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	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00452887, IN00451356, and IN00452295. Complaint IN00452295 - No deficiencies related to the allegations are cited. Complaint IN00451356 - State deficiencies related to the allegations are cited at R144, R216 and R240. Complaint IN00452887 - State deficiencies related to the allegations are cited at R240. Survey dates: February 12, 13 and 14, 2025 Facility number: 014279 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 18, 2025.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on interview and record review the facility failed to ensure immediate consultation of a resident's physician and legal representative after a fall for 1 of 2 residents reviewed for closed records. (Resident 26) Findings include:	R 0036	**R036** **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**	04/01/2025

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

Lily Price | Executive Director | 03/03/2025

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	The clinical record for Resident 26 was reviewed on 2/14/25 at 11:05 a.m. The diagnoses included, but were not limited to, dementia and type II diabetes. The resident's Level of Service Assessment, dated 1/13/25, indicated Resident 26 "understands information conveyed. May miss some part or intent of the message... disoriented to the point of no longer able to function independently 3 or more days a week or part of every day for a 7-day period." A progress note in Resident 26's clinical record was reviewed on 2/14/25 at 11:25 a.m. The progress note indicated the resident had sustained a fall on 1/17/25 at 9:16 a.m. Qualified Medication Aide (QMA) 33 indicated in their report of the fall that the resident was found on the floor by a Certified Nurse Aide (CNA) when delivering the resident's room tray. No known injuries were found, and vital signs were within normal limits. There was no documentation of notification of the resident's physician or legal representative. During an interview with the Director of Nursing (DON) on 2/14/25 at 12:30 p.m., she indicated she did not know if the resident's physician or legal representative were notified of the resident's fall on 1/17/25 at 9:16 a.m. No such documentation of notification was provided during the survey. A service plan for Resident 26, dated 9/30/24, indicated licensed nurses to notify the physician of any significant changes in resident's condition. A Fall Prevention and Management Policy, dated 2/2022, was provided by the DON on 2/14/25 at 12:35 p.m. The policy indicated, " ...Procedure ...E.		**identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** a All residents that experience falls in the community had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure the residents' physician and/or family are notified in a timely manner in the instance of a fall. Employees found to be out of compliance with medication documentation will receive additional education and 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 DON and/or designee will ensure the residents' physician and/or family are notified in a timely manner in the instance of a fall. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing and/or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving	

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	The resident's primary care provider shall be notified of any fall event. Any communication with the primary care provider along with any orders received shall be documented in the resident's medical record ... G. The resident's representative or primary emergency contact shall be notified of fall event unless otherwise stated or requested by the resident (if applicable) ..."		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 This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed:** April 1, 2025	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance Based on interview and record review, the facility failed to provide dementia training upon hire for 3 of 5 employee records reviewed for dementia training (Certified Nurse Aide [CNA] 30, CNA 32, and Qualified Medication Aide [QMA] 33).	R 0119	**R119** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/01/2025

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	Findings include: 1. The employee record for CNA 30 was reviewed on 2/13/25 at 2:15 p.m. CNA 30 began employment on 12/31/24. The employee record did not contain information that dementia training had been completed. 2. The employee record for CNA 32 was reviewed on 2/13/25 at 2:25 p.m. CNA 32 began employment on 10/8/24. The employee record did not contain information that dementia training had been completed. 3. The employee record for QMA 33 was reviewed on 2/13/25 at 2:30 p.m. QMA 33 began employment on 11/18/24. The employee record did not contain information that dementia training had been completed. During an interview on 2/14/25 at 8:52 a.m., the Business Office Manager indicated that dementia training had not been completed by CNA 30, CNA 32, and QMA 33. During an interview on 2/14/25 at 11:10 a.m., the Director of Nursing indicated the facility did not have a policy for dementia training.		**practice:** /p> **2 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:** a. Business Office Manager and/or designee will ensure dementia training is assigned to all new hire employees prior to working independently. Employees found to be out of compliance with dementia training will receive additional education and 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 BOM and/or designee will educate all new staff during new hire orientation on the requirement to complete dementia training prior to working independently. **1.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:**	

