STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWOOD MANOR	5200 S BURLINGTON DR MUNCIE, IN 47302

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 21 and 22, 2021 Facility number: 00312 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 23, 2021.	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request the granting of desk compliance, considering the low scope & severity of the citations noted and corrections implemented.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted			

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

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	between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure there were fire drills each shift and failed to ensured employees were knowledgeable of the facilities fire procedure for 9 of 12 months of fire drill records reviewed and 3 of 3 employees interviewed for the knowledge of fire safety procedure. Findings include: 1. During a 4/22/21, 9:00 a.m., review of the facility fire drill records for March 2021 to May 2020 the following concerns regarding fire drill procedures were noted: a. 4/6/2021- no time was listed, the form indicated the drill occurred during all three shifts, the form only listed one individual as "situation Discovered by" and not the 3 that would be required for 3 shifts of involvement. b. March 2021 lacked records of any drill offered this month. c. 2/23/21- no time was listed, no shift was identified. d. 1/28/21-no time was listed, the form indicated the drill occurred during all three shifts, the form only listed one individual as "situation	R 0092	·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this deficient practice. Immediate in-servicing of the Maintenance staff regarding performing complete and accurate Fire Drills and all staff regarding Fire safety and our Emergency Preparedness plan, has occurred. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents had the potential to be affected by this deficient practice. Staff has been in-serviced regarding Fire Safety and our Emergency Preparedness Plan. Maintenance staff has been in-serviced regarding complete and appropriate Fire Drills ·What measures will be put into	05/03/2021

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	Discovered by" and not the 3 that would be required for 3 shifts of involvement. e. 12/12/20- no time was listed, the form indicated the drill occurred during all three shifts, the form only listed one individual as "situation Discovered by" and not the 3 that would be required for 3 shifts of involvement. f. 11/10/20- no time was listed, the form indicated the drill occurred during all three shifts, the form only listed one individual as "situation Discovered by" and not the 3 that would be required for 3 shifts of involvement. g. July 2020 lacked records of any drill offered this month. h. June 2020 lacked records of any drill offered this month. i. May 2020 lacked records of any drill offered this month. During a 4/22/21, 10:30 a.m. interview, the Administrator indicated she was unable to find the in-service information attendance record and content for the all staff, fire preparedness training the facility had offered in the last 12 months. She additionally indicated training had been offered. 2. During an interview on 4/22/21 at 9: 38 a.m., Housekeeper 2 indicated she would unplug and pick up a sparking smoking resident TV and carry it through the hallway and take it outside of the facility. She indicated she was not aware an individual should not move a potential fire. She did not know the acronym R.A.C.E and indicated she had never been trained to use this method when responding to a fire. She did not know to		place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All staff shall be in-serviced on Fire Safety upon hire. All staff shall be in-serviced at least twice yearly on Fire Safety and our Emergency Preparedness Plan. Maintenance staff shall run complete and appropriate Fire Drills monthly, in staggered fashion as is regulation. Administrator or Designee will audit Fire Drill logs monthly x's 12 months and re in-service as needed. ·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; and Administrator or Designee shall audit Fire Drill logs monthly for Quality Assurance and re in-service if needed. All staff shall be in serviced upon hire and twice yearly on Fire Safety and our Emergency Preparedness Plan	

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	pull and alarm or close the door. During a 4/22/21, 9:41 a.m., interview, QMA 1 indicated she would unplug a sparking smoking resident TV and go get the Maintenance Supervisor. She did not indicate she would close the door or pull the alarm. She indicated she did not know the acronym R.A.C.E. During a 4/22/21, 9:47 a.m., interview, the Administrator indicated, fire drills should have times and shifts. The Facility had no records that fire drills had not been offered during the months of May, June or July 2020. She additionally indicated the facility used the acronym of RACE for their fire response plan. The Maintenance Supervisor, was the individual responsible for fire drill oversight and employee education. During a 4/22/21, 9:48 a.m., interview, the Maintenance Supervisor, who indicated he was responsible for fire drills and staff fire training, indicated he would unplug a sparking smoking resident TV and go get a fire extinguisher. He did not indicate he would close the door or pull the fire alarm. He indicated he had heard of the acronym R.A.C.E, but did not recall what the letters meant. A current, 6/11/12, facility policy titled "Disaster Preparedness Policy", which was provided by the Director of Nursing on 4/22/12 at 11:14 a.m., indicated the following, "Regularly scheduled fire drills are conducted on each shift,one drill per month, rotating shifts. Records are kept on these drills...Orientation of new employees, and review classes for all personnel are conducted in the use of firefighting equipment and in the fire evacuation plans, as needed...In case of fire,			

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	announce overhear 3 times 'CODE RED (and the location of the fire if known)' For example 'Code red kitchen, Code red kitchen, code red kitchen!' Call 911 and PULL nearest Alarm, and remember 'R.A.C.E.' R-Rescue/Remove- any resident from the area of the fire A-Alarm-Pull nearest Alarm and call 911 to report C-Confine-Confine fire by closing doors! E-Extinguish/Evacuate!"			
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 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 properly label and store respiratory inhaler medications in 1 of 1 medication carts observed. Findings include: On 4/21/21 at 2:58 p.m., medication cart 1 was observed with QMA 1 who indicated the following: a. A Flovent HFA inhaler (bronchodialator) was	R 0301	·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this deficient practice. Resident's inhalers have been marked appropriately, with their full name and date open. Further, our pharmacy has begun including a label on the actual inhaler as well	05/03/2021

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	laying in the bottom medication drawer. The inhaler had "James" written in marker on the inhaler, and lacked a label indicating resident's full name or an opened date. There were 12 doses remaining. b. A Ventolin HFA inhaler (bronchodialator) was laying in the bottom medication drawer. The inhaler had "Tracy" written in marker on the inhaler and an opened date of 7/7/19. There were 139 doses remaining. c. A Ventolin HFA inhaler (bronchodialator) was laying in the bottom medication drawer. The inhaler had "NT" written in marker on the inhaler and lacked a label indicating resident name or an opened date. There were 200 doses remaining. d. A Ventolin HFA inhaler (bronchodialator) was laying on the bottom medication drawer. The inhaler had "DR" written in marker on the inhaler and lacked a label indicating resident's full name or an opened date. There were 176 doses remaining. e. A Ventolin HFA inhaler (bronchodialator) was laying on the bottom medication drawer. The inhaler lacked a resident name or opened date. There were 174 doses remaining. During an interview on 4/21/21 at 2:01 p.m., the Director of Nursing (DON) indicated the inhalers should be labeled with the resident name and a date opened. A current facility policy, undated, titled, "Rosewood Manor Policy Medication Storage," provided by the DON on 4/22/21 at 9:55 a.m., indicated "The facility shall develop and implement a policy for lawful disposal of unused,		as the box it comes in. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Eight residents had the potential to be affected by this deficient practice. All resident inhalers have been located and marked appropriately. All resident inhalers have been marked appropriately, with their full name and date open. Further, our pharmacy is now including a label on the actual inhaler as well as the box it comes in. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Pharmacy will now include a label on the actual inhaler as well as the box it comes in. Nursing staff has been in-serviced on ensuring labeling compliance as medications are in-taken. In addition, the DON or her Designee will audit the med cart for labeling compliance on respiratory inhalers weekly x's 1 month until 100% compliance is achieved and then monthly thereafter.	

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	outdated, discontinue or recalled medications." ·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; and The DON or Designee will perform med cart audits weekly x's 1 month until 100% compliance is achieved and then monthly to ensure labeling compliance			