STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

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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 IN00432578 and IN00431396. Complaint IN00432578- Federal/State deficiencies related to the allegations are cited at F0689. Complaint IN00431396- No deficiencies related to the allegations are cited. Survey dates: June 3, 4, 5, 6, and 7, 2024. Facility number: 000020 Provider number: 155059 AIM number: 100288690 Census Bed Type: SNF/NF:40 Total: 40 Census Payor Type: Medicare: 30 Medicaid: 2 Private: 8 Other: 0 Total: 40 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3. Quality review completed June 11, 2024	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is (6-18-2024). The facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bryce Tomasi	Administrator	06/27/2024

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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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent falls for a cognitively impaired resident, 1 of 3 residents reviewed for accidents. (Resident C) Finding includes: During an observation on 6/3/24 at 9:52 a.m., Resident C's door was completely closed. During a continuous observation on 6/3/24 at 11:08 a.m., the resident was in her room with the door slightly ajar (door opened a crack with curtain blocking any view) and unable to visualize the resident. The resident was saying "Hello" repetitively in a manner to summon assistance. Her summons for assistance was faintly audible two doors down from the resident's room due to the door being slightly ajar. At 11:11 a.m., an unknown staff member passing by, entered the room while the resident summoned for assistance. During an observation on 6/3/24 at 12:49 p.m., the resident's door was completely shut. During an interview at the time of observation on 6/4/24 09:17 a.m., the resident indicated she had been at the facility approximately one week and had not used her call light yet.	F 0689	p="" paraid="1316445696" paraeid="{76895a63-2b89-43fc-b697-a3b19d8f7faa}{206}">F-689 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The DON/Designee reviewed and updated Resident C's fall care plan with current interventions on 6/18/2024 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:The DON/Designee reviewed the fall care plan and updated with current interventions for residents on 6/18/2024 What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The DON/Designee educated the nurses on policy "Incidents accidents", fall interventions and checking on residents when yelling out from room on (6-17-2024). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or	06/18/2024

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	During a continuous observation on 6/5/24 at 10:12 a.m., the resident activated her call light. The door was ajar but unable to visualize inside resident's room. An unknown staff member entered the room at 10:18 a.m. to answer the call light. Resident C's clinical record was reviewed on 6/5/24 at 12:49 p.m. The resident admitted to the facility on 2/2/24. Diagnoses included the following: unspecified dementia, unspecified polyneuropathy, weakness, other abnormalities of gait and mobility, delusional disorder, restless leg syndrome, maxillary fracture of left side, fracture of nasal bones, and adjustment disorder with mixed anxiety and depressed mood. Current physician's orders included the following: quetiapine fumarate (delusional disorder) -administer 25 mg (milligrams) by mouth once daily, dated 5/2/24; escitalopram (depression) -administer 10 mg by mouth once daily, dated 5/3/24; lorazepam (anxiety)-administer 0.5 mg by mouth twice daily, dated 3/7/24; buspirone (depression)-administer 10 mg by mouth three times daily, dated 3/7/24; and hydrocodone-acetaminophen (pain) 5-325 mg-administer every 8 hours by mouth, dated 2/2/24. An order, dated 4/24/24 included the following: Apply hipsters on as resident allows every shift for fall intervention. Review of a Fall Risk Assessment, dated 2/2/24, indicated the resident was at high risk for falls. A quarterly Minimum Data Set (MDS) assessment, dated 5/11/24, indicated the resident's		progressively disciplined as indicated. 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: DON/Designee will monitor documentation, care plan for new intervention, and observation of fall interventions for any fall for resident with cognitive impairment and observe for staff attending to residents yelling out from room, 5 times a week x 4 weeks, then 3 times a week x 4¿weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed: 6/18/2024	

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	cognition was severely impaired. The resident exhibited delusions and wandering. She required moderate to maximum assistance for transfers, toileting, and walking. The resident was dependent on staff for putting on and taking off footwear. A wheelchair was used for mobility. The resident was frequently incontinent of bowel and bladder. Falls since the prior assessment included two or more without injury. The MDS lacked falls with injury. This was inconsistent with the fall event notes. A care plan for falls, dated 2/5/24, indicated the resident was at risk for falls related to confusion/forgetfulness, functional impairment, impaired balance with transfers, incontinence, lower extremity weakness, unsteady gait, and use of high risk medications. Interventions included the following: Bring resident to nurses station when trying to get out of bed all night long (2/5/24), Encourage and assist with wearing non-skid footwear (2/5/24), Encourage staff to put the resident in bed after dinner meal instead of recliner (5/20/24), floor mat beside bed (4/30/24), reassess fall risk factors annually and as needed (2/5/24), when trying to get up unassisted, offer diversional activities such as a busy box (2/5/24), and tilted wheelchair seat (6/4/24). Review of fall event notes indicated the following unwitnessed falls: On 3/9/24 at 2:38 a.m., the resident was found sitting on the floor beside her lowered bed. The resident was incontinent. No injury was noted. The care plan was not updated with any new interventions. On 3/10/24 at 9:03 a.m., the resident was found on the floor outside of the bathroom door. The			

