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	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOM AT EAGLE CREEK	5045 W 52ND ST INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 25 and 26, 2023. Facility number: 003915 Residential Census: These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 9, 2023.	R 0000	Submission of this response and Plan of Correction is not a legal admission that the deficiency exists or, that the statement of deficiencies was correctly cited, and is not to be construed as an admission against any interest by the residence, or any employees, agents, or other individuals who drafted or who may be discussed in the response or Plan of correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0268 Bldg. 00	410 IAC 16.2-5-5.1(a) Food and Nutritional Services - Deficiency (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. Based on observation and interviews, the facility failed to provide a meal to resident who was receiving hospices services for 1 of 1 resident reviewed for nutrition (Resident 40). Findings include: During an observation on 4/25/23 at 12:50 p.m., Resident 40 was observed lying in bed. She had a	R 0268	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 1. For resident 40 (41) physician changed diet order to soft food and ensure. How will the facility identify other residents having the potential to be affected by the same practice	05/19/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Helga Bradley	Executive Director	05/19/2023

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	low air loss mattress with bolsters to keep her from rolling off the bed. Resident 40 had a sealed bottle of ensure (nutritional supplement) next to her bed. Resident 40 was alert and indicated she was thirsty. LPN 6 opened the bottle of ensure, placed a straw into the bottle and Resident 40 consumed 70% of the strawberry ensure. A staff member brought Resident 40's family member a lunch meal into the apartment but did not bring one for Resident 40. At this time LPN 6 indicated Resident 40 was hospice and did not receive a meal because she was pocketing her food and not swallowing the food. On 4/25/23 at 2:00 p.m., a Resident 40's review was reviewed. She had the following diagnoses, but not limited to spinal stenosis, lumbar radiculopathy, Parkinson's disease, degenerative disk disease, back pain, GERD (gastro-esophageal disease), dizziness, hyperlipidemia, hypertension, hypothyroidism, depression, and anxiety. On 4/26/24 at 12:04 p.m., the ED (Executive Director) provided a copy of Resident 40's diet order. The order was dated 4/24/23 and indicated to change Resident 40's diet to ensure by mouth three times daily per family request. On 4/26/23 at 12:42 p.m., the Wellness Director provided a copy of Resident 40's physician orders. The orders lacked a review date. The print date was 4/26/23. The diet order read to offer a regular diet, thin liquids, and family to provide ensure as a supplement. On 4/26/23 at 12:42 p.m., the Wellness Director provided a copy Resident 40's physician plan of care dated, 6/17/22, it indicated Resident 40 was to have a regular diet.		and what corrective action will be taken? 2. All residents have the potential to be affected by the same practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. 3. All staff will be inserviced on Dietary compliance and meal substitutions. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? 4. Dietary manager will monitor resident roster to ensure all residents receive nutritional balanced meals. By what date the systemic changes will be completed? 5. Systemic changes will be completed by May 19th, 2023..	

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	On 4/26/23 at 11:48 a.m., an interview was conducted with the ED and Wellness Director. The Wellness Director indicated Resident 40 should be getting a tray and staff should be assisting her with eating. The lunch tray offered yesterday was chicken tenders. Resident 40 could not eat that food. A policy titled, "Personal Service Plan," was provided by the ED on 4/26/23 at 12:37 p.m., it indicated, "...The personal service plan should include specific and individualized needs of the resident, specific and individualized approaches for the care of the resident based on their needs...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure raw meats were not stored over prepared foods and food was sealed and dated for 1 of 1 observation of the kitchen; and failed to ensure a beard guard was worn while serving lunch for 1 of 1 observation of the dining. These concerns had the potential to effect 55 of 55 residents served from the kitchen. Findings include: 1. During a kitchen tour, on 4/25/23 at 10:10 a.m., inside a 3-door refrigerator, a box of raw sausage links was observed on a middle shelf. Below the raw sausage links was a large plastic container of pears that was overwrapped with cellophane. The Dietary Manager (DM) indicated the raw meat	R 0273	What corrective actions will be accomplished for those residents found to have been affected by the defficient practice? 1. The Dietary Manager immediately moved the raw meat to the bottom shelf and dated and label all open food items how will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 2. All residents have the potential to be affected by the same practice. What measures will be put into	05/19/2023

