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	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: December 6, 7 & 8, 2022 Facility number: 014213 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 13, 2022.	R 0000		
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure background checks and reference checks were completed for 4 of 5 employee files prior to their start date. (Dementia Care Director, QMA 3, HHA 6 and CNA 7) Findings include: Employee records were reviewed on 12/8/22 at 9:45 a.m. The Dementia Care Director, Qualified Medication Aide (QMA) 3, Home Health Aide 6, and Certified Nursing Assistant (CNA) 7 employee records lacked reference checks or	R 0116	/p> 2. The facility's business office manager (BOM) and administrator will review and verify background check results of current employees and take measures accordingly. 3. Inservice will be conducted by the regional director of operations (RDO) and/or designee with the	01/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Harrison	RDO	12/23/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	criminal background checks. During an interview, on 12/8/22 at 9:45 a.m., the Business Office Manager indicated the employee file information was not complete. She had no further information than what had been provided. A current facility policy, revised 12/11/20, titled, "Prohibition of Employing or Contracting with a Person," provided by the Director of Nursing on 12/8/22 at 3:16 p.m., indicated the following: "...Purpose: It is the goal of the community to provide a safe and secure environment for all residents, families, guests, and staff members. In an effort to ensure the safest environment possible, each employee will be {SIC} undergo a criminal background check before they are allowed to start employment...."		BOM and administrator on the company's policies for hiring and background checks protocols. The BOM and administrator, will both verify the results of each background check report prior to the employee hiring. 4. The BOM and/or administrator will audit all current employee files by 1/8/2023, and all new employee files prior to first working day to ensure background checks meet requirements. This will be an ongoing standard of facility practice. 5. Compliance by 1/8/2023.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services			

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	or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a staff member was Cardiopulmonary Resuscitation (CPR) certified and trained in First Aid for 7 of 21 shifts reviewed for the week of staffing provided by the facility. This deficiency had the potential to affect 113 of 113 residents residing in the facility. Findings include: A review of the employee schedule, on 12/8/22 at 9:31 a.m., indicated there lacked any staff members certified in CPR and First Aide for seven night shifts, for the week of 11/30/22 through 12/6/22. During an interview, on 12/8/22 at 11:45 a.m., the Director of Nursing indicated the facility had no specific written policy regarding staff certification requirements, but the facility followed state guidelines. The seven night shifts lacked staff with certification in CPR and/or First Aid.	R 0117	1. No adverse effects related to alleged deficiency. 2. Deficiency had the potential to effect 113 of 113 residents residing in the community. No residents had adverse effects related to the alleged deficiency. 3. The director of nursing (DON) or designee will schedule in-house basic life support CPR/1st Aid class. DON or designee will place marker on the schedule indicating staff with active CPR/1st Aid certifications to ensure adequate certified staff on duty 24/7. BOM will keep certification binder for active employees. 4. The DON or designee will audit employee schedule weekly to ensure certified staff is scheduled 24/7. Quality Assurance (QA) committee will review audits monthly and make recommendations as needed.	01/08/2023

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			5. Compliance by 1/8/2023.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to provide job specific orientation to newly	R 0119	1. Dementia Care Director, CNA 7, HHA 6, QMA 3 and QMA 5	01/08/2023

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	hired staff members for 5 of 5 staff reviewed for employee records. (Dementia Care Director, CNA 7, HHA 6, QMA 3, and QMA 5) Findings include: Employee records were reviewed on 12/8/22 at 9:45 a.m. The Dementia Care Director, Qualified Medication Aide (QMA) 3, QMA 5, Home Health Aide (HHA) 6, and Certified Nursing Assistant (CNA) 7 employee records lacked indication or documentation of job specific orientation. During an interview, on 12/8/22 at 9:45 a.m., the Business Office Manager indicated employee file information was not complete. She had no information other than what had been provided.		general and job specific orientations completed. 2. Current employees have the potential to be affected by the alleged deficient practice. The community's BOM will review and verify the general orientation and job specific orientation of current employees are complete. If not complete, directors will take measures accordingly. 3. In-Service will be conducted by RDO and/or designee with the hiring supervisors, BOM and administrator on general and job specific orientations. 4. The BOM will audit all current employee files by 1/8/2023 and all new employee files after hire to ensure general and job specific orientation checklists are completed. This will be an ongoing standard of community practice. 5. Compliance by 1/8/2023.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom			

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	administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on interview and record review, the facility failed to administer TB (tuberculin) skin testing prior to starting employment with the facility for 5 of 5 staff reviewed for employee records. (Dementia Care Director, CNA 7, HHA 6, QMA 3, and QMA 5) Findings include:	R 0121	/p> 2. Current employees have the potential to be affected by the alleged deficient practice. The BOM will audit current employee records and employee deficient in TB skin test will be completed.	01/08/2023