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			a This process will be reviewed by BOM/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed:** April 1, 2025	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to ensure resident rooms and common areas were clean and free of odor. This had the potential to affect 90 of 90 residents that reside in the facility. Findings include: A facility tour was conducted with the Director of Nursing (DON) on 2/12/25 at 10:39 a.m. The flooring in the hallways and elevators on the 1st, 2nd, 3rd and 4th floors were observed to have dust and dirt debris in corners and along the base boards. During a Confidential Interview, they indicated the hallways have odors and were dirty.	R 0144	**R144** **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a All residents have the potential to be affected by 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**	04/01/2025

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	Observations of the hallways and elevators were conducted on 2/12/25 at 12:30 p.m., 2/13/25 at 8:45 a.m., 2/13/25 at 2:25 p.m., and 2/14/25 at 9:30 a.m. The hallways and elevators were observed with dust and dirt debris on the bottom corners and along the base boards. The elevators had brown streaks on the inside flooring. The 3rd floor elevator had a glob of a brown substance on the elevator button. An interview was conducted with Resident B on 2/12/25 at 2:08 p.m. She indicated housekeeping was supposed to clean her apartment once a week. It had been a few weeks, and she had not received housekeeping services. The last two weeks she has received her once a week housekeeping, but the housekeeping staff does not clean. The housekeeping staff cleaned the mirror in the bathroom and wiped the toilet lid with a paper towel. He did not sweep, mop, clean the toilet, or clean the shower. An interview was conducted with Resident 22 on 2/13/25 at 1:24 p.m. She indicated she was the resident council president. The building's common areas, furniture in the common areas, and elevators were not clean at all. Housekeeping was a common complaint in the resident council. Resident 32 was the resident council secretary; she would be able to provide the resident council notes. A resident council minutes documentation, no written date, indicated "housekeeping bad!! ...New chairs in lobby. Clean or replace." An environmental tour with the Maintenance Supervisor (MS) was conducted on 2/14/25 at 1:19 p.m. During the tour, the hallways and elevators		a Maintenance Director and/or designee will ensure resident rooms and common areas are clean and free of odor. Any housekeeping/maintenance employee not following facility housekeeping protocols will receive additional education and corrective action. **3 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** a Housekeeping/maintenance staff will be in-serviced on facility housekeeping protocols and requirements. **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 This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until	

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	were observed. The hallways on each floor had dust and dirt debris along the base boards and corners of the flooring. The elevators were observed with brown scuffs, and the 4th floor had a strong skunk odor. The MS indicated at that time; the residents' rooms are to be cleaned once a week. The housekeeper should clean bathrooms, kitchen areas, sweep and mop the floor, and remove the trash. The housekeeper does sweep and mop the hallways and common areas in the facility. He would add on the list to clean the baseboards in the hallways. The 4th floor often does have an odor. The elevators are stained from the mulch outside. The residents do go outside and step in the mulch. After they return and go up the elevator the mulch contains an oil that stains the elevator flooring. There were plans to replace the flooring in the elevators. The MS indicated he was currently short staffed with housekeeping. This citation relates to Complaint IN00451356.		resolved. **5 By what date will the systematic changes be completed:** April 1, 2025	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, interview, and record review, the facility failed to ensure a resident's ability to self-administer medications by completing a self-administration evaluation for 2 of 2 residents observed with medications in their rooms. (Resident 81 and Resident B) Findings include: 1. The clinical record for Resident 81 was reviewed on 2/12/25 at 1:00 p.m. The diagnoses included, but were not limited to, transient ischemic attack (TIA) and type II diabetes.	R 0216	**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 action will be taken:**	04/01/2025