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	resident was yelling out, "Get me up." No injury was noted. Resident lacked non-skid footwear. The care plan was not updated with any new interventions. On 3/11/24 at 6:20 p.m., the resident was found sitting on the floor between her bed and the recliner. Her wheelchair wheels were unlocked. No injury was noted. The care plan was not updated with any new interventions.The care plan was not updated with any new interventions. On 3/24/24 at 6:02 p.m., the resident was found sitting on the floor beside her recliner. The resident was confused. No injury was noted. A fall on 3/24/24 at 11:24 p.m.lacked an event note. The care plan was not updated with any new interventions. On 4/2/24 at 4:15 p.m., the resident was observed sitting on the floor inside of the door with blood all over her head, face, hands, and the floor. The resident indicated she was working in the garden and fell over. Wheelchair was unlocked. Injuries included an abrasion to the top of the scalp and a laceration to the left forehead.The care plan was not updated with any new interventions. On 4/18/24 at 9:00 p.m., the resident was found in her room on her buttocks in front of the recliner while transferring herself-lacked an event note. No injury noted. The care plan was not updated with any new interventions. On 4/21/24 at 11:12 p.m., the resident was found sitting on the floor beside her bed. Her wheelchair was unlocked. No injury noted. The care plan was not updated with any new interventions. On 4/23/24 at 9:31 p.m., the resident was found			

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	sitting on the floor and yelling out for help and stated she had dropped the papers she was carrying and went to get them. Her wheelchair was unlocked. No injury noted. The care plan was not updated with any new interventions. On 5/19/24 at 2:00 a.m., the resident was found sitting on the floor in front of the recliner with the foot rest still elevated. No injuries were noted. On 6/3/24 at 5: 26 p.m., the resident was found on her knees beside the bed. The resident indicated she had slipped out of her wheelchair. The wheelchair was unlocked. No injury was noted. Review of Post Fall 72-Hour Monitoring Reports lacked specific times for monitoring the resident and assessments every 8 hours for the 24 hour, 48 hour, and 72 hour time frames for the following fall dates: 3/24/24, 4/2/24, 4/18/24, 4/21/24, 4/23/24, 5/19/24, and 6/3/24. A Nurse's Note, dated 3/24/2024 at 6:08 p.m., indicated the resident was noted on the floor beside her recliner. She was assisted by two staff into her wheelchair. A Nurse's Note, dated 3/24/24 at 6:30 p.m., indicated the resident was agitated. Orders for Haldol 2.5 ml (milliliters) intramuscularly (for agitation) and repeat in one hour if no improvement and urine dipstick (test for urinary tract infection). The urine dipstick test was negative. A Nurse's Note, dated 3/24/2024 at 11:24 p.m., indicated the resident was found sitting on the floor beside her recliner. No injury noted. Staff assisted the resident into he wheelchair.			

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	An emergency room visit note, dated 4/2/24, indicated the resident had a cut on her forehead, nose fracture, and a facial fracture related to a head injury. Radiology reports were not provided upon request. An Interdisciplinary Team (IDT) Note, dated 4/19/24, indicated the root cause of the fall on 4/18/24 was due to the resident transferring herself. An IDT Note, dated 4/24/24, indicated the resident did not use the call light for assistance. Confidential interviews were conducted during the course of the survey and indicated the following: -The resident was known to have falls upon admission. The resident preferred her door be left open to watch the traffic up and down the hall. -It was not appropriate for staff to keep residents's doors closed when residents were at high risk for falls to keep their door closed. The door kept closed impaired the inability to see in the room and provide good supervision. -During an interview on 6/5/24 at 3:06 p.m., the resident was in her bed and indicated she did not want her door closed. During an observation on 6/6/24 at 2:25 p.m., RN 5 asked permission to perform treatment to pressure ulcer and the resident indicated the staff was not going to do anything with her. She instructed staff to leave the room. Upon exiting room, RN 5 stated she would close the door. Resident yelled, "Get your hands off my door." The resident's door was left open.			