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	Employee records were reviewed on 12/8/22 at 9:45 a.m. The Dementia Care Director, Qualified Medication Aide (QMA) 3, QMA 5, Home Health Aide (HHA) 6, and Certified Nursing Assistant (CNA) 7 employee records lacked indication or documentation of completion of TB skin tests prior to working with residents. During an interview on 12/8/22 at 9:45 a.m., the Business Office Manager indicated employee file information was not complete. She had no information other than what had been provided. A current facility policy, dated 9/13/21, titled, "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," provided by the Director of Nursing on 12/8/22 at 3:10 p.m., indicated the following: "...Policy: A. A health screen is required for each employee prior to resident contact. 1. The facility must assure that at the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work...."		3. In-service will be conducted by RDO and/or designee with hiring supervisors, BOM and administrator by 1/8/2023 on requirements regarding new employees and TB compliance. 4. The BOM will audit new employee files prior to 1st working day and final audit after to ensure TB skin test documentation for each new hire is complete. 5. Compliance by 1/8/2023.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable.			

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	(5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility allowed a Licensed Practical Nurse to administer care with an expired license for 1 of 35 employees reviewed for active licensure (LPN 2). Findings include: Employee Record Review indicated LPN 2's nursing license had expired on 10/31/22, per the MyLicense.IN.gov website, accessed on 12/7/22 at 11:22 a.m. A review of LPN 2's schedule indicated she worked the evening shifts on 11/1/22, 11/2/22, 11/3/22, 11/7/22, 11/8/22, 11/9/22, 11/10/22, 11/12/22, 11/13/22, 11/16/22, 11/17/22, 11/18/22, 11/23/22, 11/26/22, 11/27/22, 11/29/22, 11/30/22, 12/1/22, 12/2/22 and 12/5/22. During an interview, on 12/8/22 at 11:30 a.m., the Director of Nursing indicated LPN 2's nursing license had expired 10/31/22. The facility was not aware and should have required an updated license in October for LPN 2. No further information was provided.	R 0123	/p> 2. The administrator/BOM will conduct an audit of all employee files to ensure all licenses and certifications are current. No residents were noted to be affected by the alleged deficiency. 3. Staff will be inserviced on the necessity of keeping licenses and certifications in compliance by the Director of Nursing by January 8, 2023 4. QA audits will be conducted monthly x 6 by the BOM/administrator and/or designee to ensure that all licensed and certified personnel are active so the alleged deficiency does not reoccur. Quarterly QA committee will review monthly audits and recommendations for need of	01/08/2023

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			further auditing. 5. Compliance by 1/8/2023.	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and interview, the facility failed to store trash in a safe and sanitary manner. Findings include: During an initial facility tour, on 12/6/22 at 10:00 a.m., the following was observed: a. Seven white bags of trash were piled on the floor outside the elevator on the 2nd floor. b. Three white bags of trash were piled on the floor outside the elevator on the 3rd floor. c. A black bag of trash was on the floor outside of room 331. d. Three white bags of trash were piled on the floor outside the elevator on the 4th floor. e. A white bag of trash was on the floor outside of room 425. The elevators were observed to be used by the residents throughout the survey. The elevator was positioned on each level with resident rooms to each side of the elevator doors.	R 0155	/p> /p> 2. 113 out of 113 had the potential to be affected by the alleged deficient practice. No adverse affects from the alleged deficiency. 3. Employees and residents will be in-serviced on not leaving trash outside apartment doors and/or near elevators Administrator or designee will institute trash collection rounds and times to ensure trash is not placed outside of apartments and/or near elevators. 4. Administrator and department	01/08/2023

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	During an interview, on 12/7/22 at 12:23 p.m., Qualified Medication Aide 3 indicated the aides were responsible for collecting and disposing of the resident's trash. If residents were able, they placed their trash outside their room door and the aides brought the trash to the elevators on each floor. The aides went into the resident's rooms and collected the trash for the residents that were not able to set their own trash bags out in the hallway. These bags were also brought to the elevators and placed on the floor. They returned later to the elevators with a bin and picked up all of the trash bags on the floor at the elevators on each level. She was not aware of any specific time frame in which the task was completed. During a facility tour, on 12/7/22 at 12:25 p.m., the following was observed: a. Four white bags of trash were on the floor outside the elevator on the 4th floor. b. Four white bags of trash were on the floor outside of room 410. c. Five white bags of trash were piled on the floor outside the elevator on the 3rd floor. d. A bin to collect the trash was not in sight during the above mentioned observations. During an interview, at the time of observation on 12/7/22 at 10:40 a.m., the Administrator indicated the five bags of trash on the floor outside of the elevator on the 3rd floor was not acceptable. During an interview, on 12/7/22 at 12:43 p.m., the Director of Nursing (DON) indicated she had noticed things accumulating at the elevator various times throughout the day. The trash process "seemed like a revolving door." It was not appropriate to have trash on the floor at the		directors will complete daily walks x 8 weeks in designated areas to ensure no trash is left outside apartments or by elevators. QA committee will review at QA meetings to determine ongoing need after 8 weeks. 5. Compliance by 1/8/2023.	