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	The resident's Level of Service Assessment, dated 12/11/24, indicated Resident 81 "understands information conveyed. May miss some part or intent of the message..." A service plan for Resident 81, dated 9/18/24, indicated nursing staff would administer his medications. A Self Administration Medication Assessment, dated 11/21/22, indicated "...Instructions: Complete in order to assess a resident's ability to self-administer medications. Check the appropriate response below for each item listed. The resident must be able to perform each step indicated below prior to beginning self-administration of medications..." The resident assessment indicated he was unable to correctly perform any of the tasks listed under the assessment criteria. An observation was conducted, on 2/13/25 at 2:25 p.m., of Resident 81's room. Resident 81 had his fluticasone nasal spray and antacid medication stored in his room. An interview was conducted, on 2/13/25 at 2:28 p.m., with Resident 81. He indicated he administers these medications himself and buys over the counter medication when he goes to the store and stores them in his room. A clinical record review was conducted on 2/13/25 at 3:01 p.m. Resident 81's clinical record did not contain a current evaluation for his ability to self-administer medications. During an interview with the Director of Nursing (DON) conducted on 2/13/25 at 3:30 p.m., she indicated that the facility should be storing and administering all Resident 81's medications		a All residents that self-administer their medications had the potential to be affected by the alleged deficient practice. DON and/or designee will audit all residents who are independent with their medications to ensure a self-medication assessment is scheduled every 6 months and completed in a timely manner. Employees found to be out of compliance with completing scheduled assessments will receive additional education and 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 DON and/or designee will audit all residents who are independent with their medications to ensure a self-medication assessment is scheduled every 6 months and completed in a timely manner. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols 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**	

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	because he does not self-administer. 2. The clinical record for Resident B was reviewed on 2/12/25 at 2:00 p.m. The diagnoses included, but were not limited to, stroke. The resident's Level of Service Assessment, dated 12/13/24, indicated Resident B "understands information conveyed. May miss some part or intent of the message..." A service plan for Resident B, dated 9/13/24, indicated the resident self-administered her medications. A Self Administration Medication Assessment, dated 1/21/21, indicated "...Instructions: Complete in order to assess a resident's ability to self-administer medications. Check the appropriate response below for each item listed. The resident must be able to perform each step indicated below prior to beginning self-administration of medications ...Assessment Results. Resident has been assessed and deemed to self medicate at the following level: Administration by licensed nurse. Resident requires medications to be stored and locked: yes..." The resident assessment indicated she was unable to correctly state the medication's proper dosage, what each medication was for, common side effects, and unable to read instructions for medication use on container of medications. An observation was conducted of Resident B in her room on 2/12/25 at 2:08 p.m. The resident's room was observed to have inhalers sitting on a table. During an interview with Resident B, she indicated she administers her medications herself. An interview was conducted with the DON on 2/13/25 at 2:02 p.m. She indicated Resident B does		**assurance program will be put into place:** a This process will be reviewed by DON/designee on each independent resident, then upon each new admission and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **By what date the systemic changes will be completed:** April 1, 2025	

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	self-administer her medications. The self-administration of medications assessment, dated 1/21/21, was the current self-medication assessment in the resident's medical chart that had been conducted. A Medication Management, Administration, & Storage policy was provided by the DON on 2/13/25 at 1:54 p.m. It indicated, "...Purpose: The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines. The community will have available, on the premises or on call, the services of a license nurse at all times. Policy: A. Assessment: 1. The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. The assessment will determine what level of assistance, if any, is needed by the resident. Medication set-up and storage protocol will be implemented based on the assessment outcome. The medication assessment will be reviewed biannually as part of the review process, and episodically with any significant change of condition or level of service indicate..." This citation relates to Complaint IN00451356.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure vital signs and weights were obtained as ordered; priming of two units of insulin utilizing a flex pen; obtaining orders for a resident that utilizes a continuous glucose monitor sensor (Libra), and ensure staff	R 0240	**R240** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	04/01/2025