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	During an interview on 06/7/24 at 9:55 a.m., CNA 9 indicated she was familiar with the resident's care and was aware the resident had frequent falls. She believed the resident last fell approximately one and one half months ago. During an interview on 6/7/24 at 10:24 a.m., LPN 7 indicated she was familiar with the resident's care. The resident had fallen as a result of waking up and attempting to self transfer without asking for assistance by activating her call light. Due to cognitive impairment, the resident attempted to ambulate on her own. During an interview on 6/7/24 at 12:33 p.m., the DON indicated the following interventions were included to decrease falls: therapy inclusion, using non-skid footwear, and non-skid strips on the floor. The resident seemed disoriented prior to falls. During interview on 6/7/24 at 12:36 p.m., CNA 9 indicated she had worked Monday, Wednesday, Thursday and Friday this week and had not been told in report from other staff members that the resident had fallen this week on Monday. She was not aware of the interventions for the resident to have hipsters or a tilted seat on her wheelchair. During an observation on 6/7/24 at 12:37 p.m., the resident was in her bed and the ADON entered the room to answer the call light. She completely closed the door upon exiting the resident's room. During a continuous observation on 6/7/24 at 2:33 p.m., the resident was yelling, "Hello." Administrator walked by the room without looking into the resident's room. At 2:42 p.m., the resident was sitting in her wheelchair beside her bed not			

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	yelling out. At 2:45 p.m., the administrator walked by and after rounding the corner, the resident started yelling out, "Help. Help. Help. Help please." At 2:48 p.m., the Business Office Manager, BOM walked down the hallway and heard resident yelling out, knocked on the door, and offered assistance. She exited the room at 2:49 p.m. The door was left open. At 2:51p.m., the resident began yelling, "Please make my bed. Please make my bed." At 2:52 p.m., the SSD was in hallway and did not acknowledge the resident as she passed by the resident's room while she was yelling out, "Please fix my eyeglasses so I can see out of them. Please do it." Resident's room is the fourth door from nurses station and is more than halfway down the hall from nurses station. Continuous observation until 2:59 p.m. During interview on 6/7/24 at 3:37 p.m., DON indicated the resident's door was frequently closed because "I think she likes it that way." She was unable to provide additional monitoring documentation other than the post fall 72-hour monitoring reports. No specific times were indicated on the forms for monitoring beyond the hourly checks up to completion of the freuquet monitoring. As a result, there was no way to tell how far apart monitoring was completed. She did not like the post fall monitoring forms, but that was the form staff used. A current facility policy, dated 6/30/23, titled "GUIDELINES FOR INCIDENTS/ACCIDENTS/FALLS", provided by the Administrator on 6/7/24 at 10:51 a.m., indicated the following: "Policy: ...This information will be used to implement corrective actions to include any needed training to prevent reoccurrences when possible...2. ...residents who have an unwitnessed fall must have neuro checks started			

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	and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed [by staff], fall. ...9. Documentation of the physical and mental status of the resident[s] involved will be completed each shift [every 8 hours minimally] over the next 72 hours...10. The occurrence is to be communicated shift to shift as part of the report until the resident is stabilized and at least 72 hours post fall. ...11. All falls will have a site investigation...in an effort to define the "root cause" of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence...." This citation relates to complaint IN00432578. 3.1-45(a)(2)			
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. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing			

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	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 and interview, the facility failed to ensure the posted daily nurse staffing data was completed at the beginning of the shift and readily available for residents and visitors during 3 of 3 observations. Findings include: During an observation on 6/3/24 at 9:38 a.m., the posted daily nursing staffing was located in the main lobby to the left of the receptionist desk. The documentation included the number of each position of RN, LPN, and CNA's for each shift as follows: day shift 1 RN, 2 LPN's and 4 CNA's, evening shift 4 LPN's and 5 CNA's, night shift 2 LPN's and 2 CNA's. It lacked the number of hours per shift for each RN, LPN, and CNA worked along with the resident census for that day. Review of the 6/4/24 daily nurse staffing sheet indicated day shift hours included 1 RN= 8.0, 2	F 0732	F-732 It is the policy of this facility to post daily staffing data at the beginning of the shift and readily available for residents and visitors. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Administrator/Designee educated	06/18/2024