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	elevators nor at the resident's rooms throughout the facility. A current document titled "Resident Lease Agreement:," provided by the Administrator on 12/6/22 after entrance conference, indicated the following: "...Attachment 7 Service Plan Agreement ...D. Services ...2. Covered Services (b) Chore Services - Services needed to maintain the Resident's Residential Living Unit, in a clean, sanitary and safer environment...."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the			

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	provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure assessments were completed and a service plan developed (Resident 36), and the service plans were signed by the resident or resident representative (Residents 89 and 120) for 3 of 8 residents reviewed for service plans. Findings include: 1. The clinical record for Resident 36 was reviewed on 12/8/22 at 10:51 a.m. The resident admitted to the facility on 4/12/22. A Level of Service Assessment/Evaluation, dated 12/6/22, provided by the Director of Nursing (DON) on 12/8/22 at 2:49 p.m., lacked documentation to determine level of care and assessment areas were blank. During an interview on 12/8/22 at 2:05 p.m., the DON indicated the Resident 36's evaluation dated 12/6/22 was the first documented assessment since admission. The evaluation lacked documentation of assessment areas. 2. Resident 89's clinical record was reviewed on 12/6/22 at 2:00 p.m. Diagnoses included, but were not limited to, blindness in both eyes and essential primary hypertension. Review of the resident's service plan, dated 2/26/22, indicated the resident was oriented to person, place and time or sufficiently oriented to function independently. The service plan was not signed by the resident or a representative. During an interview, on 12/7/22 at 3:06 p.m., the	R 0217	217 /p> 2. 113 out of 113 residents had the potential to be affected by the alleged deficient practice. No adverse effects as a result of alleged deficient practice. DON and/or designee will audit all resident files to ensure all service plans are completed and signed. Any incomplete service plans will be updated and signed. 3. Regional Director of Health Services will inservice Director of Nursing and Memory Care Director by December 29, 2022, on completing service plans and obtaining required signatures. Director of Nursing and/or designee will inservice nurse on service plans and getting service plans signed by January 8, 2023. 4. Director of Nursing and/or designee will audit assessment and service plan due each month at the end of the month to ensure compliance. QA committee will review audits at Quarterly QA	01/08/2023

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		A. BUILDING 00 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

(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
	Director of Nursing (DON) indicated the clinical record lacked a service plan signed by the resident or resident representative. 3. Resident 120's clinical record was reviewed on 12/7/22 at 3:36 p.m. The resident admitted to the facility on 5/9/22. Diagnoses included, but were not limited to, dementia in other diseases classified elsewhere with behavioral and personal history of transient ischemic attack. Review of the resident's service plan, dated 8/8/22, indicated the resident was disoriented and no longer able to function independently. The service plan was not signed by the resident or a representative. During an interview, on 12/8/22 at 9:53 a.m., the DON indicated the resident's service plan lacked a resident or resident representative signature. A current facility policy, titled "Service Plan Policy," provided by the DON on 12/7/22 at 3:43 p.m., indicated the following: " ...PURPOSE: The purpose of this Policy is to outline necessary components of the resident evaluation and assessment process to ensure that the individual needs, desires, and preferences of the resident are obtained and noted in the Service Plan as needed and appropriate within the frequency and assessment schedule specified. POLICY: Each resident will have a written plan of care that is developed based on initial evaluation/assessment, semiannual assessments, and with any changes in resident needs .... PROCEDURE: 1. An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated as least semiannually and upon a known substantial		meeting x 6 months and make recommendations if audits need to be continued. 5. Compliance by 1/8/2023	