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	responded to call lights timely for 2 of 5 residents' records reviewed, 2 of 7 residents observed during medication administration, and 6 of 11 residents interviewed. This had the potential to affect 90 of 90 residents that reside in the facility. (Residents' 14, 17, 22, 27, 32, 39, 40, 78, 81, and Resident B) Findings include: 1a. The clinical record for Resident 81 was reviewed on 2/12/25 at 2:00 p.m. The diagnoses included, but were not limited to, type II diabetes mellitus. An observation of a medication administration for Resident 81 was conducted with Qualified Medication Aide (QMA) 1 on 2/13/25 at 8:43 a.m. During the medication administration of obtaining Resident 81's blood sugar utilizing a glucometer, the resident indicated he had been stuck in the finger for five weeks. At that time, the resident had pointed at his bedside to a prescription medication box requesting his Libra blood sugar monitor to be placed. It came in last evening. QMA 1 indicated she was not qualified to place the sensor on. She would notify the Director of Nursing (DON) to place the sensor on the resident. An observation of an insulin medication administration for Resident 81 was made with QMA 1 on 2/13/25 at 10:57 a.m. QMA 1 was observed obtaining the resident's blood sugar by utilizing a glucometer. Resident 81 indicated to the DON at that time, he had been stuck in the finger for five weeks. The blood sugar sensor came in last evening and no one had placed it. The DON indicated she would place the blood sugar sensor after the resident had eaten his lunch meal.		a **2 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:** a All residents had the potential to be affected by the alleged deficient practice. DON and/or designee will in-service clinical staff on following doctors' orders, obtaining proper doctor orders, priming insulin pens prior to use and answering call lights in a timely manner. DON and/or designee will audit physician orders for correctness. DON and/or designee will ensure proper orders are in place for Libre devices. DON and/or designee will audit insulin medication pass to ensure med passers are priming insulin needles. DON and/or designee will review the call light report each morning and address any issues. Employees found to be out of compliance with medication documentation will receive additional education and 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 All clinical staff will be	

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	Resident 81's clinical record did not include physician orders the resident was to utilize a continuous glucose monitoring sensor. An interview was conducted with Resident 81 on 2/14/25 at 10:16 a.m. He indicated the DON tried to put on my blood glucose sensor, but it would not stick and fell off. They have to order another one. An interview was conducted with the DON on 2/14/25 at 12:23 p.m. She indicated she had placed the sensor on Resident 81 yesterday, 2/13/25. The resident's outside medical provider had told the staff there was a ten day turn around for the resident's Libra once ordered. An interview was conducted with the DON on 2/14/25 at 2:54 p.m. She indicated after she placed the Libra sensor, the resident admitted to pulling off his sensor last night. At this time, she had reached out to the outside medical provider to obtain a copy of the order. 1b. A physician order, dated 10/15/24, indicated Resident 81 was to receive 18 units of Novolog insulin (fast acting insulin) in the morning, 16 units of Novolog insulin at noon, and 20 units of Novolog insulin in the evening. An observation of an insulin medication administration for Resident 81 was conducted with QMA 1 on 2/13/25 at 8:43 a.m. During the administration, QMA 1 was observed utilizing a Novolog insulin flex pen. QMA 1 indicated the resident was to receive 18 units of Novolog. She was observed dialing up 18 units and administered the insulin to Resident 81 in his abdomen. There was no observation of QMA 1		re-educated and in-serviced on following doctors' orders, obtaining proper doctor orders, priming insulin pens prior to use and answering call lights in a timely manner. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing and/or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols 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 This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved.	

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	priming the insulin flex pen with two units prior to the administration of the 18 units. 2. The clinical record for Resident 78 was reviewed on 2/12/25 at 2:30 p.m. The diagnoses included, but were not limited to, type II diabetes mellitus. A physician order, dated 12/27/24, indicated Resident 78 was to receive Humalog insulin (fast acting insulin) utilizing a sliding scale. The scale was the following: 140 - 200 blood sugar reading = 4 units of insulin, 201 - 250 = 6 units of insulin, 251-300 = 8 units of insulin, 301- 350 = 10 units of insulin, and 351 - 399 = 12 units of insulin. An observation of an insulin medication administration for Resident 78 was made with QMA 1 on 2/13/25 at 11:18 a.m. QMA 1 was observed utilizing a Humalog insulin flex pen to administer four units of Humalog insulin. After obtaining the resident's blood sugar, she then administered four units of Humalog insulin in the resident's abdomen. There was no observation of QMA 1 priming the insulin flex pen with two units prior to administering the four units of insulin. An interview was conducted with the DON on 2/14/25 at 3:00 p.m. She indicated the staff was to follow the manufacture instructions to administer insulin utilizing flex pens. "Instructions for use. Humalog insulin flexpen" manufacture instructions at website www.pi.lilly.com, dated 7/2023, was retrieved on 2/16/25. It indicated "...Priming your pen: Prime before each injection. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or		**5 By what date the systemic changes will be completed:** April 1, 2025	

