STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155291	A. BUILDING 00 B. WING	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 2, 3, 4, 5 and 6, 2024 Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 4 Medicaid: 43 Other: 28 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 19, 2024.	F 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure a resident had a bariatric bed with mobility bars and her call light was in reach for 1 of 5 resident reviewed for	F 0558	**F-558 Reasonable Accommodations Needs/Preferences** This plan of correction constitutes	07/05/2024

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

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	accommodation of needs (Resident 43). Findings include: On 6/2/24 at 11:23 a.m., Resident 43 was observed lying on her left side on the edge of her mattress. The upper portion of her mattress was outside of the bed frame. Her call light was observed on the floor. On 6/3/24 at 2:18 p.m., Resident 43's was in her room, in her wheelchair, and her call light was observed on the floor. On 6/4/24 at 10:04 a.m., Resident 43 was in her room, in her wheelchair, and her call light was observed on the floor. On 6/5/24 at 9:39 a.m., Resident 43 was observed sitting on the edge of her bed with her feet on the floor. Her mattress was observed to be askew, the top portion of the mattress was outside of the bed frame. She indicated she wanted mobility bars to be able to move easier in bed. On 6/5/24 at 10:27 a.m., Resident 43's record was reviewed. On 5/1/23 her weight was recorded as 382 pounds. Her diagnoses included, but were not limited to, obesity, sleep apnea (breathing difficulty during sleep), congestive heart disease (heart disease), chronic obstruction pulmonary disease (COPD), acute respiratory failure with hypoxia (not enough oxygen in the blood), diabetes mellitus (blood sugar disorder), and schizophrenia (mental illness involving difficulty with thought, emotion, and behavior).		this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * Resident 43 has call light within reach and mobility bars have been placed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents have the potential to be affected by the alleged deficient practice. * Observational rounds will be completed by Care Companions/Designee daily to ensure that call lights are in reach and accommodation of needs are being met for all residents. * An inservice will be completed by DNS/Designee for nursing staff to include ensuring call lights are in reach and accommodation of needs are met for residents by 7/5/24.	

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	A care plan, dated 8/14/23, indicated Resident 43 required assistance with activities of daily living (ADL) including bed mobility, transfers, eating and toileting related to impaired mobility, congestive obstructive pulmonary disease (COPD), shortness of breath while lying flat, respiratory failure, and congestive heart failure. The goal was to support resident because she had a desire to improve her current functional status. A nursing approach was to assist with bed mobility as needed. A fall care plan, dated 8/3/24, indicated Resident 43 was at risk for falls. The goal was to reduce fall risk factors. A nursing approach indicated to keep the call light in reach. A call light care plan goal, dated 8/3/24, indicated Resident 43 would use the call light for assistance appropriately. A nursing approach indicated she would be educated on the importance of using the call light for assistance and be able to express herself as necessary. On 6/5/24 at 10:17 a.m., the Director of Nursing Services (DNS) indicated she did not know if Resident 43 had a bariatric bed (a wider, reinforced bed with a thicker, sturdier mattress for resident's over 350 pounds), and she would look into bed rails (aid in improving mobility). On 6/5/24 at 11:54 a.m., the DNS indicated the facility changed Resident 43's standard bed for a bariatric bed and provided her with bed rails for her mobility in bed. On 6/4/24 at 3:28 p.m., the Executive Director (ED) indicated the facility did not have a policy for call lights, but indicated the call light device should have been in reach of the resident to use.		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** * Inservice nursing staff to include ensuring call lights are in reach and accommodation of needs are met for residents completed 06/19/24. * Observational rounds will be completed by Care Companions/Designee daily to ensure that call lights are in reach and accommodation of needs are being met for all residents. **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:** * The DNS/Designee will be responsible for the completion of the Call Lights and Accommodation of Needs QAPI tools for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.	

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	On 6/6/24 at 12:03 p.m., a policy for resident's accommodation of needs and appropriate mattress use was requested. The DNS indicated the facility did not those policies. 3.1-3(v)(1)		.	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)			

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	(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record reviews, the facility failed to provide a safe, clean, comfortable environment to ensure pest control interventions were effective for 5 of 5 months of recommendations reviewed. This deficiency had the potential to affect 75 of 75 residents residing in the facility. Findings include: 1. During a kitchen tour, on 6/2/24 at 10:47 a.m., several dozen flying insects were observed alighting from clean dishes when the clean dish shelf was slightly wiggled. On 6/2/24 at 10:48 a.m., Cook 16 indicated she had seen flying insects all around the kitchen. On 6/2/24 at 10:49 a.m., the Dietary Manager (DM) indicated she had seen the Maintenance Man (MM) using a vacuum device to remove the flying insects. On 6/2/24 at 10:57 a.m., the DM indicated the large tub under the 3 compartment sink was there because the sink leaked. The tub was observed with standing water.	F 0584	**F-584** **Safe/Clean/Comfortable/Homelike Environment** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * The 3-compartment sink in the kitchen has been repaired and the tub with water removed. * The ice machine in the kitchen has been placed out of service and is neither leaking water nor has a blanket under it.	07/05/2024

