1:04 p.m. It read, "Each resident shall have the right to: ...14. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality." This Residential Tag relates to Complaint IN00397134.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall			

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	have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure at least a minimum of one awake person with current CPR (cardiopulmonary resuscitation) and first aid certificates were on site at all times for 113 of 113 residents who reside at the facility. Findings include: The facilities staffing schedule, as worked, for the time period of December 9 - 20, 2022 was provided by Interim ED (Executive Director) on 12/15/22 at 1:04 p.m. The current CPR and first aid certificates for all staff were provided by BOM (Business Office Manager) on 12/20/22 at 12:05 p.m. Upon cross referencing the staffing schedule for the time period of December 9-20, 2022, the facility did not have a staff member with current CPR and/or first aid certification on the following dates and shifts: 12/9/22 - no one with first aid certification for the night shift (11 p.m. to 7 a.m.). 12/10/22- no one with first aid or CPR certification for the evening (3 p.m. to 11 p.m.) shift or the night shift. 12/11/22 - no one with first aid or CPR certification for the evening (3 p.m. to 11 p.m.) shift or the night shift. 12/12/22 - no one with a first aid certification for the night shift. 12/13/22 - no one with first aid or CPR certification	R 0117	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R117 **1. What Corrective action(s) will be accomplished forthose residents found to have been affected by the deficient practice** a. No residents experienced adverse effects from the alleged deficient practice. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put**	02/10/2023

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	for the day shift. 12/14/22 - no one with first aid certification for the night shift. 12/15/22 - no one with first aid certification for the night shift. 12/16/22 - no one with first aid or CPR certification for the night shift. 12/17/22 -no one with first aid certification for the night shift. 12/18/22 - no one with first aid certification for the night shift. An interview with Interim ED conducted on 12/20/22 at 2:16 p.m. indicated, the facility had newly hired employees take a BLS (Basic Life Support) class and believed the class included first aid, but after speaking with the instructor from the class, he confirmed the BLS class that was completed did not include first aid certification.		**into place:** a. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview and record review, the facility failed to ensure the facility was clean, odor free, and in good repair for 10 of 14 residents' reviewed for environment. (Resident 37, 91, 92, 110, B, F, L, P, R and Z) Findings include: An observation was made of the facility on 12/15/22 at 2:17 p.m. The elevator by nurses station was observed with dirt, food crumbs along the corners and the flooring sides of the elevator.	R 0144	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R144 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **No residents were affected by the alleged deficient practice.**	02/10/2023

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	The 3rd floor hallway had a sulfer like smell. Observations were made of the facility on 12/16/22 at 11:14 a.m., 12:10 p.m., 3:33 p.m. The front lobby flooring by the elevator was observed with black grime all long the corners and floor trimming. The elevator was observed with black dirt substance all along the trim and floor corners and a purple candy wrapper. The 1st floor wall bottom trim was observed to have grey dust and corners of the flooring had dust, dirt and cob webs. An observation of the facility on 12/19/22 at 12:10 p.m. The 1st floor hallway was observed with dust along the bottom floor trim and dirt and grime in the corners along the walls. The lobby flooring by the front elevator was observed with black grime in corners and along wall. The 3rd floor hallway had sulfer like smell. An interview was conducted with Resident F on 12/15/22 at 2:15 p.m. He indicated the 4th floor stinks, like urine, trash, body odor, people not taking care of themselves. You can smell "weed" at anytime, any floor, especially in the elevators, every now and then on the patio, it used to be a regular at the gazebo, but not much anymore. Sometimes, there's dirt, debris, sticky floors, but that's the residents who might drop a drink and won't tell anyone. An interview was conducted with Resident B on 12/16/22 at 8:57 a.m. She indicated the facility floors are dirty, and it smells bad. The 1st and 3rd floor was the worse with "reaking of marijuana" odor. An interview was conducted with Resident 91 on 12/16/22 at 9:10 a.m. She indicated there was a "heavy marijuana" odor on the 3rd floor.		**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. b. c. d. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. b. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	

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	An interview was conducted with Resident R on 12/16/22 9:40 a.m. He indicated his apartment was in need of repairs. He had doors that needed to be replaced and walls with gouges that need to be repaired and painted. It has been in that condition since he moved in which was coming up to a year. An interview was conducted with Resident P on 12/16/22 at 9:47 a.m. He indicated on all the floors you can smell "marijuana" just by walking down the hallway. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated the hallway smells like urine. She has placed an air freshener outside her door. After interview, a plug in was observed in an outlet in hallway outside of the resident door. An environmental tour was conducted with the Maintenance Director (MD) on 12/19/22 at 2:15 p.m. During the tour, Resident Z was observed in her room. She indicated, there were times a "strange smell" in her hallway. Resident 37's room was observed with a warped floor at the entrance of the bathroom and dry wall exposed on the bathroom wall. The MD indicated the flooring had been like that for awhile. Resident R's room on the 3rd floor was observed with the following: several scrapes on walls with visible drywall paper observed in the living room, bedroom and kitchen area. 2 internal doors had large gouged holes, trim on a door frame was broken and missing, and 1 window had a diagonal crack the entire length of the window from corner to corner. Resident R indicated the apartment had been in that condition since move in date. The MD indicated at that time, the resident wanted to move in right away and had declined to wait for the apartment to be			