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	should have been on the bottom shelf and not over the container of pears. A plastic bag of shredded cheese was observed without an open date. A plastic container of shredded cheese was observed with a broken lid. The shredded cheese was open to the air where the lid was broken on the corner and the piece was missing. Inside a 3-door freezer, a 10 pound cylinder of raw ground beef was on a middle shelf. Below the raw ground beef cylinder was a box of pizzas. The DM indicated the raw ground beef should have been on the bottom shelf and not over the box of pizzas. On 4/25/23 at 10:45 a.m., the Executive Director (ED) indicated the raw meat should not be over other foods. She indicated Dietary Aide 9 put the raw meat in the refrigerator and freezer and just "didn't think about it." A current policy, titled, "Infection Control - Food Storage," dated September, 2011, was provided by the ED, on 4/25/23 at 10:41 a.m. A review of the policy indicated, " ...It is the policy of the Dining Services Department that food storage occurs in a strictly defined manner ...Cooked foods are stored above raw meats, poultry, or fish ...In the refrigerators, cooked food is stored on shelves above raw food to prevent cross-contamination from dripping ...." A current policy, titled, "Infection Control - Food Preparation & Service," dated September, 2011, was provided by the ED, on 4/25/23 at 10:52 a.m. A review of the policy indicated, " ...prepare and serve all foods ...to prevent the transmission of		place or what systemic changes the facility will make to ensure that the deficient practice does not recure? 3. All food has been stored in the proper area and labeled with open and discard dates. Beard gaurds are being worn in kitchen. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? 4. Kitchen staff will be educated on the proper way to store raw meats and food labeling and proper facial coverings (beard guards) By what date the systemic changes will be completed? 5. Systemic changes will be completed by May	

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	disease-carrying organisms ...." 2. During a lunch service, on 4/25/23 at 11:59 a.m., DA 9 was observed in the kitchen with only a surgical mask covering his face. The surgical mask was below his mustache and the side of his beard were exposed. He was preparing plates of food for the residents. On 4/25/23 at 12:16 p.m., DA 9 indicated he should have been wearing a beard guard and immediately pulled one from the box in front of him to put it on. On 4/25/23 at 12:19 p.m., the DM indicated DA 9 should have been wearing a beard guard when putting food on plates for the residents. On 4/25/23 at 12:22 p.m., the ED indicated DA 9 should have been wearing a beard guard when doing lunch service. A current policy, titled, "Food Preparation," dated September, 2011, was provided by the ED, on 4/25/23 at 12:48 p.m. A review of the policy indicated, " ...Food Handling ...Hats/caps/hairnets for protective hair covering ...."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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. Based on observation and interviews, the facility failed to label an open bottle of Tubersol when it was opened for 1 of 1 medication refrigerator observed.	R 0300	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	05/19/2023

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	Findings include: On 4/25/23 at 10:15 a.m., during an observation of the Wellness Center's refrigerator where medications are stored, a bottle of Tubersol was inside the door of the refrigerator. The bottle had a fill date of 1/23/23. The bottle was opened, and some fluid was missing from the bottle. The bottle was not dated when opened. The Wellness Coordinator indicated the bottle should have been dated when it was opened and indicated she would destroy it. A policy, tited, "Storing General Medications," was provided by the ED (Executive Director) on 4/25/23 at 12:42 p.m., it indicated, " ...Storage of multi-dose packaging. If a multi-dose packaging system is used, special storage containers should be supplied by the pharmacy. The containers should bed sized to efficiently store the multi-dose packages ....".		1. The Tubersol was removed from the refrigerator and destroyed by the Wellness Director as it was not labeled correctly. All nursing staff members has been re-educated to ensure no medication is stored in an unmarked container without proper labeling as indicated in the facility policy and procedure. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 2. All residents have the potential to be affected by the same practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? 3. Wellness Director or designee will conduct an audit to monitor and ensure that all facility nursing staff are compliant with the storing of medication with appropriate date and labeling. These audits will occur weekly for one month, biweekly for one month and then monthly thereafter. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? 4. Collected data from the audit process will be reviewed monthly and reported to the Executive Director for further	