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	On 6/2/24 at 11:00 a.m., a wet blanket was observed around the bottom of the ice machine in the kitchen. The DM indicated the blanket was there because the ice machine leaked. On 6/2/24 at 11:02 a.m., small flying insects were observed flying in the kitchen. On 6/2/24 at 11:03 a.m., the DM indicated a local pest control company was in the facility about a month ago. The pest technician showed her how to clean the drains in the kitchen. She indicated she cleaned a lot of "junk" out of 3 drains in the kitchen using a toilet brush, but the flying insects came back. 2. On 6/2/24 at 11:47 a.m., Resident 7's room was observed. Her mattress, without a mattress cover, had a dark stain in the middle of the mattress. Over 50 flying insects were observed on the mattress, on top of the stain. Flying insects were observed flying in her room. On 6/2/24 at 1:43 p.m., Resident 7 was observed in her room with her back to her bed. The stain on Resident 7's mattress was observed to be cleaned but the flying insects were still observed to be on the mattress where it had been cleaned. On 6/3/24 at 1:59 p.m., the Housekeeping Supervisor provided documentation, dated 6/2/24, Resident 7's mattress had been discarded and replaced. Her room was deep cleaned to include drawers where she had old snacks and food, drawing bugs and used "placeware." Her curtains were changed. 3. On 6/2/24 at 11:59 a.m., Resident 65 indicated he had gnats in his room with a lot of gnats in the bathroom. Flying insects were observed in his		* Pest control company completed their treatment of flying insects on 7/5/24 for the kitchen and resident rooms to include the rooms of Resident #65, #12, #53, #124, #25, #13, #226, and #7. * Resident #7 mattress was discarded and replaced. The room has been deep cleaned. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents have the potential to be affected by the alleged deficient practice. * All kitchen areas and residential rooms were inspected to ensure they were clean and working to become pest free 7/5/24. * Daily cleaning of drains and sink area completed with use of the drain solution per instructions by culinary staff. * Daily cleaning will be completed of residential rooms by housekeeping staff/designee with housekeeping following the deep clean schedule for resident rooms. * An inservice will be completed by ED/Designee for staff to include appropriate cleaning of residential rooms, dining room/kitchen by 7/5/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	room at this time. 4. On 6/2/24 at 12:04 p.m., Resident 12 was observed in his bed. His room was observed with flying insects. The floor had food debris, possibly crushed potato chips. 5. On 6/2/24 at 1:21 p.m., Resident 53 indicated he had gnats in his room. Flying insects were observed in his room at this time. 6. On 6/3/24 at 10:31 a.m., Resident 124 was observed to swat away flying insects during an interview. He indicated that was another thing he had concerns about was all these "gnats." 7. On 6/3/24 at 1:51 p.m., Resident 25's record was reviewed. Her diagnoses included, but were not limited to, myxedema coma (severe hypothyroidism leading to decreased mental status, hypothermia and slowing of function in multiple organs), seizures (uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements), and dystonia (uncontrollable muscle contractions). On 6/3/24 at 2:23 p.m., flying insects were observed in Resident 25's room. She was in bed with her eyes closed, she was unarousable with her mouth open. On 6/4/24 at 9:53 a.m., Resident 25 was observed in her room, in her bed with her eyes closed and her mouth open. She was unarousable with her mouth open. Two flying insects were observed on her blanket and one flying insect was observed on her pillow..		* Inservice management staff to include appropriate cleaning of residential rooms, dining room/kitchen and adherence to schedule completed 7/3/24. * Daily inspections/cleaning of all sinks and drain areas conducted by Dietary Manager/Designee. * Care Companions/Designee to complete observational rounds daily to ensure rooms are free of debris that would assist in promoting flying insects. * Pest control services for areas of concern have been reevaluated by servicer to ensure effective treatment plan in place **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:** *The Dietary Manager/Designee will be responsible for the completion of the Presence of Drain Flies/Presence of Breeding Ground for Drain Flies QAPI tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director, If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination	

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	8. On 6/4/24 at 10:12 a.m., Qualified Medication Aide (QMA) 9 was observed to provide medications for several residents. On 6/4/24 at 10:26 a.m., QMA 12 was observed to swat away a flying insect as she was preparing medications for Resident 13. On 6/4/24 at 10:32 a.m., QMA 12 was observed to swat away a flying insect as she was preparing medications for Resident 13. On 6/4/24 at 10:47 a.m., QMA 12 was observed entering Resident 53's restroom to wash her hands. A flying insect was observed in the room. 9. On 6/10/23 at 4:08 p.m., a Resident Grievance form, dated 6/2/24, was reviewed for Resident 226. It indicated the resident reported an insect was on her. She saved it in a napkin. The ED spoke with the resident and the insect was a winged ant. The resident's room was deep cleaned. 10. On 6/10/23 at 4:10 p.m., a Resident Grievance form, dated 4/23/24, was reviewed for a resident no longer residing in the building. The resident complained of "gnats." No follow-up for gnats was noted. 11. On 6/10/24 at 4: 15 p.m., the Resident Council Meeting Minutes were reviewed. a. On 4/2/24, the Resident Council indicated the "gnats" were getting better. b. On 6/4/24, a statement in the minutes, indicated, " ...chemicals received soon for more treatments for gnats ...." On 6/2/24 at 12:42 p.m., the pest control documentation from the local pest company used by the facility was provided by the Executive		of the responsible employee.	