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	repaired prior to his move in. He does have replacement doors for the resident. He has had the replacement doors for about a month. The 3rd floor hallway was observed with a sulfer like smell and corners of the hallway walls had debris in the corners. On the 4th floor, Resident 110's room was observed with a raised floor in the living area and a piece of flooring broke off in the kitchen. Resident 92's room was observed with a beach ball size mudded area on the ceiling. The MD indicated at that time, the ceiling had been repaired by the previous MD a year ago. After, The 1st floor hallway was observed. The wall floor trim was observed to have grey dust all along it. The lobby elevator had black grime and inside the elevator was observed with debris in the corners. The MD indicated at that time, the floors should be swept daily, and the common areas of the facility should be done on Fridays. The 1st floor has the most traffic. "The smell of marijuana can be smelled all the time on all the floors." The facility does not allow smoking in the facility, but "what do you do?" The resident(s) have to be caught, and it was difficult to catch them. The housekeeping policy was provided by the Interim Executive Director on 12/20/22 at 8:42 a.m. "...Responsibility:..B. It is the responsibility of the certified nursing staff to assist with maintaining public areas and ensuring they are clean and orderly....Procedure:...B. All public areas shall be maintained in a clean and orderly condition..."			
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 observation, interview and record review, the facility failed to ensure 24 hour access to the facility at all times. This had the potential to affect 113 of 113 residents in the facility. (Residents B, G, H, L, M, P and R) Findings include: 1. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. The diagnoses for Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The 9/30/22 Level of Service Assessment/Evaluation indicated Resident B was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed, but may miss some part or intent of the message. 2. The clinical record for Resident L was reviewed on 12/20/22 at 2:00 p.m. The diagnoses for Resident L included, but were not limited to, anxiety. She was admitted to the facility on 7/1/22.	R 0148	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R148 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **a. In-service completed will be completed for all staff on after hours protocol for front door bell.** **b. Residents will be educated on after hours protocol for entering community.** **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will**	02/10/2023

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	The 10/5/22 Level of Service Assessment/Evaluation indicated Resident L was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed without difficulty. 3. The clinical record for Resident M was reviewed on 12/16/22 at 10:30 a.m. The diagnosis included, but was not limited to, heart failure. A level of service assessment dated 9/30/22 indicated Resident M "...understands information conveyed without difficulty. Communicates information and is understood...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." The front double doors of the facility had a sign that read, "Doors locked 8:00 p.m. to 8:00 a.m. Ring door bell after hours," with an arrow pointing to a doorbell to the right of the double doors. An interview was conducted with the IED (Interim Executive Director) on 12/15/22 at 3:00 p.m. He indicated the front doors locked at 8:30 p.m. If a resident needed to get in after that time, there was a doorbell for them to use. An observation of the front double doors was made with the IED on 12/15/22 at 3:00 p.m. An interview was conducted with him at this time. He pressed the doorbell to the right of the double doors. No sound was heard. The IED indicated the doorbell signal went to the call light/pager system of the facility.		**be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** **a. In-service completed will be completed for all staff on after hours protocol for front door bell.** **b. Residents will be educated on after hours protocol for entering community.** c. d. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. b. c. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	

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		A. BUILDING 00 B. WING	12/20/2022

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	On 12/15/22 at 3:02 p.m., after the above observation, the IED asked one of the staff members in the hallway near the nurse's station about the doorbell. She indicated to her knowledge, the front door bell didn't work and she didn't carry a pager to get the notification. An interview was conducted with the Admissions Coordinator in the presence of the IED on 12/15/22 at 3:05 p.m. She indicated the front doorbell was hooked up to the pager system and staff had to let you inside. She came to the facility the previous night around 10:00 p.m., and one of the staff members let her inside "after about 10 minutes." An interview was conducted with Resident B on 12/16/22 at 11:23 a.m. She indicated the front doors locked at 8:00 p.m., and sometimes she was out until midnight or 1:00 a.m. after being with family. About a month ago, she came back to the facility around 1:00 a.m. Her grandson was ringing the front door bell, calling the facility on the phone, and knocking on the door for half an hour to get into the facility. No one ever responded, so "eventually I called another resident and they came and let us in." She and another resident now had an agreement with each other to let each other into the facility when they planned to be out after 8:00 p.m. and the doors were locked. She would call the other resident when she was on her way home and inform her when she would be arriving. She'd heard about some residents having to jump the patio fence to get into the facility. Over this past summer, around midnight, she was in the activity room playing cards, and she saw a male resident jump the patio fence to get into the facility. She was unsure who the resident was, because she was newer to the facility at the time.			

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	An interview was conducted with Resident M on 12/16/22 at 11:32 a.m. He indicated after 8:00 p.m., the front doors are locked, and it is difficult to get into the facility. He has been out past 8:00 p.m., and was unable to get back in. After returning, he pushed the door bell and called into the facility for staff to let him in and no one would come to the door. He waited out front for 20-30 minutes calling and ringing the door bell, and staff would not answer. Resident P indicated he went around the back of the facility and jumped the privacy fence where the smoking area was due to that door was always left unlocked. He currently calls another resident that resides in the building to let him in the building, because staff do not answer the door bell or the phone. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated she was scared to leave the facility after 8:00 p.m., because she was scared to be left outside.4. The clinical record for Resident R was reviewed on 12/16/22 at 10:00 a.m. The diagnosis included, but was not limited to, coronary artery disease. A Saint Loius University Mental Status (SLUMS) assessment dated 8/27/22 indicated Resident R was cognitively intact. An interview was conducted with Resident R on 12/16/22 at 9:40 a.m. He indicated the residents have to be back in the building by 8:00 p.m., or the residents are unable to get back into the building. The door bell does not work and/or does not get answered by the staff. The residents will also call into the facility to alert staff they need to be let in, but the staff does not answer the phones. He has not witnessed, but has heard some residents have had to jump the privacy fence to use the unlocked back door in the smoking area to get into the			