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			recommendations. The Wellness Director or designee is responsible for assuring data presentation. By what date the systemic changes will be completed? 5. Systemic changes will be completed by May 19th, 2023	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to secure a medication/treatment cart on the second floor of the facility for 1 of 1 random observation. Findings include: During an observation on 4/25/23 at 10:46 a.m., a medication/treatment cart was unlocked. It was stationed outside the Wellness Office. Inside the cart were medications belonging to Resident 58 and 59. Resident 58 had a bottle of liquid Tylenol in the cart. Resident 59 had a box of ear drops that were opened and undated. There was a bottle of centrum silver that had a handwritten label but was illegible. In the cart were needles for insulin, test strips for, and a blood sugar monitoring, and a variety of dressing supplies. At that time, the Wellness Coordinator indicated the cart should be locked. She indicated some residents residing at the facility have dementia. The Wellness Coordinator locked the medication	R 0304	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 1. The Wellness Director secured the medication/treatment cart immediately. All residential nursing staff members have been re-educated on the policy and procedures for locking medication/ treatment carts when in their absence. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 2. all residents have the potential to be affected by the same practice. What measures will be put into place or what systemic changes	05/19/2023

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	cart. A policy titled; "Storing General Medications" was provided by the ED (Executive Director) on 4/25/23 at 12:42 p.m. It indicated, " ...Medication Carts. Medication carts may be used as storage containers and as a means of delivering medication throughout the community if used discreetly. Unsecure medication carts should not be left unattended ...".		the facility will make to ensure that the deficient practice does not recur? 3. Wellness Director or designee will conduct an audit to monitor and ensure that all medication/ treatment carts are kept locked and in the absence of facility personnel as per policy and procedure. The audits will occur daily for 30 day and then weekly thereafter. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 4. Wellness Director or the designee will collect the data from the audit process will be reviewed monthly and reported to the Executive Director for further recommendations. The Wellness Director or the designee is responsible for assuring data presentation. By what date the systemic change will be completed? 5. Systemic changes will be completed by May 19th, 2023.	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information:			

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	(1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interviews, the facility failed to dispose of a resident's medications in compliance with laws for 1 of 1 resident (Resident 64). Findings include: On 4/26/23 at 10:36 a.m., Resident 64's record was reviewed. She had the following diagnoses, but not limited to early onset Alzheimer's dementia without behavioral disturbance, episode of recurrent major depressive disorder, hypertension, and type 2 DM (diabetes mellitus). Resident 64's medications orders included: a.) amlodipine tablet 5 milligrams (mg) daily b.) atenolol tablet 25 mg daily c.) desvenlafaxine tablet 50 mg daily d.) duloxetine capsule 30 mg daily e.) gabapentin capsule 300 mg two times daily f.) hydrochlorothiazide 12.5 mg daily g.) levothyroxine tablet 100 mcg daily h.) losartan tablet daily i.) metformin tablet 500 mg daily j.) prednisolone suspension 1% 1 drop in both eyes daily k.) quetiapine tablet 25 mg at bedtime	R 0306	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? 1. All facility nursing staff will be re-educated on Policy and Procedure of Medication Disposition of Controlled, Discontinued and Deceased Residents. 2. All residents have the potential to be affected by the same practice. 3. All discharged and deceased residents' clinical records will be audited by Wellness Director or designee. 4. Wellness Director or designee will	05/19/2023

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	A progress note dated 2/13/23 at 12:00 p.m., indicated Resident 64 was discharged with 2 days of medications. Resident 64's record lacked documentation of disposition of her medications. During an interview with the Wellness Coordinator on 4/26/23 at 12:37 p.m., she indicated they did not dispose of Resident 64's medications according to their policy. She indicated she did not know she was supposed to account for resident's medications. A policy titled, "Medication Disposition of Controlled, Discontinued, and Deceased Residents," indicated, " ...All remaining items shall bed destroyed by 2 licenses nurses and documented on the medication disposal, return to pharmacy or resident/legally responsible party form. ...".		Collect the data from the audit process and will be reviewed monthly and reported to the Executive Director for further recommendations. The Wellness Director or designee is responsible for assuring data presentation. By what date the systemic changes will be completed? 5. Systemic changes will be completed by May 19th, 2023.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to document code status/advanced directives on physician order sheet for 4 of 5 residents reviewed for advanced directive orders (Resident 11, 23, 29, and 40).	R 0349	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 1.Wellness Director or designee will ensure code status/advance directives will	05/19/2023