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	Director (ED). The Pest Control Documents indicated, dated 1/11/24, indicated the targeted pests were mice and cockroaches. The structural and sanitation concerns that could cause pest problems found and provided to the facility were as follows with the pest company recommendations: a. Interior kitchen area had floor tiles or baseboards loose and or missing. Recommendation was made to repair floor tiles and baseboards to eliminate potential pest harborage and breeding sites. b. Front door an exit door did not close to seal properly with a ¼" gap or greater existing. Recommendation was made to install/replace door sweep. c. Rear door floor tiles or baseboards were loose or missing. Recommendation was made to repair the tiles and baseboards to eliminate potential pest harborage and breeding sites. d. Interior kitchen issues, the floor drains were in need of cleaning. All of the floor drains in the kitchen had a thick layer of biofilm built up inside them that needed scrubbed out and cleaned thoroughly. Recommendation was made to clean in and around drains frequently to help prevent pest breeding sites. e. In the kitchen, underneath the dish sink, a recommendation was made that the area needed cleaned thoroughly as there was some standing water and a lot of grease and grime built up on the baseboards. Recommendation was made to address the sanitation issues. The Pest Control Documents indicated, dated 2/28/24, indicated the targeted pests were mice, cockroaches, and large flies. The structural and sanitation concerns that could cause pest problems found and provided to the facility were			

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	as follows with the pest company recommendations: a. Interior kitchen area had floor tiles or baseboards loose and/or missing. Recommendation was made to repair to eliminate potential pest harborage and breeding sites. b. Rear door floor tiles or baseboards were loose or missing. Recommendation was made to repair the tiles and baseboards to eliminate potential pest harborage and breeding sites. c. Interior kitchen issues, the floor drains were in need of cleaning. Recommendation was made to clean in and around drains frequently to help prevent pest breeding sites. The Pest Control Documents indicated, dated 3/29/24, indicated the targeted pests were mice and cockroaches. The pest activity found was in the interior kitchen area, small flies were found during pest control service. "There were quite a few small flies noted." The structural and sanitation concerns that could cause pest problems found and provided to the facility were as follows with the pest company recommendations: a. Interior kitchen area had floor tiles or baseboards loose and or missing. Recommendation was made to repair the tiles and baseboards to eliminate potential pest harborage and breeding sites. b. Interior kitchen issues, the floor drains were in need of cleaning. Recommendation was made to clean in and around drains frequently to help prevent pest breeding sites. The Pest Control Documents indicated, dated 4/30/24, indicated the targeted pests were mice, cockroaches, and large flies. a. Interior kitchen area had floor tiles or baseboards loose and or missing.			

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	Recommendation was made to repair the tiles and baseboards to eliminate potential pest harborage and breeding sites. b. Interior kitchen issues, the floor drains were in need of cleaning. Recommendation was made to clean in and around drains frequently to help prevent pest breeding sites. c. Underneath the dish sinks, there was a lot of grease and dirt build up on the floor and on the walls. Recommendation was made to address these sanitation issues. d. Behind the cooler and the ice machine there was some grease and dirt build up. Recommendation was made to address this sanitation issue. The Pest Control Documents indicated, dated 4/30/24, indicated the local pest control technician indicated he had a conversation the Executive Director, " ...about the ongoing small fly issue, took a walk through of [sic] the kitchen and showed her all of the sanitation issues relating to the small flies, the floor drains being the main issues. I also pulled one of the covers off and showed the Executive Director and some of the kitchen staff the biofilm build up within a couple of the floor drains ...." The Pest Control Documents indicated, dated 5/3/24, indicated the targeted pests were small flies. The structural and sanitation concerns that could cause pest problems found and provided to the facility were as follows with the pest company recommendations: a. Interior kitchen area had floor tiles or baseboards loose and/or missing. Recommendation was made to repair the tiles and baseboards to eliminate potential pest harborage and breeding sites. c. Interior kitchen area underneath the dish sink			

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	and some of the prep equipment, there was a lot of standing water. Recommendation was made to address this sanitation issue. d. Pest control company actions taken: Cleaned the drains and areas that were causing the small fly issue and fogged the kitchen to reduce the population. Pest activity was found during service. The Pest Control Documents indicated, dated 5/31/24, indicated the targeted pests were mice, cockroaches, and large flies. The structural and sanitation concerns that could cause pest problems found and provided to the facility were as follows with the pest company recommendations: a Small flies were noted during pest control service in the kitchen, specifically by the dish area. There were quite a few small flies harboring by the trash cans and the garbage disposal. b. Interior kitchen area had a hole/gap noted above the dish area. There were holes in the wall paneling that need fixed. Recommendation was made to seal the gap to prevent pest entry or harborage. Floor tiles or baseboards were loose or missing. Recommendation was made to repair tiles or baseboards to eliminate potential pest harborage or breeding sites. b. Interior hallways had holes and gaps noted in the hallway by the back door, kitchen, and the laundry room. There was "a lot of messed up" drywall by the floor wall junction. Recommendation was made to seal the holes to prevent pest entry or harborage. c. Front door entry point exit door did not close or seal properly and had a ¼" gap or greater exists. Recommendation was made to install replace door sweep. d. Interior kitchen area had grease build up in/on/by under the cook line there was grease			

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	155291	A. BUILDING 00 B. WING	06/06/2024

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	build up on the floor. Recommendation was made to clean buildup. e. Under the dish area, there was some sort of grease and grime build up on the floor and the wall that had attracted small flies. Recommendation was made to address the sanitation issue. f. Under the dish machine there was grease, grime and food build up on the underside of the dish machine that needs cleaned. Recommendation was made to address this sanitation issue. On 6/5/24 at 11:54 a.m., the Director of Nursing Services (DNS) indicated the facility was unable to provide any Maintenance Man's (MM) records of insect control. They had a pest company come out twice a month. The MM had ordered drain insect repellent, and it arrived 6/5/24. On 6/5/24 at 2:57 p.m., the ED provided a receipt for drain insect repellent. It was dated 5/31/24, for Drain Shark (drain fly treatment, attacks and consumes organic breeding grounds for drain flies, sewer flies, fruit flies, gnats and other common drain-dwelling pests). On 6/6/24 at 11:15 a.m., the ED indicated she was not satisfied with the facility's current local pest control company efforts. The facility had been using this pest control company twice a month, she wanted to change their schedule to every other week. She had been looking into using another pest control company. She indicated the MM acquired the drain pest control solution from another company. The MM would return from vacation next week and would instill the drain pest control solution. A current policy, titled, "Pest Control," dated 9/23, was provided by the ED, on 6/4/24 at 3:28 p.m. A			

