STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(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. This visit included the Investigation of Complaints IN00379657, IN00379969 and IN00385351. Complaint IN00379657 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Complaint IN00379969 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00385351- Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 1, 2, 3, 4, 5, 8, 9 and 10, 2022 Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census Bed Type: SNF/NF: 115 SNF: 4 Total: 119 Census Payor Type: Medicare: 12 Medicaid: 97 Other: 10 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 15, 2022.	F 0000	The plan of correction is to serve as Carmel Health & Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Carmel Health & livings or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **The facility respectfully requests desk review for the following citations**	

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

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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 keep the call light within the resident's reach for 2 of 2 residents randomly observed for accommodation of needs. (Resident 69 and 49) Findings include: 1. During an observation, on 08/01/22 at 12:00 p.m., the call light was not within reach of the resident. The call light was hanging on the wall. During an observation, on 08/02/22 at 10:09 a.m., the call light was not within reach of the resident. The call light was hanging on the wall as previously observed. During an observation on 08/02/22 at 10:20 a.m., the Unit Manager for the 400/500 unit gave the call light to the resident to see if she was able to use it if desired. The resident was able to push the call light button. The record for Resident 69 was reviewed on 08/03/22 at 11:50 a.m. Diagnoses included, but were not limited to, malignant neoplasm of cervix, chronic obstructive pulmonary disease, anxiety disorder and diarrhea. During an interview, on 08/01/22 at 12:00 p.m., the resident stated she had been trying to get some	F 0558	**F558: The facility failed to keep the call light within the resident's reach for 2 of 2 residents randomly observed for accommodation of needs.** **1. What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i. Resident #69 & #49 without ill effects and call lights were placed within resident reach during survey. **2. 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;** i. All residents have the potential to be affected. Full house audit conducted on 8/11/22 without further concerns. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	08/26/2022

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	help, and since she could not reach the call light button, she started yelling for help. The resident indicated she was able to use the call light system if desired. During an interview, on 08/01/22 at 12:30 p.m., LPN 1 indicated the call light button should have been within reach of the resident and not on the wall. During an interview, on 08/02/22 at 10:20 a.m., the Unit Manager for the 400/500 unit indicated the call light was supposed to be within reach of the resident and it should not be hanging on the wall. 2. During an observation, on 08/02/2022 at 10:21 a.m., Resident 49 who was alert and oriented was sitting in a wheelchair next to the bed with the over-the-bed table in front of her. The resident's hair was wet, and she indicated she had just had her hair washed. During the interview, the resident's call light was observed to be clipped to the bed sheets behind the resident's wheelchair. The resident indicated she did not want to stay up too long and would ask staff to assist her when she was ready to go back to bed. When questioned about her call light, the resident indicated she did not know where her call light was. The resident was informed the call light was clipped to the sheet on the bed behind her. The resident indicated she could not reach the call light. A facility policy, titled "Resident Rights," dated 06/06/2019 and provided by the Corporate Support Nurse on 08/04/22 at 3:13 p.m., indicated "...Equal access to quality care, regardless of source payment, receive care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life...."		i. All staff educated on the accommodation of needs to include call lights within reach. ii. Environmental rounds to ensure call light placement per audit schedule. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audits. **5. by what date the systemic changes for each deficiency will be completed.** i. Completed by 8/26/22	

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	3.1-3(v)(1)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to identify and provide needed care in a timely manner for 1 of 2 residents reviewed for pressure ulcers. (Resident 16) Finding includes: On 08/04/2022 at 4:09 p.m., a skin observation of Resident 16 was completed with the assistance of the Unit Manager (UM) and an unidentified CNA. The resident required total assistance to change position in the bed. When the resident was rolled to her right side, two stage 2 pressure areas were observed. The first area was on the resident's lower left gluteal, measuring by sight to be approximately 5 cm (centimeters) long and 1 cm wide. A second open area was on the upper left thigh, at the gluteal fold, measuring by sight to be approximately 4 cm long and 1 cm wide. Both	F 0686	**F686: The Facility failed to identity and provide needed care in a timely manner for 1 of 2 for a resident reviewed pressure ulcers.** **1. What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i. Resident #16 without ill effects. Comprehensive wound assessment completed wand protocols followed. **2. how other residents having the potential to be affected by the same deficient practice will be identified and**	08/26/2022

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	areas appeared clean and without drainage or odor. The wound beds appeared to be red in color and both areas appeared to have pink granulation tissue. During an interview, with the UM at this time, she indicated she was unaware the resident had open areas and indicated she thought the resident had redness in the gluteal area. The UM applied DermaPhor ointment to the areas, which had been ordered by the physician on 06/28/2022 to apply to the resident's coccyx and gluteal area 3 times a day. She indicated she would notify the doctor of the areas for further orders and treatment. The record for Resident 16 was reviewed on 08/04/2022 at 4:25 p.m. Diagnosis included, but were not limited to, anxiety disorder, Alzheimer's disease, hypertension, diabetes mellitus, gastro-esophageal reflux disease and atrial fibrillation. The resident was documented to be incontinent of bowel. A physician's order, dated 11/18/2021, indicated "Weekly head to toe skin inspection to completed (sic) per licensed nurse. If any new areas are noted, please complete the change of condition event. Once A Day on Thu (Thursday) 03:00 PM - 11:00 PM". An "Administration History," received from the Clinical Support Nurse (CSN) on 08/10/2022 at 4:37 p.m., indicated the resident had been documented as assessed on 07/14/2022, 07/21/2022, 07/28/2022 and 08/04/2022. The CSN indicated the facility nurses documented "by exception" indicating if the resident was noted to have concerns at the time of the assessment, the nurse would initiate a change of condition. Documentation was lacking		**what corrective action(s) will be taken;** **i.** All residents have the potential to be affected. Full house skin audit will be completed on all residents. Pending assessment, will have all wound documentation completed and supported documentation provided. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i. All licensed nursing staff will be educated on skin care policy, to include timely identification and treatment intervention of skin issues/concerns. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be	