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	too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and '0' is seen in the dose window..." 3. The clinical record for Resident B was reviewed on 2/12/25 at 2:00 p.m. The diagnoses included, but were not limited to, stroke. The resident's Level of Service Assessment, dated 12/13/24, indicated Resident B "understands information conveyed. May miss some part or intent of the message..." A physician order, dated 8/26/20, indicated Resident B was to have her weights obtained every Thursday. If the resident's weight was greater than three pounds the medical provider was to be notified. A physician order, dated 5/14/20, indicated Resident B was to have vitals obtained three times a day. The vitals and weight records, for January 2025, were provided by the DON on 2/14/25 at 11:09 a.m. It did not include vitals obtained three times a day nor weekly weights. The last recorded vitals and weight obtained for the resident was on 1/13/25 at 3:50 p.m. An interview was conducted with Resident B on 2/12/25 at 2:08 p.m. She indicated the staff were not obtaining weights weekly nor taking her vitals three times a day. An interview was conducted with the DON on			

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	2/12/25 at 11:02 a.m. She indicated she was unaware Resident B had orders for vitals three times a day and weekly weights. Those orders were old. She would call the medical provider to clarify if those orders needed to be continued. 4a. During a Confidential Interview, the staff were not responding to the call lights timely. 4b. An interview was conducted with Resident 27 on 2/13/25 at 1:19 p.m. She indicated it depended on who was working regarding if the call light was answered. Some take a long time to answer. 4c. An interview was conducted with Resident 22 on 2/13/25 at 1:24 p.m. She indicated she does receive complaints from the residents about call lights not answered timely. 4d. An interview was conducted with Resident 32 on 2/13/25 at 1:30 p.m. She indicated she wasn't sure if the call light system worked. The staff doesn't answer. 4e. An interview was conducted with Resident 39 on 2/13/25 at 1:45 p.m. She indicated she had to wait a long time for staff to answer her call light. 4f. An interview was conducted with Resident 40 on 2/13/25 at 1:59 p.m. She indicated the staff do not answer the call lights. "The staff take forever." An environmental tour was conducted with the Maintenance Supervisor on 2/14/25 at 1:19 p.m. The Maintenance Supervisor indicated there was nothing wrong with the call light system. The facility has four phones that are connected to the call light system. The resident pushes the box, and it will alert the staff, via the phones, which resident and room number that was needing			

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	assistance. He runs a call light response report daily. If the call light response time was lengthy, he highlights and reports to the Executive Director and the Director of Nursing (DON). During the tour, Resident 14 indicated the staff take a long time to answer the call lights. Resident 17 indicated some of the staff are not quick to respond to the call lights. Call light response reports, dated 2/8/25, 2/9/25, 2/12/25 and 2/13/25, indicated the following dates and the length of time it took the staff to respond to the call lights: 2/9/25 at 8:54 p.m., resident pushed call light - staff response time 10:21 p.m. (87 minutes), 2/12/25 at 7:59 a.m., resident pushed call light - staff response time 8:46 a.m. (47 minutes), 2/12/25 at 1:13 p.m., resident pushed call light - staff response time 2:01 p.m. (48 minutes), 2/12/25 at 9:45 p.m., resident pushed call light - staff response time 10:47 p.m. (62 minutes), and 2/13/25 at 12:07 p.m., resident pushed call light - staff response time 12:41 p.m. (34 minutes). During an interview with the DON and the Executive Director on 2/14/25 at 3:00 p.m., the DON indicated she has been addressing the lengthy call light responses with the staff. This citation relates to Complaints IN00451356 and IN00452887.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to dispose of refrigerated foods timely with the potential to affect 90 of 90	R 0273	**R273** **1 What Corrective action(s) will be accomplished for those**	04/01/2025