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	review of the policy indicated, " ...Purpose of the Policy: To provide an environment free of pests and rodents. Policy: The facility will maintain an effective pest control program so that the facility is free of pests and rodents ...The facility should have a contract with a Pest Control Operator (PCO) ...The PCO will make regular scheduled visits and additional visits as needed ...." 3.1-19(a)(4) 3.1-19(f)(4) 3.1-19(f)(5)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility filed to ensure Minimum Data Set (MDS) assessments were accurately coded for residents who had been diagnosed and determined to have a serious mental illness for 2 of 3 residents reviewed for Pre-Admission Screen and Record Review (PASRR) (Residents 24 and 14). Findings include: 1. On 6/5/24 at 8:23 a.m., Resident 24's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, major depressive disorder, delusional disorder, personality disorders and hallucinations. She had a PASRR Level II, dated 8/24/23, which indicated she was considered to have a major mental illness and gave instruction to code her MDS assessment section 1500, "yes."	F 0641	**F-641 Accuracy of Assessments** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * Resident 24 and Resident 14 Minimum Data Set Assessments	07/05/2024

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	Resident 24's admission MDS assessment, dated 8/31/23, section 1500 was incorrectly coded, "no." 2. On 6/5/24 at 9:54 a.m., a record review was completed for Resident 14. She had the following diagnoses which included, but were not limited to, schizophrenia, unspecified intellectual disabilities, hypertension, and heart failure. An annual Minimum Data Set (MDS) assessment was completed for Resident 14 on 10/18/23. Section A1500 was completed and a "0" was entered for the answer. It should have been marked with a "1" to indicate mental illness (MI) and/or intellectual disability or a related condition. On 6/4/24 at 9:40 a.m., the Executive Director (ED) indicated they followed the RAI manual for accuracy of the MDS.		were updated to reflect resident PASRR condition. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents requiring a PASRR Level II have the potential to be affected by the alleged deficient practice. * All residents Minimum Data Set Assessments will be audited to ensure assessment Section 1500 accurate to reflect resident PASRR condition by 7/5/24. * ED/Designee will review PASRR information to ensure Level II completed as needed. * An inservice will be completed by Social Services Support to include Coordination of PASRR and Assessments by 7/5/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** * All residents Minimum Data Set Assessments will be audited to ensure assessment Section 1500 accurate to reflect resident PASRR condition by 7/5/24. * ED/Designee will review PASRR information to ensure Level II completed as needed. * An inservice by Social Services Support to include Coordination of PASRR and Assessments completed 7/2/24.	

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			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: * The SSD/MCF/Designee will be responsible for the completion of the Social Services PASRR QAPI Tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.			

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	§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to assess 1 of 4 residents for coordination of preadmission screening and resident review (PASARR) who required a referral for a level II assessment based on medical diagnoses and medication usage (Residents 64). Findings include: On 6/5/24 at 9:49 a.m., a record review was completed for Resident 64. He had the following diagnoses which included, but were not limited to, metabolic encephalopathy (a chemical imbalance in the brain), psychotic disorder with delusions due to known physiological condition, anxiety disorder, and depression. Resident 64 had a level I. The level I lacked information to include resident's mental illness diagnosis and use of Haldol (a psychotropic medication used to treat mental and mood disorders). This information would have triggered a level II to be completed if, not omitted. A policy titled, "PASRR Policy," was provided by the Director of Nursing Services (DNS) on 6/5/24 R 11:55 a.m. It indicated, " ...Any resident with an intellectual, mental disability or related condition will be referred to the designated mental health or intellectual disability authority with a significant change in mental or physical status ..."	F 0644	**F-644 Coordination of PASARR and Assessments** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * Resident 64 Level I updated to reflect resident PASRR condition. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents requiring a PASRR Level II have the potential to be affected by the alleged deficient practice. * All residents with PASRR/Level I will be audited to ensure accurate to reflect diagnoses and	07/05/2024

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			medication usage who may require a Level II by 7/3/24. * ED/Designee will review PASRR information to ensure Level II completed as needed. * An inservice will be completed by Social Services Support to include Coordination of PASRR and Assessments by 7/5/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** * Inservice Social Services staff to include Coordination of PASRR and Assessments completed 7/2/24. Social Services Director/Memory Care Support Specialist/Designee will review PASRR information with each resident when admitted, and with significant mental health changes ensuring accurate diagnoses and medication reflects the Level I and Level II appropriately beginning 7/5/24. * ED/Designee will review PASRR information to ensure Level II completed as needed. * Inservice by Social Services Support to include Coordination of PASRR and Assessments completed on 7/2/24. **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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			* The Social Services Director/Memory Care Support Specialist/Designee will be responsible for the completion of the Social Services PASRR QAPI Tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation and interview, the facility failed to provide nail care for a resident who was unable to care for his own nail care for 1 of 4 residents (Resident 67) reviewed for activities of daily living (ADLS). Findings include: During an observation on 6/3/24 at 9:40 a.m., Resident 67's nails were long and dirty. When asked if he wanted his nails that long, he indicated he called his daughter to have her cut them, but she was too busy working.	F 0677	**F-677 ADL Care Provided for Dependent Residents** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of	07/05/2024