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	building due to no response from the staff. 5. The clinical record for Resident P was reviewed on 12/16/22 at 10:30 a.m. The diagnosis included, but was not limited to, heart failure. A level of service assessment dated 11/28/22 indicated Resident P "...understands information conveyed without difficulty. Communicates information and is understood...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." An interview was conducted with Resident P on 12/16/22 at 9:47 a.m. He indicated if a resident leaves the facility and returns after 8:00 p.m., they are unable to get back in. The staff do no answer the phone nor answer the door bell. 6. The clinical record for Resident H was reviewed on 12/15/22 at 3:00 p.m. The diagnosis included, but was not limited to, asthma. A level of service assessment dated 9/30/22 indicated Resident H "...understands information conveyed without difficulty. Communicates information and is understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." An interview was conducted with Resident H on 12/15/22 at 2:15 p.m. She indicated if she leaves the facility she makes sure she returns back before 8:00 p.m. She does not want to be locked out. She has heard that happens. 7. The clinical record for Resident G was reviewed on 12/15/22 at 3:00 p.m. The diagnosis included,			

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	but was not limited to, hypertension. A level of service assessment dated 9/30/22 indicated Resident G "...understands information conveyed. May miss some part or intent of the message. Communicates information and is understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." An interview was conducted with Resident G on 12/15/22 at 2:18 p.m. She indicated the front door was locked at 8:00 p.m. "I wish there was a way to get into the building after 8:00 p.m." When she does leave, she "always" makes sure she returns before 8:00 p.m., because she does not want to get locked out. An interview was conducted with the Maintenance Director on 12/20/22 at 3:38 p.m. He indicated the staffs' pagers are notified if the door bell was pushed out front. The door bell had been broken recently for less than a week, but it was repaired on 12/2/22. The Resident Lease Agreement was provided by the IED on 12/15/22 at 2:24 p.m. It read, "RESIDENT ACCOMMODATIONS...3. Security. Security shall be provided 24 hours a day and shall include lockable entrances and on-site personnel. All residents shall have 24-hour access."			
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:			

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	(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 obtain semi-annual weights for 2 of 5 residents whose clinical records were reviewed. (Residents B and F) Findings include: 1. The clinical record for Resident F was reviewed on 12/19/22 at 2:30 p.m. The diagnoses for Resident F included, but were not limited to, chronic obstructive pulmonary disease. He was admitted to the facility on 3/20/20. The service plan, last updated 10/2/22, indicated Resident F agreed for the facility to coordinate all of his healthcare needs. The most recent weight in the vitals section of the electronic health record was from 10/4/21 at a weight of 195.6 pounds. There were no subsequent weights in the electronic health record or his hard chart. An interview was conducted with the RRN (Regional Registered Nurse) on 12/20/22 at 9:59 a.m. She indicated she was unable to locate any subsequent weights for Resident F. Some residents had weights documented sporadically in their electronic health record, because they had an order for weights, but there was no consistency in	R 0216	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R216 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents requiring semi-annual weights, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all CNAs, QMAs and Nurses on proper obtaining and documenting or weights. Employees found to be out of compliance with properly obtaining residents weights will receive additional education and possible corrective action.	01/27/2023

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	how they'd been obtaining weights for everyone else. 2. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. The diagnoses for Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The vitals section of the electronic health record did not include any weights for Resident B. An interview was conducted with the RRN (Regional Registered Nurse) on 12/20/22 at 9:59 a.m. She indicated she was unable to locate any weights for Resident B after her initial admission weight. Some residents had weights documented sporadically in their electronic health record, because they had an order for weights, but there was no consistency in how they'd been obtaining weights for everyone else. An interview was conducted with the RRN on 12/19/22 at 12:53 p.m. She indicated they did not have a policy regarding weights and they just followed physician's orders and the regulations for obtaining a resident's weight on admission and semiannually.		**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. A weights binder will be prepared and all nursing staff educated on the policy no later than January 31, 2022. Any clinical staff member out of compliance with facility's policies and protocols relating to weights will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to obtaining weights during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit weight binder two (2) times per month for two (2) months, then one (1) time a month for twelve (12) months, and then as needed to ensure that weights are being properly obtained and recorded. Results to be reviewed at monthly QI meetings and make further recommendations based off	

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			audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
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 maintain the kitchen in a cleanly manner, store food properly, and ensure proper functionality of the dishwasher with the potential to affect 113 of 113 residents in the facility. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 12/20/22 at 11:50 a.m. Interviews with the DM were conducted during the tour. During the tour an observation of the stove hood was made. There was dust and debris hanging from the sprinklers and around the light bases. There was grease splatter built up on the top of the hood. The DM indicated the stove hood was cleaned monthly. An outside company used to come in and clean it, but that hadn't been done in	R 0273	1. No residents were affected by the alleged deficient practice. 2. All residents had the potential to be affected by the alleged deficient practice. 3. In-Service completed by Dietary Manager with all kitchen staff. In service topics will include proper food storage including labeling and dating, hand hygiene, and cleanliness of dishes. All new hires in the culinary department will be trained on these topics upon onboarding. 4. The Culinary Manager, or designee, will audit staff hand hygiene daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months. The Culinary Manager, or designee, will audit dry storage	02/10/2023