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	residents residing at the facility. Findings include: On 2/12/25 at 10:10 a.m., the facility walk- in refrigerator was observed with the Dietary Manager (DM). The walk-in refrigerator contained two plastic containers of blueberry yogurt dated 12/23/24. The containers indicated the best by date for the yogurt was 1/30/25. A package of cheddar cheese cubes had a date of 10/1 written on the package. The best by date on the package of cheddar cheese cubes was 2/8/25. During an interview on 2/12/25 at 10:10 a.m., the DM indicated the yogurt, and the cheddar cheese cubes should have been thrown away. 410 IAC 7-24-191 Ready-to-eat, potentially hazardous food; date marking...(b) Except as specified in (d) and (e) of this section, refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a retail food establishment and if the food is held for more than twenty-four (24) hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in subsection (a) and: (1) the day the original container is opened in the retail food establishment shall be counted as day one (1); and (2) the day or date marked by the retail food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.		**residents found to have been affected by the deficient practice** a All residents have the potential to be affected by 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 Dietary Manager and/or designee will ensure all refrigerated food are disposed of in a timely manner. Any dietary employee not following proper food storage protocols will receive additional education and 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 Dietary staff will be in-serviced on food storage protocols to ensure refrigerated foods are stored properly. **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:**	

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			a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. a Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5. By what date the systemic changes will be completed:** April 1, 2025	
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to timely address pharmacy reviews for 3 of 5 residents reviewed for pharmacy reviews (Resident C, Resident 1, and Resident 81). Findings include: 1. The clinical record for Resident C was reviewed on 2/12/25 at 10:46 a.m. The diagnoses included, but were not limited to, congestive heart failure and kidney disease. A service plan, last updated 10/24/24, indicated Resident C needed assistance with ordering and setting up medications. She needed a licensed nurse to follow up with prescribers, as needed, for	R 0299	**R299** **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 action will be taken:** a All residents that receive pharmacy reviews had the	04/01/2025

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	medication management. The goal was for her to achieve the highest level of medication assistance while maintaining independence. The interventions included, but were not limited to, community pharmacy would set up medications as ordered by the physician. On 2/13/25 at 11:21 a.m., the Director of Nursing (DON) provided the Pharmacy Consultation Report, dated 10/10/24, which indicated Resident C was taking pantoprazole (medication to treat stomach) 40 milligrams (mg) twice daily. The order had been active since April 1, 2024. The recommendation was to decrease the pantoprazole 40 mg to one tablet by mouth daily. The clinical record did not contain documentation that the physician had addressed the 10/10/24 pharmacy recommendation. The February 2025 Medication Administration Record (MAR) indicated Resident C had received pantoprazole 40 mg twice daily. 2. The clinical record for Resident 1 was reviewed on 2/12/25 at 2:46 p.m. The diagnoses included, but were not limited to, hypertension and diabetes. A service plan, last updated 10/17/24, indicated Resident 1 needed assistance with ordering and setting up medications. The goal was for him to achieve the highest level of medication assistance while maintaining independence. The interventions included, but were not limited to, community pharmacy would set up medications as ordered by the physician. On 2/13/25 at 11:21 a.m., the DON provided the Pharmacy Consultation Report, dated 10/10/24,		potential to be affected by the alleged deficient practice. DON and/or designee will audit all residents who receive pharmacy recommendations to ensure timely response and/or updates from the physician. **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 DON and/or designee will audit all pharmacy reviews, as they occur, to ensure timely response and/or updated from the physician. The Director of Nursing and/or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols 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 Pharmacy recommendations will be reviewed by DON/designee as they are received as part of the QA process. b Results will be reviewed as part of the QA process in order to	