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	Findings include: 1. On 4/25/23 at 3:45 p.m., a comprehensive chart review was completed for Resident 11. She had the following diagnoses, but not limited to schizophrenia, diabetes mellitus (DM), hyperlipidemia, tardive dyskinesia, tremors, obstructive sleep apnea (OSA), hypertension, and vitamin D deficiency. Resident 11's record lacked an order for advanced directives. On 4/26/23 at 9:27 a.m., the Executive Director (ED) provided a copy of the physician's order. The section for code status was blank. The date on the physician's order was 4/26/23. 2. On 4/25/25 at 2:00 p.m., a comprehensive record review was completed for Resident 23. She had the following diagnoses, but not limited to hypertension, Alzheimer's dementia, psychosis, coronary artery disease (CAD), constipation, vitamin D deficiency, and pain. Resident 23's record lacked and order for advanced directives. On 4/26/23 at 9:27 a.m., the ED provided a copy of the physician's order. The section for code status was blank. The date on the physician's order was 4/26/23. 3. On 4/26/23 at 4:15 p.m., a comprehensive chart review was completed for Resident 29. She had the following diagnoses, but not limited to hypertension, chronic obstructive pulmonary disease (COPD), smoker, and constipation. Resident's record lacked an order for advanced directives. On 4/26/23 at 9:27 a.m., the ED (Executive Director) provided a copy of the physician's order. The section for code status was blank. The date on the		be inputted on all residents' profiles upon admission and or change of code status of advance directives. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 2. All residents have the potential to be affected by the same practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? 3. The Wellness Director or designee will reeducate on physician's order sheet to ensure Code status/advance directives are in place and readily available. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? 4. The Wellness Director or designee will audit for signed code status/advances directives from physicians quarterly for six months By what date will the systemic changes be completed? 5. Systemic changes will be completed by May 19th, 2023.	

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	physician's order was 4/26/23. 4. On 4/25/23 at 2:00 p.m., a comprehensive chart review was completed for Resident 40. She had the following diagnoses, but not limited to spinal stenosis, lumbar radiculopathy, Parkinson's disease, degenerative disk disease, back pain, GERD (gastro-esophageal disease), dizziness, hyperlipidemia, hypertension, hypothyroidism, depression, and anxiety. Resident's record lacked an order for advanced directives. During an interview with the Wellness Coordinator and ED on 4/25/23 at 4:25 p.m., they indicated they were unsure of how often physician orders are updated. The Wellness Coordinator indicated when they were on their old system it did capture the advanced directives. The ED indicated she spoke to a peer, and he told her that his building updates physician orders on a quarterly basis. A policy titled "Physician Order Summary," dated September 2011, was provided by the ED on 4/25/23 at 3:48 p.m., it indicated, " ...Physician orders must be written for code status/advance directives, must include appropriate supporting documentation ...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents,			

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		A. BUILDING 00 B. WING	04/26/2023

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	including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on review and interviews, the facility failed to implement an infection control program that provided surveillance for the collection of data to analyze infections, track, and monitor for infections for the resident of the facility for 55 of 55 residents residing at the facility. Findings include: During an interview with the ED (Executive Director) and Wellness Coordinator on 4/26/23 12:38 regarding infection control, the Wellness Coordinator indicated they monitored for adverse effects of antibiotics the residents were ordered. The Wellness Coordinator indicated she did not have a binder with monthly comparisons. The Wellness Coordinator indicated she would reach out to other Wellness Coordinators to see how their infection control programs. She indicated she was not familiar with infection control monitoring. The Wellness Coordinator indicated she met with her nurses, and she depends on the nurses to tell her when a resident receives an order for an antibiotic. During an interview with the ED on 4/26/23 at 12:53 p.m., she indicated QA (Quality Assurance) reader might be able to monitor infection control. She indicated they did not provide surveillance or analyze infections. The ED indicated they did not have a policy for the infection control program.	R 0407	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 1. The facility must establish an infection control program, that provides surveillance for the collection of data to analyze infections track and monitor for infections for 55 out of 55 residents that reside in the facility. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 2. All residents have the potential to be affected by the same practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? 3. The Wellness Director or designe will implement a infection control binder to include tracking and monitoring of infectious. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? 4. The Wellness Director or designe will go over weekly with	05/19/2023