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	3 months. There was a rack of clean dishes against the wall in an area near the dishwasher. The plates and bowls on the rack were not stored inverted. A salad bowl had a one inch curly black hair on the rim. The silverware was stored in silverware holders on the top rack. The eating end of the silverware was facing outward for retrieval from the holder, as opposed to the handle side facing outward for retrieval. The DM indicated the handles of the silverware should be facing outward and the plates and dishes should be stored upside down. There was a plate dispenser with a stack of plates near the steam table. The plates were not inverted in the dispenser. Cook 9 was plating food for residents for the lunch service at this time. The top plate had a dried, yellow food substance towards the middle of the plate. Cook 9 retrieved the top plate with the dried, yellow food substance and proceeded to plate it with fries and a bratwurst. After Cook 9 was informed of the dried food substance on the plate, he moved the fries over with tongs, observed the dried food substance, and indicated he didn't notice it prior to plating. There was a sticker on the side of the dishwasher indicating the wash cycle was to reach 155 degrees Fahrenheit and the rinse was to reach 180 degrees Fahrenheit. The DM ran 3 cycles through the dishwasher. For the first 2 cycles, the rinse needle read 182 degrees Fahrenheit, but the needle never moved, even between cycles. The rinse cycle did not initiate during the third cycle. There was a brown, flaky substance built up on the top of the dishwasher. The DM indicated she was uncertain from where the brown flaky		and walk ins daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months to ensure no food s left open to air in these areas. The Culinary Manager, or designee, will audit the dishmachine daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months to ensure proper temperatures are met. The results of the audits/reviews will be discussed at the quarterly Quality Improvement Meeting monthly until compliance is 100%. 5. Completion date 2/20/2023	

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	substance was coming, but the dishwasher should be wiped down daily. She indicated the rinse needle was not moving at all and did not know what was wrong with it. The December, 2020 Dish Machine - High Temperature Sanitizing Log on the wall opposite the dishwasher indicated the wash temperatures were 180 degrees and the rinse temperatures were 150 degrees twice daily from 12/1/22 through the morning temperatures on 12/19/22. The DM indicated incompetence of the person who completed the December, 2022 dishwasher log. The walk in refrigerator had 4 pitchers of undated orange juice on one of the shelves. One of the pitchers' contents were significantly darker than the other three. The DM indicated the darker colored one was a different brand than the other three, and that all the pitchers should have dates on them. The walk in freezer had a pie with a white cream topping on one of the shelves. The pie had a piece missing and was not thoroughly sealed. There was no date on the pie. The dry storage area had a sugar bin with a Styrofoam cup inside. There was a bin containing plastic lids on the bottom shelf of one of the racks. There were crushed chips mixed in with the lids. The floors of the kitchen had debris, wrappers, and food packets on them. There was debris built up along the corners of the kitchen where the walls and floors met. The DM indicated the floors should be swept and mopped regularly. The DM provided the November, 2022 Monthly Dietary Cleaning Schedule on 12/20/22 at 2:05 p.m.			

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	The baseboards were signed off as completed, but did not indicate a date. There was no documentation of kitchen floors or stove hood cleaning provided. The Mechanical Cleaning and Sanitizing Policy and Procedure was provided by the DM on 12/20/22 at 2:05 p.m. It read, "Machines (single-tank, stationary-rack, door-type machines and spray-type glass washers) using chemicals for sanitization may be used provided that: ...8) High temperature sanitation will be at 180 degrees F or higher. d) All dishwashing machines shall be thoroughly cleaned at least once a day or more often when necessary to maintain them in a satisfactory operating condition. The Refrigerated Storage Policy and Procedure was provided by the DM on 12/20/22 at 2:05 p.m. It read, "Potentially hazardous food requiring refrigeration after preparation shall be labeled or tagged with the date and time of preparation..." The Cleaning Frequency Policy and Procedure was provided by the DM on 12/20/22 at 2:05 p.m. It read, "Non-food contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris."			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when			

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	applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to ensure the proper labeling of prescription medications by not ensuring prescription medication labels, with all needed information, were affixed to: individual insulin/diabetic medication pens, a box of Zofran tablets, an opened vial of methotrexate, used inhalers, an opened vial of testosterone, and 13 unidentified, loose tablets at the bottom of a wire basket for 1 of 1 medication rooms within the facility. Findings include: A medication storage observation was conducted on 12/20/22 at 10:22 a.m. with QMA (Qualified Medication Assistant) 4. 1. In the medication room on the main level by the nursing station, the following was observed: a. In a wire basket placed on top of a cardboard box sitting on the floor of the medication room was: - An opened vial of methotrexate 50 mg/2 ml (milligrams per milliliter) with no resident or prescription label affixed to it or its box. - An opened box of Zofran (anti-nausea) 4 mg tablets. The box indicated it contained 30 tablets, but there were only 5 tablets in the box. The box did not have a resident name or prescription label affixed to it. - At the bottoms of the wire basket, were 13 unidentified and loose pills.	R 0301	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R301 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will do an audit of the medication room to ensure medications are properly labeled in accordance with the state regulation: (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of	01/27/2023

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	b. In the medication refrigerator, were two Basaglar (a diabetic medication) pens without a resident's name or prescription label affixed. c. In the sink: - A baggie that contained 5 used inhalers with inhalation medication canisters without a resident's name or prescription label affixed. - An opened vial of testosterone for Resident 124 without an opened date. 2. In a small grocery type cart parked in the nursing station, the following was observed: - A plastic bag with a prescription label affixed for Resident 47 contained a used Novolin pen. The Novolin pen itself did not have a prescription label affixed. - A plastic bag with a prescription label affixed for Resident 56 contained a used Lantus pen. The Lantus pen itself, did not have a prescription label affixed. - A plastic bag with "412" handwritten on the bag contained a used Basaglar (a diabetic medication) pen. The Lantus pen itself, did not have a prescription label affixed. An interview with RRN (Regional Registered Nurse) conducted on 12/20/22 at 11:17 a.m. indicated, if diabetic medication pens became separated from their respective boxes/baggies or caps which had the prescription labels affixed to them, she would not be able to identify to who the medication pen belonged.		issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. An audit of the medication room will be conducted by the DON or designee. Any prescription medications found to not be properly marked with all identifying factors, will be promptly destroyed. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to labeling of prescription drugs during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit the medication room two (2) times per week for	