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	During an observation on 6/4/24 at 3:25 p.m., Resident 67's nails were still long and dirty. During an observation on 6/5/24 at 9:41 a.m., Resident 67's nails were long and dirty. A record review was completed on 6/5/24 at 10:30 a.m. He had the following diagnoses which included but were not limited to malignant neoplasm of the prostate (cancer), anemia, hypertension, and age-related physical debility. During an interview with the DNS on 6/5/24 at 9:41 a.m., she was informed of resident's nails being long and dirty. She indicated she would inform the nurse to trim his nails or she would trim them herself. Resident 67 had a care plan, dated 4/15/24 and it indicated, "Resident requires assistance with ADLS ..." His interventions included " ...Assist with bathing as needed per resident preference. Offer shower two times per week, partial bath in between ...". A policy titled, "Resident Rights" with no date was provided by the Regional Director of Clinical Services on 6/5/24 at 3:10 p.m. It indicated, "...Receive the services and/or items included in the plan of care ..." 3.1-38(a)(3)		this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * Resident 67 received assistance with nail care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: * All residents have the potential to be affected by the alleged deficient practice. * Interviews with residents were completed by Care Companions/Designee to ensure that nail care is being received per preference. Care plans updated as needed by 7/5/24. * An inservice will be completed by DNS/Designee for nursing staff to include appropriate communication with residents regarding resident's ADL assistance with nail care by 7/5/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** * Inservice nursing staff completed by DNS/Designee to include appropriate communication with residents regarding ADL assistance with nail care	

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			completed 6/19/24. * Observational rounds will be completed by Care Companions/Designee daily to ensure that nail care is being received per preference. **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:** * DNS/Designee will be responsible for completion of POC QAPI tool for Accommodation of Needs weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and			

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	483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory equipment had the equipment they needed and the equipment was covered when not in use for 2 of 2 residents reviewed for respiratory equipment (Resident 43 and 106). Findings include: 1. On 6/2/24 at 11:23 a.m., Resident 43's respiratory equipment was observed. She was observed to be on 4 liters of oxygen per minute by nasal cannula and had a BIPAP machine (non-invasive ventilator to assist with breathing) on her bedside table. Respiratory tubing was observed leading into a plastic bag, there was no BIPAP mask in the plastic bag. Resident 43 indicated a CNA (Certified Nursing Aide) threw it away and she was unable to use her BIPAP machine at night. On 6/3/24 at 2:19 p.m., the BIPAP mask was observed to be missing. The resident indicated she asked for another BIPAP mask. On 6/4/24 at 10:04 a.m., Resident 43 did not have a BIPAP mask in the plastic bag with the BIPAP tubing. She was unable to use it. On 6/5/24 at 9:30 a.m., Resident 43 did not have a BIPAP mask in the plastic bag with the BIPAP tubing. She was unable to use it. She indicated the facility staff did not order a BIPAP mask for her. On 6/4/24 at 2:19 p.m., Resident 43's record was reviewed. She was admitted on 8/11/23. On 5/1/23, and her weight was recorded as 382 pounds.	F 0695	**F-695** **Respiratory/Tracheostomy Care and Suctioning** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * Resident 43's BiPap mask was replaced. * Resident 53's nebulizer and CPAP mask were replaced and bagged. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents receiving care had the potential to be affected by the alleged deficient practice. * All residents with respiratory equipment are at risk from alleged deficient practice. * DNS/designee audited all respiratory equipment to ensure	07/05/2024

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	Her diagnoses included, but were not limited to, obesity, sleep apnea (breathing difficulty during sleep), congestive heart disease (heart disease), chronic obstruction pulmonary disease (COPD), acute respiratory failure with hypoxia (not enough oxygen in the blood), diabetes mellitus (blood sugar disorder), and schizophrenia (mental illness involving difficulty with thought, emotion, and behavior). A respiratory care plan, dated 8/14/23, indicated Resident 43 had a potential for impaired gas exchange related to obesity, acute respiratory failure, sleep apnea (stop breathing while asleep), COPD with shortness of breath while lying flat, was on continuous oxygen, pulmonary edema (too much fluids in the lungs), and history of cerebral vascular accident (stroke). The goal was for her to will adequate respiratory functions as evidenced by decreased or absence of dyspnea (difficulty with breathing), improved breath sounds, decreased or absence of shortness of breath, and improved oximetry (blood oxygen levels) results. Nursing approaches included, but were not limited to, administer oxygen as ordered - 4 liters per minute per nasal cannula and BIPAP (non-invasive ventilator to assist with breathing). A perfusion (blood flow) care plan, dated 8/14/23, indicated Resident 43 was at risk for ineffective tissue perfusion related to hypertension (HTN), history of cerebral vascular accident, and sleep apnea. The goal was to maintain adequate tissue perfusion. A nursing approach indicated the use of her BIPAP machine with observations of pallor, cyanosis (blue tint to skin), shortness of breath, headache, abnormal lung sounds and oxygen saturation (measurement of oxygen in the blood). A physician's order, dated 1/18/24, indicated		availability and proper storage. * An inservice will be completed by DNS/designee for nursing staff to include appropriate storage of respiratory equipment completed by 7/5/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** * Care Companions/Designee will complete daily observational rounds to assure respiratory equipment is stored properly when not in use and is available per MD order. * Inservice nursing staff completed by DNS/Designee to include appropriate storage/cleaning/ ensure availability of respiratory equipment completed 6/19/24. **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:** DNS/Designee will be responsible for Bipap/CPAP QA tool weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	Resident 43's BIPAP machine and mask be cleaned daily with soap and water. A physician's order, dated 4/23/24, indicated Resident 43's BIPAP should have been on at bedside and removed upon waking. On 6/5/24 at 10:17 a.m., the DNS indicated she did not know if Resident 43 had a bariatric bed and she indicated she would look into mobility bars for her. She indicated she was unaware Resident 43 was missing her BIPAP mask for multiple nights. She indicated she did the ordering and had not ordered a BIPAP mask for her. On 6/5/24 at 11:57 a.m., the Director of Nursing Services (DNS) indicated she provided a BIPAP mask for Resident 43 and Resident 43 should have had the BIPAP mask the whole time because she had physician orders to use it every night. 2. On 6/2/24 at 1:21 p.m., Resident 53's nebulizer mask was observed uncovered on top of his bedside table drawer. He indicated the CPAP mask was also in the drawer. On 6/4/24 at 11:16 a.m., Resident 53's CPAP mask was observed uncovered on top of his bedside table drawer. On 6/5/24 at 9:36 a.m., Resident 53's nebulizer mask and CPAP mask was observed uncovered on top of his bedside table drawer. On 6/6/24 at 12:08 p.m., Resident 53's record was reviewed. He was admitted on 12/20/23. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), morbid obesity			