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	change in the resident's condition, or more often at the resident's and/or Community's request .... 4. Following completion of an evaluation, a licensed Nurse in the Community shall identify and document the services to be provided by the Community, as follows: ...b. The services offered shall be reviewed and revised as appropriate and discussed by the resident and Community as needs or desires change .... d. The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request ...."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview, and record review, the facility failed to assure medications in resident rooms were secured for 2 of 5 residents observed during medication administration. (Residents 33 and 45) Findings include: 1. Resident 33 was observed during medication administration with Qualified Medication Aide (QMA) 5 on 12/7/22 at 11:48 a.m. Medications were observed on the resident's side table next to a couch in her room as follows: A bottle of melatonin (to aid in sleep), a bottle of Flonase nasal spray (to treat allergies), and a bottle of Robitussin cough syrup (a cough suppressant) A Self Administration Medication Assessment, dated 1/20/22, indicated the resident required	R 0295	1. 1. Resident 33 and 45 medications were place in locked cabinet. Residents had no negative affects related to alleged deficiency. 2. 2. All residents that have medications administered have potential to be affected by this alleged deficiency. 3. 3. Director of Nursing and/or designee will inservice nurses and QMA's on proper medication storage for residents that receive medication administration. 4. 4.Director of Nursing and/or designee will conduct random weekly audits of 10% of residents receiving medication administration to ensure all medication is placed in lock cabinet. Monthly QA committee	01/08/2023

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	medications to be stored and locked for safety. The residents clinical record lacked a physician's order to self administer medications. 2. Resident 45 was observed during medication administration with QMA 5 on 12/7/22 at 11:55 a.m. An albuterol inhaler (a respiratory inhaler) was observed laying on his chair side table. He indicated he used it when he felt he needed it. A Self Administration Medication Assessment, dated 10/1/22, indicated the resident required medications to be stored and locked for safety. The resident's clinical record lacked a physician's order to self administer medications. During an interview, on 12/7/22, the Director of Nursing (DON) indicated Residents 33 and 45 should not have medications in the room unsecured. The facility had not obtained a physician's order or assessment for them to self-administer medications. A current facility policy, dated 3/23/22 titled, "Medication Management, Administration & Storage," and provided by the DON on 12/8/22 at 3:16 p.m., included the following: "...Policy A. The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. ...The medication assessment will be reviewed biannually as part of the review process, and episodically with any significant change in condition or as level of service indicate... C. Storage of Medications:		will review audits x 6 months and make recommendation for need of ongoing audits. 5. 5. Compliance January 8, 2023	

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	1. It is the responsibility of all authorized healthcare professionals to ensure that all medications are appropriately secured at all times except when authorized personnel are present...." 410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to initiate a physician's medication order for 1 of 7 residents reviewed for medications. (Resident 36) Findings include: Resident 36's clinical record was reviewed on 12/8/22 at 10:51 a.m. Diagnoses included anxiety disorder and rheumatoid arthritis. A fax document, dated 11/21/22, from IU Health Physician's Neurology included a prescription for donepezil (to treat cognitive decline) 10 mg (milligram), 1/2 tablet (15 mg) every morning for 1 month, then a full tablet (10 mg) every morning. The resident's medication record lacked the order for donepizil and the administration record lacked this medication. During an interview, on 12/8/22 at 2:05 p.m., the Director of Nursing (DON) indicated the order for donepezil was not placed. The order should have been entered through the pharmacy and administered to Resident 36.			
R 0297 Bldg. 00		R 0297	1. 1. Resident 36 had no negative affects related to alleged deficient practice. Order sent to pharmacy, medication received and is being administered to resident. 2. 2.. Any resident receiving new orders has potential to be affected of alleged deficient practice. Director of Nursing and/or designee will review new orders for last 30 days to ensure all new orders sent to pharmacy, add to current physician orders. 3. 3.. Director of Nursing and/or designee will inservice nurses and QMA's on Medication management, administration, and storage policy by January 8, 2023. New orders will be noted with clinical initials and dated when received and sent to pharmacy. 4. 4.. Director of Nursing and/or designee will audit 25% of new orders received weekly x 4 weeks, bi-monthly x 8 weeks and	01/08/2023

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	A current facility policy, dated 3/23/22, titled, "Medication Management, Administration, & Storage," provided by the DON on 12/8/22 at 3:16 p.m., indicated the following: "...Purpose: The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines...."		monthly x 3 months to ensure orders were processed correctly into active orders. QA committee will review audits monthly x 6 months, and make recommendations for need of ongoing audits. 5. 5. Compliance January 8, 2023.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to obtain and document residents' tuberculin skin test (TB test) for 4 of 7 residents reviewed for TB testing. (Residents 36, 39, 90, and	R 0410	1. 1. Residents 36, 39, 90, and 120 will have 2-step TB test completed by January 8, 2023. Residents did not have any	01/08/2023