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		A. BUILDING 00 B. WING	12/20/2022

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			eight (8) weeks, then one (1) time a week for four (4) weeks, and then as needed to ensure that any prescription medication that are not properly labeled are discarded. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to ensure over the counter (OTC) medications were properly labeled with resident's name and physician's name for 1 of 1 medication rooms. Findings include: A medication storage observation was conducted on 12/20/22 at 10:22 a.m. with QMA (Qualified Medication Assistant) 4.	R 0302	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R302 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	01/27/2023

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	In the medication room on the main level, within the nursing station the following was observed on a wire shelf: - An opened bottle of antacid tablets without a resident's name or physician's name affixed, no opened date, and an expiration date of 12/22. - Two opened bottles of Milk of Magnesia with a resident's name or physician's name affixed and no opened date. An interview with QMA (Qualified Medication Assistant) 4 was conducted on 12/20/22 during the medication room observation. QMA 4 indicated, she did not know to who the opened bottle of antacid tablets or the opened, two bottles Milk of Magnesia belonged.		a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will do an audit of the medication room to ensure medications are properly labeled in accordance with the state regulation: (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. An audit of the medication room will be conducted by the DON or designee. Any OTC medications found to not be properly marked with all identifying factors, will be promptly destroyed. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to labeling of OTC medications during employee job-specific	

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			orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit the medication room two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, and then as needed to ensure that any OTC medications that are not properly labeled, are discarded. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
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			

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	include the following information: (1) The name of the resident. (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 observation and interview, the facility failed to ensure the timely disposal/disposition of medications for discharged residents for 1 of 1 medication rooms observed for medication storage. Findings include: A medication storage observation was conducted on 12/20/22 at 10:22 a.m. with QMA (Qualified Medication Assistant) 4. In the medication room on the main level, within the nursing station, the following was observed: 1. On the floor of the medication room was a cardboard box which contained: a. Medication pre-packs for Resident 125 which contained multiple pills. The continuous string of pre-packs were dated from 12/1/22's 8 a.m. dose through 12/6/22's 8 p.m. dose. All pre-packs were unopened. b. Medication pre-packs for Resident 126 which contained multiple pills. The continuous string of pre-packs were dated from 11/25/22's 8 a.m. dose through 12/8/22's 8 p.m. dose. All pre-packs were unopened. 3. Medication pre-packs for Resident 127 which contained multiple pills. The continuous string of	R 0306	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R306 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents receiving medication had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on proper and timely destruction of expired or discontinued medications. Employees found to be out of compliance with proper disposal of	01/27/2023

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	pre-packs were dated from 11/25/22's 8 a.m. dose through 12/8/22's 8 p.m. dose. All pre-packs were unopened. 2. On the floor of the medication room was another cardboard box which contained a box of Zofran tablets. The box indicated it had contained 30 tablets, but only 20 tablets remained inside the box. An interview with RRN (Regional Registered Nurse) was conducted on 12/20/22 at 1:32 p.m. RRN indicated, Resident 125 had discharged from the facility on 10/31/22; Resident 126 had discharged from the facility on 11/10/22; Resident 127 had discharged from the facility on 11/10/22; and Resident 128 had discharged from the facility on 9/16/22. A Medication Disposal policy was received on 12/20/22 at 11:42 p.m. from RRN. The policy indicated, "D. All discontinued medications, refused/damaged medications, medications with passed expiration dates, and all medications of residents who have expired shall be disposed of by the facility nurse at the facility location. E. When discharging a resident, the facility nurse will dispose of any medications not sent with the resident...Medication Disposal Guidelines: A...1. Take the medication out of the original containers. 2. Mix medication, either with liquid or solid, with an undesirable substance...3. Dispose with the solid waste (i.e., regular trash) in the presence of two witnesses. 4. Document the disposal on the medication disposition record..."		medications will receive additional education and possible corrective action. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. Director of Nursing or designee with provide education to all QMAs and Nurses on the timely and proper disposal of expired and discontinued medications no later than January 31, 2022. Any clinical staff members out of compliance with facility's policies and protocols relating to appropriate disposal of medications will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to medication disposal during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit the medication room and residents medication cabinets two (2) times per week	

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			for eight (8) weeks, then one (1) time a week for four (4) weeks, and then as needed to ensure that weights are being properly obtained and recorded. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
R 0327 Bldg. 00	410 IAC 16.2-5-7.1(b) Activities Programs - Nonconformance (b) The facility shall provide and/or coordinate scheduled transportation to community-based activities. Based on interview and record review the facility failed to provide outside activities, as preferenced, to 5 of 9 residents reviewed for activity participation. (Residents B, G, H, L, and Z) Findings include: 1. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. The diagnoses for Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The 9/30/22 Level of Service Assessment/Evaluation indicated Resident B was	R 0327	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R327 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **a. Bus will be evaluated for repairs.** **2. How the facility will**	02/10/2023

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	oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed, but may miss some part or intent of the message. 2. The clinical record for Resident L was reviewed on 12/20/22 at 2:00 p.m. The diagnoses for Resident L included, but were not limited to, anxiety. She was admitted to the facility on 7/1/22. The 10/5/22 Level of Service Assessment/Evaluation indicated Resident L was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed without difficulty. 3. The clinical record for Resident H was reviewed on 12/15/22 at 3:00 p.m. The diagnoses included, but were not limited to, asthma. A level of service assessment dated 9/30/22 indicated Resident H "...understands information conveyed without difficulty. Communicates information and is understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." 4. The clinical record for Resident G was reviewed on 12/15/22 at 3:00 p.m. The diagnoses included, but were not limited to, hypertension. A level of service assessment dated 9/30/22 indicated Resident G "...understands information conveyed. May miss some part or intent of the message. Communicates information and is		**identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. b. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. b. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	