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	155291	A. BUILDING 00 B. WING	06/06/2024

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	(complex chronic disease with a body mass index above 40), and diabetes mellitus (blood sugar disorder). His physician orders, dated 12/20/23, indicated to use a CPAP at bedtime and remove upon waking. His physician orders, dated 12/20/23, indicated to use albuterol sulfate 0.63 mg via nebulizer treatment every 6 hours as needed. A respiratory care plan, dated 12/20/23, indicated Resident 53 had potential for impaired gas exchange related to COPD with shortness of breath while lying flat, chronic and other pulmonary manifestations related to radiation and obstructive sleep apnea, obesity, and CPAP use. The goal was for him to have adequate respiratory function. A nursing approach indicated to use the CPAP with nebulizer treatments as ordered. On 6/4/24 at 12:43 p.m., a respiratory equipment policy was requested from the DNS. It was not provided. On 6/5/24 at 10:21 a.m., a respiratory equipment policy was requested from the DNS. It was not provided. A procedure, titled, "Bi-Level Therapy," with no date, was provided by the DNS, on 6/5/24 at 1:06 p.m. It did not provide any information about caring for the BIPAP mask when not in use. A procedure, titled, "CPAP Therapy," with no date, was provided by the DNS, on 6/5/24 at 1:06 p.m. It did not provide any information about caring for the BIPAP mask when not in use. 3.1-47(a)(6)			

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F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observations, the facility failed to label and date medications when opened and remove expired medications from use for 2 of 4 medication carts and 1 of 1 refrigerator. Findings include: 1. A hall medication cart a. Resident 64 had a vial of Haldol in the medication cart. The vial was a one time use only and lacked a date when opened.	F 0761	**F-761 Label/Store Drugs and Biologicals** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley	07/05/2024

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	b. Resident 2 had breo in the medication cart. It lacked a date when opened. 2. B hall medication cart a. A bottle of Systane eye drops was in the medication cart. It did not have a label on the bottle. b. Resident 226 had a bottle of Systane eye drops in the medication cart with no date to indicate when it was opened. 3. Refrigerator had the following: a. Resident 54 had 2 bottles of lorazepam in the refrigerator. One bottle lacked a date to indicate when it was opened. The other bottle was opened on 2/22/24 that had expired. b. Resident 6 had a bottle of lorazepam in the refrigerator. It lacked a date to indicate when it was opened. c. There was a bottle of lorazepam in the refrigerator. It lacked a label on the bottle. A medication storage guidance was provided by the director of nursing services (DNS) on 6/5/24 at 11:56 a.m., it indicated Ativan oral solution, " ...store original ... date when opened and discard 90 days after opening. Protect from light ...". 3.1-25(j) 3.1-25(m) 3.1-25(n)		Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * The discontinued medications and medications with no open date were immediately removed from the medication cart. * Resident #64 bottle of Haldol and Breo were destroyed * Resident #226 Systane eye drops were destroyed * Resident #54 and #6 Lorazapam were destroyed **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents taking medication have the potential to be affected by the alleged deficient practice. * All medication carts were audited to ensure all applicable open medications were labeled and discontinued medications were removed from the medication cart. * DNS/Designee to conduct an in-service with all licensed nursing staff and QMAs regarding medication storage and labeling by 7/5/24. **What measures will be put into place or what systemic**	

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			changes will be made to ensure that the deficient practice does not recur: * DNS/Designee to conduct an in-service with all licensed nursing staff and QMAs regarding medication storage policy completed on 6/19/24. * Medication carts will be audited daily by nurse managers/designee to ensure all open medications are labeled and discontinued medications are removed from the medication carts. Any concerns will be addressed immediately. **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:** * DNS/Designee will be responsible Medication Storage Review QA tool weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources			

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	approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure linens were not contaminated for 4 of 12 residents during dining service (Resident 3, 9, 7, 21, and 46) and failed to ensure kitchen temperature logs were completed. Findings include: 1 On 6/2/24 at 12:18 p.m., the Social Services Director (SSD) was observed bringing tablecloths and clothing protectors into the dining room. She was holding them up against her body and sleeve. She indicated she was just making sure everyone had tablecloths and clothing protectors. On 6/2/24 at 12:20 p.m., the SSD was observed putting a table cloths on a table while Resident 9 was sitting at the table, then she provided him with a clothing protector. On 6/2/24 at 12:23 p.m., the SSD was observed to pick up trash from the dining room floor and threw	F 0812	**F-812 Food Procurement, Store/Prepare/Serve-Sanitary** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * Dining room linens are being carried away from the body for all	07/05/2024