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	LPN's=15.25, 4 CNA= 31.75. Evening shift hours included 3 LPN's-=10.5, 7 CNA's= 44.75. Night shift hours included 2 LPN's=16.0 and 2 CNA's=15.25, along with a resident census of 42. Previously the 6/4/24 nurse staffing sheet lacked the number of hours for each nursing position and resident census. During an observation on 6/5/24 at 2:59 p.m., the posted daily nursing staffing was located in the main lobby to the left of the receptionist desk. The documentation included the number of each position of RN, LPN, and CNA's for each shift as follows: day shift 1 RN, 2 LPN's and 5 CNA's, evening shift 3 LPN's and 4 CNA's, night shift 1 LPN's and 3 CNA's. It lacked the number of hours per shift for each RN, LPN, and CNA worked along with the resident census for that day. During an observation on 6/6/24 at 8:53 a.m., the posted daily nursing staffing was located in the main lobby to the left of the receptionist desk. The documentation included the number of each position of RN, LPN, and CNA's for each shift as follows: day shift 1 RN and 4 CNA's, evening shift 2 LPN's and 7 CNA's, night shift 1 RN and 5 CNA's. It lacked the number of hours per shift for each RN, LPN, and CNA worked along with the resident census for that day. Review of the 6/6/24 daily nurse staffing sheet was completed at this time. It showed resident census was 42 and the daily hours included: day shift 1 RN= 8.0, 4 CNA's = 31.25, evening hours 1 RN= 8.0, 1 LPN = 2.0 and 7 CNA's = 40.0, night 1 LPN= 10.0, 3 CNA's = 21.75. Previously the 6/6/24 nurse staffing sheet lacked the number of hours for each nursing position and resident census. During an interview on 6/7/24 at 1:14 p.m., the Business Office Manager indicated the staff		the Scheduler on Staffing grid posting per facilities “BIPA Policy” on 6/18/2024. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. 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: Administrator/Designee will monitor Daily Nurse staffing sheets for completion at beginning of shift 5 times a week x 4 weeks, then 3 times a week x 4¿weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed:DATE: 6/18/2024¿	

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	155059	A. BUILDING 00 B. WING	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

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	posting in the hallway by the lobby lacked a resident census number and the hours per shift for each RN, LPN, and CNA. During an interview on 6/7/24 at 1:15 p.m., Medical Records indicated she posted the staffing for each day. She left the resident census and nurse staffing hours blank for that day and only posted the staffing number for each day. The nurse staffing hours and census are filled out the following day after she calculates the hours worked from the timecards. The sheets only need to have the current date and the staff who are in the building. The completed form is hung early to mid-morning for the previous day. During an interview on 6/7/24 at 3:09 p.m., the Administrator indicated the daily nurse staffing sheet was filled out per facility policy. Everything was filled out except for the resident census and nurse staffing hours. Those were completed the following day in the event any changes occurred. Review of an undated facility policy titled "BIPA Staffing Posting Requirement," provided by the Administrator on 6/7/24 at 1:32 p.m., indicated the following: "...Procedure: SNFs and NFs must post daily, at the beginning of each shift, the facility specific shift schedule for the 24 hour period, the number and category of nursing staff employed or contracted by the facility for each 24 hour period, as well as the total number of hours worked by the licensed and licensed nursing staff who are directly responsible for patient care. Other required posted data includes: facility name, current date and current census ...."			
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			

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	Drugs and biologicals used in the facility 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 remove and destroy expired insulin from the medication cart for 1 of 2 medication carts reviewed for medication storage. (Center Unit Medication Cart) This affected 1 of 12 residents who received medications from this medication cart. (Resident 27) Finding includes: During an interview at the time of observation on 6/5/24 at 3:57 p.m., LPN 3 indicated Resident 27's Humalog Kwikpen (insulin) 100 units/ml (milliliter)	F 0761	F761- It is the policy of this facility to remove and destroy expired insulin medications carts. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Expired Insulin was removed resident 27's and destroyed from the cart on 6/5/2024 by the DON/Designee. Resident 27 was assessed by the DON/Designee on 6/5/2024 and no negative	06/10/2024