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	which indicated Resident 1 had a prescription for hydrocodone (narcotic pain medication) that had not been provided to the facility due to the pharmacy not having a valid prescription from the provider. The recommendation was to discontinue the hydrocodone from the orders or obtain a valid prescription to place on file. The clinical record did not contain documentation that the physician had addressed the 10/10/24 pharmacy recommendation. The February 2025 MAR indicated Resident 1 had a physician's order for hydrocodone/ acetaminophen 5/325 mg take one tablet every four hours as needed for pain with a notation of "Need RX [prescription]." 3. The clinical record for Resident 81 was reviewed on 2/13/25 at 9:30 a.m. The diagnoses included, but were not limited to, urinary incontinence and type II diabetes. On 2/13/25 at 11:21 a.m., the DON provided a pharmacy consultation report, dated 10/10/24, for Resident 81. It indicated " ...Patient has 2 prescriptions for urinary incontinence that may represent a duplication of therapy. Trospium 20 mg take 1 tablet by mouth twice daily, Mirabegron ER 50 mg take 1 tablet by mouth daily ... Recommendation: Assess patient's needs and verify if able to eliminate one of these drugs." No physician response was indicated in the report or documented in the resident's chart. On 2/14/25 at 9:05 a.m., the Executive Director (ED) provided a list of active medications for Resident 81. It included active orders for " ...Mirabegron ER 50 MG-I Tab Take 1 tablet by mouth once daily ... Trospium 20 MG Tab-I Take 1 tablet by mouth twice daily".		identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed:** April 1, 2025	

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	An interview was conducted with the DON on 2/14/25 at 12:25 p.m. She indicated she did not know if there was any documentation of physician notification of the pharmacy recommendations. On 2/13/25 at 1:54 p.m., the DON provided the Pharmacy Services policy, last reviewed September 2021, which indicated, "...The Director of Nursing, or designee, will ensure that the medication review, recommendations and notifications of the physician, if necessary, is documented in accordance to policy..."			
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance Based on interview and record review, the facility failed to record the disposition of medications upon the death of a resident for 1 of 1 resident reviewed for death (Resident 24). Findings include: The clinical record for Resident 24 was reviewed on 2/14/25 at 12:20 p.m. The diagnoses included, but were not limited to, hypertension. The resident passed away at the facility on 11/24/24. A progress note, dated 11/24/24 at 12:45 p.m., indicated that Resident 24 was found unresponsive and cardiopulmonary resuscitation was initiated. Emergency services were called and pronounced Resident 24 as deceased. The coroner's office had transported the body at 12:27 p.m. The clinical record did not contain information about the disposition of Resident 24's	R 0357	**R357** **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 No residents had the potential to be affected by the alleged deficient practice. Nursing staff will be educated on proper procedures in the event of a resident death. Including, but not limited to properly destroying medications. DON or designee will do a discharge audit of all	04/01/2025

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	medications. During an interview on 2/14/25 at 1:20 p.m., the Director of Nursing (DON) indicated only the disposition of narcotic medications was recorded. Resident 24's medications had been thrown away by the staff. On 2/13/25 at 1:54 p.m., the DON provided the Pharmacy Services policy, last revised September 2021, which indicated, "...Medications administered by the community 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 include the following information: The name of the resident The name and strength of the drug The prescription number The reason for disposal The amount disposed of The method of disposition The dated of the disposition The signature of the person conducting the disposal of the drug The signature of a witness, if any, to the disposal of the drug..."		residents who have expired to ensure all proper procedures have been followed. **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 death discharges will be conducted by the DON or designee to ensure all medications are properly destroyed. 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 and/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 death discharge as it occurs for two (2) months, then every other month for twelve (12) months, and then as needed to ensure that all	

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			proper information is being properly reflected on the face sheet and transfer form. Results to be reviewed at monthly QI meetings and make further recommendations based on 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 April 1, 2025.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on observation, interview, and record review, the facility failed to ensure infection control was maintained while administering	R 0407	**R407** **1 What Corrective action(s) will be accomplished for those**	04/01/2025