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	it away. She did not do any hand hygiene and put a table cloth on Resident 21's table and provided clothing protectors for Resident 21, Resident 46, Resident 7, and Resident 3. A current policy, titled, "Laundry/Linen" dated 12/2021, was provided by the Executive Director (ED), on 6/4/24 at 3:28 p.m. A review of the policy indicated, " ...To ensure the proper care and handling of linen and laundry to prevent the spread of infection ...Clean linen must be protected from soiling or contamination ...Clean linen should be carried away from body to prevent contamination ...." A current policy, titled, "Hand Hygiene Policy" dated 12/2021, was provided by the Executive Director (ED), on 6/4/24 at 3:28 p.m. A review of the policy indicated, " ...to provide a standardized approach to Hand hygiene to reduce or minimize the transmission of infection from potential microorganism on the hands of all employees ...American Senior Communities will follow the Centers for Disease and Prevention (CDC) guidelines for the standards of hand hygiene ...." 2. During a kitchen tour, on 6/2/24 at 10:36 a.m., several temperature (temp) logs were observed incomplete. a. The Prep Cooler had no morning temps for 6/1/24 or 6/2/24. b. The High Temperature Dish Machine had no temp logs for morning, lunch, or dinner on 6/1/24. A current policy, titled, "Food Storage," dated 5/23, was provided by the Executive Director (ED), on 6/4/24 at 3:28 p.m. A review of the policy indicated, " ...Thermometers should be checked utilizing an internal thermometer at least two times each day. Temperatures should be recorded prior		residents including resident 9. * Employees are performing proper hand hygiene when placing table linens and clothing protectors as needed for all residents including residents 21, 46, 7, and 3. * Temp logs are completed 2 times per day for the prep cooler and the high temperature dish machine. * No resident identified has been affected by this practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents have the potential to be affected by the alleged deficient practice. * A staff inservice will be completed by ED/Designee to include proper handling of table linens, clothing protectors, and proper hand hygiene by 7/5/24. * An inservice for culinary staff will be completed by ED/Designee to include temp logs to be completed at least twice daily by 7/5/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** * A staff in-service was completed by ED/Designee to include proper handling of table linens, clothing protectors, and proper hand hygiene by 6/12/24.	

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	to breakfast preparation and again prior to dinner service. 3.1-19(l) 3.1-21(i)(2)		* An inservice for culinary staff completed by ED/Designee to include temp logs to be completed at least twice daily by 6/12/24. * Dietary Manager/Designee will round daily to ensure kitchen temp logs are filled out at least two times each day; table linens carried properly; hand hygiene being performed per protocol. **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:** * Dietary Manager/Designee will be responsible Food Procurement, Store/Prepare/Serve-Sanitary QA tool weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control			

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	program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin			

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure appropriate personal protective equipment (PPE) was utilized during high contact resident care, to prevent the potential for the spread of infection for a resident for (Resident 62) who had an open wound with recurrent infections for 1 of 2 residents reviewed for enhanced barrier precautions (EBP). Findings include: During a random observation on 6/4/24 at 9:43 a.m., Resident 62 was observed in the spa room on the secured memory care unit, where she received a shower from an unidentified nursing assistant (CNA). The CNA did not have an isolation gown or gloves on as she conducted Resident 62's shower. Resident 62 was seated on a shower chair, and evidence of stool incontinence was	F 0880	**F-880 Infection Prevention & Control** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	07/05/2024

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	present by smell and stool was observed on the shower floor near the drain. When asked where the Resident's wound was, the CNA gently asked the resident to lean forward, and with her bare hand lifted the skin of her right buttock to reveal the wound. The wound dressing was not in place and the open wound was in direct contact with the shower chair. The wound edges were regular but appeared macerated and there was a scant amount of green drainage present inside the wound. When asked why the CNA did not have a gown or gloves, or other PPE on, she indicated, it was too hot in the shower room. On 6/4/24 at 2:00 p.m., Resident 62's medical record was reviewed. She was a long-term care resident with diagnoses which include, but were not limited to, dementia (a degenerative brain disease which affects cognitive function and memory), cellulitis (bacterial skin infection), lymphedema (a chronic condition that causes swelling in the body due to a buildup of lymph fluid) and reduced mobility. On 4/22/24 a new open area was discovered on her right buttock. On 4/24/24 the Nurse Practitioner (NP) ordered an x-ray of the right hip for the suspicion of possibly infected hardware. The results were received and concluded evidence of degenerative join disease, no fracture, and did not indicate any sign/symptom of infection. On 4/25/24 at 8:06 a.m., the Interdisciplinary Team (IDT) determined the root cause of her facility acquired pressure ulcer had developed from friction caused by scooting on her wheelchair. There were no signs or symptoms of infection and		**practice:** * CNA for Resident 62 was immediately inserviced about Enhanced Barrier Precautions to include use of PPE while giving a shower. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents on Enhanced Barrier Precautions have the potential to be affected by the alleged deficient practice. * An inservice will be completed by DNS/designee for nursing staff to include proper infection control practice regarding PPE for residents on Enhanced Barrier Precautions during high contact resident care activities by 7/5/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** * Inservice nursing staff completed by DNS/Designee to include proper infection control practice regarding PPE for residents on Enhanced Barrier Precautions during high contact resident care activities completed on 6/19/24. * Observational rounds will be completed daily by DNS/designee to ensure that PPE is worn for residents on Enhanced Barrier	