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	understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." 5. The clinical record for Resident Z was reviewed on 12/20/22 at 1:45 p.m. The diagnoses included, but were not limited to, hypertension. She was admitted to the facility on 4/26/22. The 11/28/22 Level of Service Assessment/Evaluation indicated she communicated information and was understood. She understood information conveyed without difficulty. The 6/15/22 Resident Committee Meeting Agenda/Minutes was provided by the Marketing Director on 12/16/22 at 3:22 p.m. It read, "Resident Services: Bus, still not working. How or what is needed to asst [assist] members to & from the store, or go out to see movies. Issue: The bus is being repaired per [name of previous Administrator.]" The December, 2022 activity calendar was provided by the IED (Interim Executive Director) on 12/15/22 at 2:24 p.m. It did not include any outside activities like restaurants, shopping, bowling, etc. An interview was conducted with the AD (Activity Director) on 12/16/22 at 11:12 a.m. She indicated she'd worked there since August, 2021. When she first began working, the facility bus "worked twice and that was it," within her first month there. By September, 2021, the bus no longer worked. She wanted to take the residents to see a local Christmas lights display, but they didn't have transportation for getting them there. She hadn't been able to take them shopping, to			

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	parks, restaurants, or picnics. If they had transportation, she would schedule an activity outside of the facility at least weekly. In August, 2022, they borrowed a bus from a sister facility to take residents to the state fair, but that was the last outside activity they'd had. She'd spoken to the IED a week or so ago about borrowing the bus again to take residents to the local Christmas lights display, but hadn't heard back yet. She stated, "I'm hoping to." Residents had been asking her about doing outside activities and when the bus would be ready. An interview was conducted with Resident B on 12/16/22 at 11:23 a.m. She indicated she went to the state fair in August, 2022, and that was the only outside activity the facility had. She would go on more if they had more. She would like to go to the museum, shopping, restaurants, and the park when it's warm. Sometimes she felt affected by not going out. She was told when she admitted that they had a bus for activities to take residents places. "Then to get here and find out the bus is broke down. I was like finally we get to go somewhere when we went to the fair," but they borrowed the bus. Sometimes she felt "cooped up" and wanted to get out, mostly when it was warm. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated she would like to go to outside activities, like going to the store, to the casino, bowling, and things like that "that we should be able to go to, like senior things that we can't do." An interview was conducted with Resident H on 12/19/22 at 2:15 p.m. She indicated the activity bus had not been working for 2 years, since she'd been living there. She got a local bus pass,			

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	because there was no bus to take residents to outside activities. An interview was conducted with Resident G on 12/15/22 at 2:18 p.m. She indicated the facility did not have an activity bus. She went as a guest with Resident H and used her local buss pass sometimes, as Resident H was allowed to take 1 guest with her on the bus. If Resident H did not go anywhere, she couldn't go anywhere either. She would like to go to outside activities. An interview was conducted with Resident Z on 12/19/22 at 2:21 p.m. She indicated she would love to leave for outside activities, but they hadn't had a bus since she'd been there. The New Resident Orientation Policy-Activities was provided by the Regional Marketing and Sales Director on 12/19/22 at 3:00 p.m. It read, "PURPOSE: The purpose of this policy is to ensure that all new residents receive an orientation pertaining to the community activities in a timely manner. POLICY: It is the purpose of the community to create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life."			
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. (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			

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	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 utilized for residents transferred to the hospital included the following information: the address of the facility being transferred to, resident property when transferred to an acute care facility, nurse's notes relating to the resident's functional abilities and physical limitations, condition of resident at the time of transfer, treatments, current diet, and date of chest x-ray and skin test for tuberculosis for 2 of 2 closed records reviewed. (Resident 73 and C) Findings include: 1. The clinical record for Resident 73 was reviewed on 12/20/22 at 10:00 a.m. The diagnosis included, but was not limited to, hypertension. A progress note dated 11/17/22 indicated Resident 73 had been transferred to the hospital due to a fall. The transfer paperwork that was provided to the Emergency Medical Services for Resident 73 on transfer date 11/17/22 was provided by the Regional Registered Nurse (RRN) on 12/20/22 at 11:44 a.m. It included the following: Notice of Transfer or discharge form and Emergency Printout form. The Emergency Printout form did not include the following resident information: current diet, the	R 0354	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R354 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will do admission audit of all residents to ensure all proper documentation is listed on the residents facesheet (emergency printout) **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	01/27/2023

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	resident's condition at the time of transfer, functional abilities and physical limitations, and date of chest x-ray and/or skin test for tuberculosis. An interview was conducted with the RRN on 12/20/22 at 12:53 p.m. She indicated she was unaware the residents' transfer forms needed to include specific information.2. The clinical record for Resident C was reviewed on 12/19/22 at 2:19 p.m. Resident C's diagnoses included, but not limited to, cirrhosis of the liver, hypertension, diabetes, and chronic obstructive pulmonary disease. A nursing note dated 12/12/22 at 11:37 a.m. indicated, Resident C's legs were swollen and was transferred to the local hospital for fluid overload. A Notice of Transfer or Discharge from and Emergency Printout were provided by RRN (Regional Registered Nurse) on 12/20/22 at 12:03 p.m. The transfer/discharge form nor the emergency printout contained the following information: the address of the facility being transferred to, resident's personal property when transferred to an acute care facility, nurse's notes relating to the resident's: functional abilities and physical limitations; nursing care; treatments, and current diet and condition on transfer, or date of chest x-ray and skin test for tuberculosis. An interview with RRN conducted on 12/20/22 at 11:54 a.m. indicated, the nurse in the facility the day of Resident C's transfer sent with the resident the emergency printout and the transfer/discharge form, but cannot indicate if the other necessary information had been relayed to receiving facility. Resident C's nursing notes did not indicate what		a. An audit of all new admissons will be conducted by the DON or designee. Any clinical staff member out of compliance with facility's policies and protocols relating to proper documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to recording proper documentation during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit each admission as it occurs for for two (2) months, then every other month for twelve (12) months, and then as needed to ensure that all proper information is being properly reflected on the facesheet. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed**	