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	medications with glove use, water pitchers with floating particles, and disinfection of glucometers for 6 of 6 residents observed during medication administrations. (Residents' 12, 78, 81, 82, 89, and 105) Findings include: 1. The clinical record for Resident 82 was reviewed on 2/12/25 at 12:30 p.m. The diagnoses included, but were not limited to, alcoholic hepatitis. 2. The clinical record for Resident 89 was reviewed on 2/12/25 at 12:35 p.m. The diagnoses included, but were not limited to, cirrhosis. 3. The clinical record for Resident 12 was reviewed on 2/12/25 at 12:40 p.m. The diagnoses included, but were not limited to, seizures. 4. The clinical record for Resident 105 was reviewed on 2/12/25 at 12:45 p.m. The diagnoses included, but were not limited to, vascular dementia. An observation was conducted of medication administrations with Qualified Medication Aide (QMA) 2 on 2/12/25 at 12:38 p.m. QMA 2 was observed administering medications to Residents' 82, 89, 12, and 105. During the administrations, QMA 2 was pouring water for those residents from a water pitcher on the medication cart. The water pitcher was observed with brown particles floating in the water. At 12:54 p.m., an interview was conducted with QMA 2. QMA 2 indicated she had not seen the particles floating in the water until now. She cleans the water pitcher at the end of her shift. After, she fills the water pitcher with ice and water for the next shift. The residents have reported to her that the "water here is nasty!" She		**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 staff adorning gloves before providing care, using water from pitcher on med cart, and the proper cleaning of glucometers 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 appropriate hand hygiene. Employees found to be out of compliance with hand hygiene 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 All clinical staff will be re-educated and in-serviced on proper use of adorning gloves during care, water in the pitcher on the med cart and proper cleaning of glucometers. Any clinical staff member out of compliance with facility's policies and protocols relating to hand hygiene will	

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		A. BUILDING 00 B. WING	02/14/2025

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	doesn't drink it. 5. The clinical record for Resident 81 was reviewed on 2/12/25 at 2:00 p.m. The diagnoses included, but were not limited to, type II diabetes mellitus. An observation of a medication administration for Resident 81 was made with QMA 1 on 2/13/25 at 8:43 a.m. QMA 1 was observed preparing to obtain Resident 81's blood sugar reading utilizing a glucometer at the medication cart in the hallway. She gathered all supplies, utilized hand sanitizer, and donned on a pair of gloves. A glucometer was pulled out of a container that contained a total of three glucometers. At the medication cart, QMA 1 was observed touching her keys with gloved hands, the glucometers, the medication cart lock, the resident's doorknob, the computer tablet, and the resident's bed. After, with the same gloved hands, she obtained the resident's blood sugar reading with the glucometer. She then returned to the medication cart and placed the glucometer back into the container. QMA 1 returned into the resident's room and administered insulin to the resident. There was no observation of disinfection of the glucometer observed before or after obtaining the resident's blood sugar reading. QMA 1 did not utilize hand hygiene for doffing and donning a new set of gloves prior to obtaining the resident's blood sugar reading. An interview was conducted with QMA 1 on 2/13/25 at 11:10 a.m. She indicated she used alcohol wipes or the germicidal bleach wipes to disinfect the glucometers. 6. The clinical record for Resident 78 was reviewed on 2/12/25 at 2:30 p.m. The diagnoses included, but were not limited to, type II diabetes mellitus.		receive progressive corrective action. The Director of Nursing and/or designee will educate all newly hired clinical staff on policies and protocols relating to hand hygiene 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 This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved **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 April 1, 2025.	

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	An observation was made of a medication administration for Resident 78 with QMA 1 on 2/13/25 at 11:05 a.m. QMA 1 was observed preparing to obtain the resident's blood sugar reading. QMA 1 utilized hand sanitizer then donned on gloves at the medication cart. She picked up an electrical device from the cart then went into Resident 78's apartment with gloved hands to obtain the resident's blood sugar reading. QMA 1 was observed touching her keys, the computer tablet, and the resident's door and doorknob with her gloved hands. She then obtained the resident's blood sugar utilizing an electrical device to read the resident's continuous blood glucose sensor. She then returned to the medication cart. QMA 1 pulled out an insulin flex pen from the medication cart and returned to the room. After, she administered the insulin in the resident's abdomen. There was no observation of hand hygiene for donning or doffing a new set of gloves after touching the medication cart, resident's door, and doorknob. An interview was conducted with the Director of Nursing (DON) and Executive Director (ED) on 2/13/25 at 3:28 p.m. She indicated QMA 1 should not have donned on gloves outside of residents' room without hand hygiene and doffed and donned a new set prior to touching the residents. The ED indicated that germicidal wipes are to be used to disinfect the glucometers. The city water was not good. The brown particles in the water pitcher could be coming from the water.			