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	the Np ordered medihoney to the area and equagel cushion. On 5/7/24 Resident 62 was placed in enhanced barrier precautions due to a wound infection. A wound round note, dated 6/4/24, indicated the history of the wound as follows: On 4/30/24 - reviewed right hip x-ray, no hardware noted in x-ray and no abnormalities. "Nursing reports after investigation area started as blister most likely from friction of patient placing self in wheelchair and rubbing on arm rest and also witnessed by staff scooting self in wheelchair could also cause friction." On 5/7/24 - "suspect wound DTI [deep tissue injury] now presenting as unstageable, wound worsening this week." A new antibiotic was ordered and she was started on Doxceycycline 100mg twice a day for 7 days as well as a topical antibiotic of 500mg of crushed flagyl to the wound bed twice a day for 7 days. On 5/28/24 - "suspect root cause of wound could be a cyst or abscess." A CT was ordered and scheduled for 6/6/24. A nursing progress note, dated 5/13/24 at 10:24 a.m., indicated the treatment to her right buttocks was completed with drainage and odor noted present. A nursing progress note, dated 6/3/24 at 11:00 a.m., indicated, the treatment to her right buttock wound was completed. A foul odor and copious amounts of green drainage was noted. On 6/4/24 the wound team restarted Resident 62 on an antibiotic Doxycycline 100mg twice a day for 10 days related to cellulitis.		Precautions during high contact resident care activities. **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:** * DNS/Designee will be responsible for the Enhanced Barrier Precautions PPE tool weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	Resident 62's had a comprehensive care plan which was initiated on 5/5/24 related to her infected pressure ulcer. The care plan indicated she was at risk for becoming colonized with Mulit-drug-Resistant Organisms (MDROs) and required enhanced barrier precautions for her protection. Interventions for this plan of care included, but were not limited to, wear gown and gloves prior to high contact resident care activities. On 6/6/24 at 11:00 a.m., the Director of Nursing Services provided a copy of current facility policy titled, "Standard and Transmission-Based Precautions (Isolation) Policy," reviewed, 4/24/24. The policy indicated, " ...Enhanced Barrier Precautions expands the use of PPE beyond situations in which exposure to blood and body fluid is anticipated, it refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... Use of Personal Protective Equipment- Gown and Gloves during high-contact resident care activities: dressing, bathing/showering ...." 3.1-18(a)			
F 0882 SS=E Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;			

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	155291	A. BUILDING 00 B. WING	06/06/2024

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	§483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on observation, interview and record review, the facility failed to designate an Infection Preventionist (IP) who was available for a minimum of 20 hours a week and did not share the duties/responsibilities of other departments, to ensure daily monitoring and implementation of the Infection Control and Prevention program for 5 of 5 months reviewed. This deficient practice had the potential to affect 75 of 75 residents who resided in the facility: Findings include: Upon survey entrance, name and certification of the facilities IP was requested and provided. The Executive Director (ED) indicated the facility's IP was Licensed Practical Nurse, (LPN) 4, who also served as the full time Minimum Data Set (MDS) Coordinator. On 6/4/24 at 10:24 a.m., the Regional IP Consultant (RIPC) indicated the facility had been without a full-time IP for a couple of months, but he came to the building about 1-2 times a month in order to update the infection tracking binder, complete the infection mapping and antibiotic stewardship reports. The RIPC indicated, his time in the building was less than 20 hours per week, but in the absence of a full-time IP, the MDSC was responsible for the daily implementation and oversight of the program.	F 0882	**F-882 Infection Preventionist Qualifications/Role** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** * No resident identified has been affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** * All residents have the potential to be affected by the alleged deficient practice.	07/05/2024

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	During an interview on 6/4/24 at 1:34 p.m., with the RIPC and the MDSC present, the MDSC indicated, she did have an IP certification and had temporarily filled the position in January. The MDSC indicated, she spent the majority of her time on MDS tracking, scheduling and assessment submission. She also helped out with weekly wound rounds. On 6/6/24 at 10:07 a.m., the Facility Assessment was reviewed. The assessment was dated 1/23/24 and LPN 4 signed as the IP. Standard competencies for the IP position indicated, " ...Infection control and prevention program, daily surveillance of infection completed ..." Further, the assessment indicated the facility required a full-time IP and that, " ...if answered yes, they may not share other duties ...." During an interview on 6/6/24 at 11:36 a.m., the IP program and position vacancy was reviewed with the ED. The ED indicated, in the absence of a full-time IP staff, the facility had the RIPC help out and the MDSC cover daily tasks. When the Facility assessment specifications were reviewed, the ED agreed that if the MDSC had been asked to fill the role of the IP, another staff member should have been appointed to fill the MDSC role, so that the IP would not share duties to maintain a comprehensive and effective daily program implementation.		* DNS/designee will conduct an inservice with nurse managers on requirements of IP qualifications/role by 7/5/24. *IP program will be overseen a minimum of 20 hours per week by Minimum Data Set Coordinator until IP hired and fulfills requirements beginning 7/5/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** * DNS/designee will conduct an in-service with nurse managers on requirements of IP qualifications/role by 7/5/24 * IP program will be overseen a minimum of 20 hours per week by Minimum Data Set Coordinator until IP hired and fulfills requirements beginning 7/5/24. **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:** ED will ensure licensed nurse holding the IP certificate will be committed to spending a minimum of 20 hours per week overseeing the IP program. This will be reviewed by the Quality Assurance Performance Committee overseen by the ED. If a threshold of 100% is not achieved an Action Plan will be developed to ensure	

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