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	information was given to the receiving facility.		a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview and record review, the facility failed to maintain an infection control practice to help prevent the development and transmission of diseases and infection by not appropriately disinfecting a glucometer and lancet pen prior to and after use on residents for 22 of 22 residents who receive blood glucose checks and failed to properly prevent and/or contain COVID-19 for 1 of 5 residents observed during medication administration. (Resident 41). Findings include: 1. a. On 12/19/22 at 12:12 p.m., an observation was made of LPN (Licensed Practical Nurse) 2 performing a blood glucose check on Resident 119. LPN 2 placed a new lancet into the lancet pen and replaced the lancing device cover. LPN 2 did not clean or disinfect the lancet pen or cover prior to use. LPN 2 then performed the blood glucose check on the glucometer which was not cleansed or disinfected prior to use on Resident 119. After completion of the blood glucose check, she removed the lancet cover with bare hands, disposed of the lancet, and wiped down the lancet	R 0406	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R354 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will do admission audit of all residents to ensure all proper documentation is listed on the residents facesheet (emergency	01/27/2023

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	pen and cover with an alcohol wipe. LPN 2 did not properly disinfect the lancet pen, its cover, or the glucometer after its use. b. An observation of LPN 2 was conducted on 12/19/22 at 12:25 p.m. LPN 2 entered into Resident 41's room to perform a blood glucose check. LPN 2 performed the blood glucose test on Resident 41, but had not cleaned/disinfected the lancet pen, its cover, or the glucometer prior to or after it being used with Resident 41. LPN 2 then placed the potentially contaminated glucometer into her pocket and headed to the next room. c. Another observation of LPN 2 was conducted on 12/19/22 at 12:37 p.m. LPN 2 entered Resident 47's room to perform a blood glucose check. Once in the room, she prepped the resident's finger with an alcohol wipe, and without any gloves on, she performed the blood glucose check on the glucometer. LPN 2 did not clean/disinfect the lancet pen, its cover, or the glucometer prior to or after its use with Resident 47. A list of residents with communicable diseases was provided by RRN (Regional Registered Nurse) on 12/19/22 at 2:30 p.m. The list indicated, the facility had one resident with viral hepatitis, one resident with HIV (Human Immunodeficiency Virus) and three residents with hepatitis C, who receive blood glucose checks within the facility. An interview with RS (Regional Support) was conducted on 12/19/22 at 1:03 p.m. RS indicated, the facility does not have a glucometer cleaning policy, but follows the recommendation of the CDC (Center for Diseases and Control) and state regulations. An interview with LPN 2 was conducted on		printout) **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. An audit of all new admissons will be conducted by the DON or designee. Any clinical staff member out of compliance with facility's policies and protocols relating to proper documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to recording proper documentation during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit each admission as it occurs for for two (2) months, then every other month for twelve (12) months, and then as needed to ensure that all proper information is being properly reflected on the facesheet. Results to be reviewed	

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	12/19/22 at 2:23 p.m. indicated, she had completed all of the blood glucose checks that morning. The glucometer manufacturer's instructions were received by RRN on 12/20/22 at 2:52 p.m. They indicated, "It is the recommendation of the manufacture [sic, manufacturer] to use mild soap and water, 70% iso-proply alcohol (IPA), or 1:10 diluted bleach solution; wipe front and back with soft damp cloth [sic] Clean outside of meter using a lint free cloth dampened with soapy water or IPA Disinfecting-1:10 dilution of water and bleach (or bleachwipe), dampen a paper towel and thoroughly wipe down the meter or use Super Sani-Cloth & Sani-Cloth HB Germicidal disposable wipes. Clean exterior with lint free tissue moistened with 1:10 bleach/water disinfectant, wipe dry. Apply an EPA-Registered disinfectant per product directions. Allow glucometer to dry thoroughly between uses." The Sani-Cloth wipes used by the facility were reviewed. The instructions on the container indicated, "To Disinfect: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three minutes. Use additional wipe(s) if needed to assure continuous 3 minute wet contact time. A thorough rinse with potable water is required for surfaces in direct contact with food." 2. An observation of the outside of Resident 41's room was conducted on 12/19/22 at 12:25 p.m. At that time, Resident 41's door did not have any signage indicating Resident 41 was under any isolation precautions, nor was there any personal protective equipment (PPE) located outside of her room. When LPN 2 entered Resident 41's room to perform a blood glucose check she was wearing a		at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	

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	cloth face mask, Resident 41 had indicated, she had COVID, but LPN 2 then corrected her, saying she had a cold. LPN 2 had not donned the proper PPE needed to enter Resident 41's room prior to entry. A nursing note in Resident 41's chart dated 12/16/2022 at 11:10 a.m. indicated, "Resident has not been feeling well since 12/13. Advised to quarantine to her room by staff. This morning resident developed additional symptoms and was tested for COVID which resulted in a positive result. Family, MD[sic, medical doctor], and staff notified. Appropriate notification made to all residents families. Will retest resident on 12/20. Resident will remain in isolation." An interview with LPN 2 conducted on 12/19/22 at 2:23 p.m. indicated, she was unaware that Resident 41 was in droplet isolation precautions because she had tested positive for COVID. A COVID-19 Infection Control Policy provided by Interim ED (Executive Director) was provided on 12/20/22 at 1:04 p.m. The policy indicated, in the event of a confirmed COVID-19 case in a resident, the resident should be placed in transmission based precautions (TBP) under droplet and contact precautions immediately for a 10 day time period. TBP personal protective equipment "will include: - Eye Protection-goggles or face shield that covers the front and sides of the face - One pair of clean, nonsterile gloves - Gown - Respirator mask N95 filtering mask"			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection			