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	120) Findings Include 1. Resident 36's clinical record was reviewed on 12/8/22 at 10:51 a.m. The resident's Immunization Record indicated Tubersol (to test for TB infection) was administered on 10/20/22. The "Date Read and Results" columns were blank. The record had no further documentation present. 2. Resident 39's clinical record was reviewed on 12/7/22 at 2:58 p.m. Diagnoses included, but were not limited to, other pulmonary collapse. During an interview on 12/7/22 at 2:44 p.m., the DON indicated the resident's clinical record lacked a first and second step preadmission/admission tuberculin test. 3. Resident 90's clinical record was reviewed on 12/8/22 at 2:38 p.m. During an interview, on 12/8/22 at 3:16 p.m., the DON indicated the resident's clinical record lacked a first and second step preadmission/admission tuberculin test. 4. Resident 120's clinical record was reviewed on 12/7/22 at 3:36 p.m. During an interview on 12/8/22 at 11:01 a.m., the DON indicated the resident's clinical record lacked a first and second step preadmission/admission tuberculin test. A current policy, titled "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," provided by the Administrator on		negative affects by alleged deficient practice. 2. 2. All new admissions have potential to be affected by alleged deficient practice. Audit to be completed and any records found to deficient will be updated. 3. 3. Nurses will be inserviced by Director of Nursing and/or designee on obtaining and documenting residents TB test to meet required regulations for new admissions. New Admission TB test will be added to monthly calendar to ensure TB test are administered correctly for required 2 step TB test. 4. 4. Director of Nursing and/or designee will audit new admission record after 24 and 72 hours after admission to ensure TB test was administered and documented. Director of Nursing and/or designee will audit chart again 21 days after admission to ensure 2nd step TB test was administered and documented. Director of Nursing and/or designee will do these audits monthly x 6 months. QA committee will review audits x 6 months and make recommendations for need of ongoing audits. 5. 5. Completion January 8, 2023	

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	12/7/22 at 2:10 p.m., indicated the following: "...PURPOSE: Residents and Employees of health care communities have been identified as a high-risk group for re-activation of latent TB infection, acquisition of TB infection and potential spread of TB within the community. This policy defines the comprehensive TB screening program for the community. POLICY: ...B. A health screen is required for each resident: 1. The screen will include a Mantoux tuberculin test unless a previously positive reaction can be documented. 2. Tuberculosis screening shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours and annually thereafter. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. 3. For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employee [sic] the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test ....D. A signs and symptoms checklist will be completed upon admission and annually for residents...."			
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever,			

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	night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to ensure residents were current with documentation of an annual tuberculin test or annual tuberculin health screening for 2 of 7 residents reviewed for annual tuberculin health screening. (Residents 89 and 121) Findings include: 1. Resident 89's clinical record was reviewed on 12/6/22 at 2:00 p.m. The resident's last tuberculin test or annual tuberculin health screening was dated 4/26/21. During an interview, on 12/7/22 at 3:06 p.m., the Director of Nursing (DON) indicated the resident's clinical record lacked a current tuberculin test or annual tuberculin health screening. 2. Resident 121's clinical record was reviewed on 12/8/22 at 11:00 a.m. The resident's last tuberculin test or annual tuberculin health screening was dated 4/26/21. During an interview on 12/8/22 at 1:35 p.m., the Director of Nursing (DON) indicated the resident's clinical record lacked a current tuberculin test or annual tuberculin health screening. A current facility policy, titled "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," provided by the Administrator on 12/7/22 at 2:10 p.m., indicated the following: "...PURPOSE: Residents and Employees of health care communities have been identified as a high-risk group for re-activation of latent TB	R 0412	1. 1. Residents 89 and 121 had TB Health screen completed by 1/8/2023. Residents did not have any negative affects by alleged deficient practice. 2. 2. All residents have potential to be affected by alleged deficient practice. Audit to be completed and any records found to deficient will be updated. 3. 3. Annually, in February all residents will have TB Health Screen completed by Director of Nursing and/or designee. 4. 4. Director of Nursing will complete audit after annual screen is completed to ensure compliance with state requirements. QA committee will review audit completed by Director of Nursing starting in February 2023, and monthly thereafter until all residents are compliant with regulation including an resident out of community during annual screening. 5. 5. Completion January 8, 2023	01/08/2023

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	infection, acquisition of TB infection and potential spread of TB within the community. This policy defines the comprehensive TB screening program for the community. POLICY: ...B. A health screen is required for each resident: 1. The screen will include a Mantoux tuberculin test unless a previously positive reaction can be documented. 2. Tuberculosis screening shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours and annually thereafter. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. 3. For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employee [sic] the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test ....D. A signs and symptoms checklist will be completed upon admission and annually for residents....			