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	was opened, expired, and stored in the left top drawer of the Center Unit Medication Cart. There was no other Humalog in the cart readily available for the residents administration that could have been used in place of the expired insulin. The resident's Humalog was opened on 5/1/24 and expired on 5/29/24. She had administered 8 units of insulin to the resident from the expired Humalog Kwikpen on 6/5/24. The resident had also received expired insulin on the following dates: 5/30/24, 5/31/24, 6/3/24, and 6/4/24 for a total of 6 expired doses. Humalog used after 28 days from the opened date was not as effective to manage the resident's blood sugar. Dates on insulin should have been checked prior to each administration. The Humalog Kwikpen should have been discarded on 5/29/24. Resident 27's clinical record was reviewed on 6/5/24 at 4:05 p.m. Diagnosis included type 2 diabetes mellitus with diabetic nephropathy. A current physician's medication order, dated 3/28/24, included Humalog Injection Solution 100 units per milliliter (ml)- Inject subcutaneously four times daily for diabetes per sliding scale: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units. If blood sugar is over 351, call the provider. Review of the Medication Administration Record (MAR) for 5/30/24 through 6/5/24 indicated sliding scale insulin was administered on the following dates and times: On 5/30/24 at supper, the resident received 2 units of Humalog. On 5/30/24 at bedtime, the resident received 8 units of Humalog. On 5/31/24 at bedtime, the resident received 2		outcome related to receiving expired insulin. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The DON/Designee completed an audit of all medication carts and removed and destroyed any expired insulins on 6/5/2024. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The DON/ the nurses on Medication storage and expiration dates on Insulin and when to remove and destroy it (6-8-2024). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. 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: DON/Designee will monitor insulin in accordance with expiration dates 5 times a week x 4 weeks, then 3 times a week x 4¿weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any	

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	units of Humalog. On 6/3/24 at bedtime, the resident received 2 units of Humalog. On 6/4/24 at bedtime, the resident received 2 units of Humalog. On 6/5/24 at supper, the resident received 8 units of Humalog. A current care plan, dated 3/28/24, indicated the resident was at risk for hyperglycemia. Interventions included, give insulin as ordered. Review of the Third Shift Insulin Expiration Review Sheets from 5/29/24 through 6/4/24, included daily signatures. The sheets indicated to review all insulin every night and pull any that are expired from the medication cart. During an interview on 6/5/24 at 4:29 p.m., the ADON indicated expired medications should have been disposed of during nightly checks and prior to administration. She believed Humalog was good for 28 or 30 days. The insulin would not work to its full potential when used beyond the expiration date. During an interview on 6/5/24 at 4:39 p.m., the ADON provided the policy and indicated Humalog should have been discarded 28 days after it was opened. During an interview on 6/5/24 at 4:39 p.m., the DON indicated signatures on the Third Shift Insulin Expiration Review Sheets should have indicated the insulins were checked for expiration. Signatures without removal of expired insulins were not an effective means of monitoring for expired insulin in the medication carts. Review of the Humalog Kwikpen manufacturer		patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed:Date: 6/10/2024	

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	instructions on 6/5/24 at 4:52 p.m., indicated Humalog prefilled pens should have been thrown away 28 days after opening. A current facility policy, dated 8/10/23, titled "GUIDELINES FOR INSULIN PENS," provided by the ADON on 6/5/24 at 4:39 p.m., indicated the following: "Purpose: It is the intent of the facility to monitor, maintain, and administer insulin, to include insulin in INSULIN PENS per manufacturer's recommendations... Procedure: ...6) Insulin pens will be considered expired after 28 days and up to 45 days depending on the manufacturer's instructions---after they are opened, no matter of the amount of insulin still remaining in the pen...." 3.1-25(o)			
F 9999 Bldg. 00	The facility failed to ensure the Alzheimer's/Dementia Special Care Unit form was completed and submitted to the Indiana Department of Health by the due date. 40 residents resided on the memory care unit. Finding includes: On 6/6/24 at 3:30 p.m., the Administrator was requested to provide a copy of the Alzheimer's/Dementia Special Care Unit form. He indicated he was unfamiliar with the requested form. On 6/7/24 at 8:35 a.m., the Administrator provided an undated Alzheimer's/Dementia Special Care Unit form.	F 9999	=”” span¿<=”” span=””> F-9999 It is the policy of this facility to ensure the Alzheimer's/Dementia Special Care Unit form was completed and submitted to the Indiana Department of Health by the due date What corrective action will be accomplished for those residents found to have been affected by the deficient practice The facility signed and submitted the Alzheimer’s/Dementia Special Unit Form and submitted to the Indiana Department of Health on 6/9/2024 How other residents having the potential to be affected by the same deficient practice will	06/08/2024

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	During an interview on 6/7/24 at 3:45 p.m., the Administrator indicated the form was just filled out this week. He had not filled out and submitted the form by 12/31/23. He would submit the form today. A facility policy was requested on 6/7/24 at 3:49p.m. During an interview on 6/7/24 at 3:52 p.m., the Administrator indicated there was no policy. 5-1.3(l)		be identified and what corrective action(s) will be taken: The RDO in-serviced the Administrator on DATE on signing the Alzheimer's/Dementia Care Unit form annually on 12-31-2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 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 Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. ="" p=""> ="" p=""> ="" p=""> ="" p=""> br="">	