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			findings and results with Executive Director 5. Systemic changes will be completed by May 19th, 2023.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on interview and observation, the facility failed to ensure that a staff member washed hands during medication administration for 3 of 5 residents observed for medication administration (Residents 35, 52, and 46). Findings include: During a medication pass on 4/25/23 at 12:15 p.m., LPN 6 used hand sanitizer to clean her hands. LPN 6 pulled a black bag out of the medication cart. Inside was a glucometer. She donned a pair of black gloves took the machine into Resident 35's apartment. There she swiped it across a patch (frees style libre) on resident's left arm. LPN 6 went back to the medication cart, with the same gloves on, retrieved Resident 35's insulin, prepared it, went back into the apartment, and administered Resident 35's insulin. She came out of the room, took the insulin pen apart, and took off the gloves. She used hand sanitizer to clean her hands. On 4/25/23 at 12:35 p.m., LPN 6 went to administer medications to Resident 52. LPN 6 donned a pair of black gloves. She indicated she was nervous. Her hands were sweating, making it difficult to apply the gloves. She took a blood pressure cuff from the top of the cart and entered Resident 52's	R 0414	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 1. The Wellness Director or designee will provide Hand Hygiene training at new employee orientation, staff meetings and huddles. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 2. All residents have the potential to be affected by the same practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? 3. The Wellness Director or designee will perform hand hygiene audits on nursing staff at random times. Daily for 30 days, weekly thereafter. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? 4.The data collected from the audit process will be reviewed	05/19/2023

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	apartment. She applied the cuff to the resident's wrist to obtain a blood pressure. After obtaining his blood pressure, she went to the medication cart to retrieve equipment to perform his blood sugar. She did not perform hand hygiene. She placed hand sanitizer to her gloves and rubbed it into the gloves. She entered the apartment and obtained his blood sugar per fingerstick. Afterwards, she went back to the cart and retrieved his ordered medications of hydrochlorothiazide (HCTZ) and acetaminophen. She returned to the Resident 52 and handed him a cup of pills. He took the medication. She left his apartment to retrieve his insulin. She left the apartment and did not change her gloves. After prepping his insulin, she returned to Resident 52 and administered the insulin. When she left the apartment, she took the gloves off and applied hand sanitizer to her hands. On 4/25/23 at 12:43 p.m., LPN 6 went to administer medications to Resident 46. LPN 6 donned a pair of black gloves. She retrieved the blood pressure cuff from the top of the medication cart. She took Resident 46's blood pressure and left the apartment to return to the medication cart. She obtained supplies to perform her fingerstick for her blood sugar and went back into the apartment. She did not change her gloves. While in the apartment, LPN 6's phone rang that was in her pocket. She indicated it was work calling her and answered it. She did not perform hand hygiene. She obtained the blood sugar and returned to the cart. She did not perform hand hygiene. She went back to the medication cart to retrieve Resident 46's medication. She prepped irbesartan, furosemide, multivitamin, aspirin, and memantine. She went back to the apartment, handed Resident 46 her medication cups with pills inside. Resident 46 took her medications. LPN 6 left the apartment,		monthly and reported to the Executive Director for further recommendations. The wellness director or designee is responsible for assuring data presentation. By what date will the systemic changes be completed? 5. Systemic changes will be completed by May 19th, 2023	

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	went back to the medication cart to obtain Resident 46's insulin. She did not perform hand hygiene and went back to the apartment and administered the insulin. When finished, she went to the medication cart, removed her gloves, and used hand sanitizer to clean her hands. A policy titled; "Handwashing" was provided by the ED (Executive Director) on 4/25/23 at 3:04 p.m. It indicated, " ...Hand washing is regarded as the single most important means of preventing the spread on infections. All associates should wash their hands to prevent the spread of infection and disease to other residents, other associates, and visitors. Suggested guidelines: appropriate fifteen to twenty second hand washing should be performed in situations including but not limited to: before preparing or handling medications ...."			