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	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 and interview, the facility failed to maintain an infection control program by not performing hand hygiene before and/or after glove use for 3 of 4 residents observed for blood glucose checks (Residents 119, 41 and 47) and placing a finger/fingernail inside a medication cup when administering medications for 1 of 5 residents during medication administration (Resident 94) Findings include: 1. a. On 12/19/22 at 12:12 p.m., an observation was made of LPN (Licensed Practical Nurse) 2 performing a blood glucose check on Resident 119. LPN 2 in preparation of performing the blood glucose check, donned a pair of gloves. LPN 2 did not perform hand hygiene prior to donning the gloves. As she placed the glove on her right hand, her ring finger penetrated the glove making a hole. She then readjusted her finger so that it then went into the glove correctly. LPN 2 placed a new lancet into the lancet pen and replaced the lancing device cover. LPN 2 did not clean or disinfect the lancet pen or cover prior to use. LPN 2 then performed the blood glucose check on the glucometer which was not cleansed or disinfected prior to use on Resident 119. After completion of	R 0407	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R406 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents requiring the use of glucometers, lancets and lancet covers by the facility, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all medical staff on procedures of appropriately disinfecting glucometers. Employees found to be out of compliance with	01/27/2023

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	the blood glucose check, LPN 2 doffed her gloves, picked up a pen to write down the blood glucose reading then performed hand hygiene. She then removed the lancet cover with bare hands, disposed of the lancet, and wiped down the lancet pen and cover with an alcohol wipe. LPN 2 did not perform hand hygiene after doffing her gloves then using the pen nor did she properly disinfect the lancet pen, its cover, or the glucometer after its use. b. An observation of LPN 2 was conducted on 12/19/22 at 12:25 p.m. LPN 2 entered into Resident 41's room to perform a blood glucose check. LPN 2 in preparation to perform the test, donned a pair of gloves but did not perform hand hygiene prior to donning the gloves. She then performed the test, doffed one glove, used her pen to record the results, exited the resident's room then doffed the other glove. She had not performed hand hygiene prior to picking up her pen, nor had she cleaned/disinfected the lancet pen, its cover, or the glucometer prior to or after it being used with Resident 41. LPN 2 placed the potentially contaminated glucometer into her pocket and headed to the next room. c. Another observation of LPN 2 was conducted on 12/19/22 at 12:37 p.m. LPN 2 entered Resident 47's room to perform a blood glucose check. Once in the room, she prepped the resident's finger with an alcohol wipe, and without any gloves on, she performed the blood glucose check on the glucometer. LPN 2 did not clean/disinfect the lancet pen, its cover, or the glucometer prior to or after its use. 2. An observation of QMA (Qualified Medication Assistant) 3 administering medications to Resident 94 was made on 12/19/22 at 11:57 a.m.		disinfecting glucometers, lancets and covers will receive additional education and possible corrective action. b. All residents in isolation precaution will have appropriate signage on the door and an appropriate PPE cart. It was indicated Resident 41 did not have appropriate PPE cart, however, resident had placed the cart inside her door. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. All clinical staff will be re-educated and in-serviced on disinfecting glucometers, lancets and covers no later than January 31, 2022. Any clinical staff member out of compliance with facility's policies and protocols relating to disinfecting glucometers, lancets and covers will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to disinfecting glucometers during employee job-specific orientation moving forward. b. Education will be given on the proper use of PPE, including gloves. Staff re-educated on checking proper signage at the	

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	QMA 3 had entered Resident 94's room, unlocked the medication cabinet in the unit, and retrieved the needed medication. She then grabbed a medication cup out of the supply box she carried with her and dropped the medication into the cup. QMA 3 then placed her index finger and long fingernail into the medication cup and pinched the cup between her index finger and thumb then handed it to the resident who then took the medication. QMA 3 had not performed hand hygiene since entering Resident 94's room and touching the resident's surroundings. In an interview with QMA 3 conducted immediately prior to entering into Resident 94's room for the medication administration, she indicated, she had used the washroom and had washed her hands otherwise she would have performed hand hygiene when entering the resident's room. A Hand Hygiene policy was received on 12/19/22 at 2 p.m. from Interim ED (Executive Director). The policy indicated, "It is the responsibility of all staff to follow proper handwashing and hygiene guidelines...B. Handwashing 1. All personnel must wash their hands for at lease twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...r. After removing gloves or aprons...C. Alcohol-Based Hand Rubs: 1. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, you may choose to use and alcohol-based hand rub...for all the following situations...b. Before preparing or handling medications...g. After removing gloves (hand hygiene is always the final step after removing and disposing of personal protective equipment)."		front door and in the breakroom regarding COVID positive residents in the community. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit the cleaning of glucometers, lancets and covers two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, then two (2) times a month for one (1) month and then as needed to ensure that proper disinfecting technique is being executed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results b. The Director of Nursing or designee will audit all COVID positive residents for proper signage and PPE carts on a case by case basis. Director of Nursing or designee will monitor proper donning and doffing of PPE by staff. **5. By what date will the systematic changes be completed** a. Education and in-service will	

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			be provided to all clinical staff between now and concluding on January 27, 2023	