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	a "change of condition" associated with the dates the skin inspections had been completed. The resident's most recent "Observation Detail List Report," with a date of completion of 08/02/2022 was received from the Clinical Support Nurse on 08/10/2022 at 4:37 p.m. The "Skin Risk Assessment" portion of the report indicated the resident required assistance to reposition, moved in a way which could cause friction or shearing, refused care, the resident's skin was often exposed to moisture and the resident had a history of pressure ulcers or other skin conditions. A facility policy, titled "Skin Assessment Policy," dated 02/01/2019 and received on 08/09/2022 at 12:14 p.m. from the CSN, indicated "...is committed to providing quality care to our residents which includes ensuring the completions of thorough skin assessments on admission and throughout the residents' stay...head-to-toe skin assessment completed by a licensed nurse upon admission and weekly thereafter...The nurse doing the assessment will document any abnormal findings affecting the skin...." 3.1-40(a)(1) 3.1-40(a)(2)		established to the auditing process, based upon the results of the audits. **5. by what date the systemic changes for each deficiency will be completed** i. Completed by 8/26/22	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives			

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	adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure medications were not left at the bed side without an order to self-administer medications for 1 of 1 resident randomly observed for accidents. (Resident 58) Finding includes: During an observation, on 08/09/2022 at 11:33 a.m., Resident 58 who was alert and oriented was observed sitting in a lounge chair in her room watching television. Sitting on the resident's bedside table was a plastic medicine cup containing multiple pills and capsules inside. The resident indicated the medications contained in the cup were her morning medications which had been delivered by the nurse earlier in the day. Resident 58 was unable to remember exactly what time the medications had been delivered, but indicated at the time of the administration, she "didn't feel like taking them" due to having an upset stomach. She added the nurse had left the medications and instructed the resident to take them. The record for Resident 58 was reviewed on 08/09/2022 at 12:12 p.m. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease, facial weakness, hyperkalemia (high potassium), gastro-esophageal reflux disease, anxiety disorder, major depressive disorder, hypertensive heart disease, hypothyroidism (low thyroid) and diabetes mellitus. Section C of Resident 58's most recent MDS (Minimum Data Set) assessment, dated 06/14/2022, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15	F 0689	**F689: The facility failed to ensure medications were not left at the bed side without an order to self-administer medications for 1 of 1 resident observed for accidents.** **1. What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i. Resident #58 without ill effects. ii. New order may keep meds at bedside. **2. 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;** i. All residents have the potential to be affected. If meds are observed at bedside medication will be removed and a comprehensive assessment will be conducted. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i. The DON/designee will provide education to all nursing	08/26/2022

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	which indicated the resident was alert and oriented. Documentation was lacking in the record of a physician's order for the resident to self-administer medications, other than the inhalers used by the resident. Review of the physician's orders indicated the resident was ordered to receive the following medications at the morning medication pass: a. Calcium with Vitamin D 500 mg (milligrams) 1 (one) tablet once a day: Upon rising 7:00 a.m. - 11:00 a.m., beginning 02/18/2019. b. Fluoxetine (a medication to treat major depressive disorder) capsule 20 mg 3 (three) capsules once a day; Upon rising 7:00 a.m. - 11:00 a.m., beginning 12/12/2019. c. Thera (multivitamin with folic acid) 400 mcg (micrograms) once a day: Upon rising 7:00 a.m. - 11:00 a.m., beginning 06/10/2021. d. Farxiga (a medication to treat diabetes mellitus) 10 mg 1 tablet once a day: Upon rising 7:00 a.m. - 11:00 a.m., beginning 12/29/2021. e. Folic Acid (for vitamin deficiency) 800 mcg 1 tablet once a day: Upon rising 7:00 a.m. - 11:00 a.m., beginning 02/04/2022. f. Metformin (a medication to treat diabetes mellitus) 1,000 mg 1 tablet twice a day: Upon rising 7:00 a.m. - 11:00 a.m., and before bedtime 6:00 p.m. - 10:00 p.m., beginning 03/03/2022. g. Cholecalciferol (Vitamin D3) 5000 units/125 mcg once a day: Upon rising 7:00 a.m. - 11:00 a.m., beginning 06/17/2022. h. Thera Multivitamin with folic acid 400 mcg 1 tablet Upon rising 7:00 a.m. - 11:00 a.m., beginning 06/10/2021. During an interview, on 08/09/2022 at 12:12 p.m.,		staff on medication administration, to include assessments and orders for self-administration. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audits. **5. by what date the systemic changes for each deficiency will be completed.** i. Completed by 8/26/22	

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	with the Director of Nursing (DON) and Unit Manager (UM), they both indicated it was not the policy of the facility to leave medications in the resident's room unattended. The DON indicated the resident had a physician's order to self-administer her inhaler, however denied the resident had a physician's order to self-administer other medications. The DON identified the medications found unattended in Resident 58's room to be, "calcium with vitamin D 500/5mcq (milliequivalent); Metformin 1000 mg; Tab 2 Vit; Fluoxetine 20 mg (3 tabs); Farxiga 10 mg; Vit B12 1000 mcq; Lovastatin 40 mg; Vit D3 5000 iu/125 mcq and Folic Acid 800 mcg". A facility policy, titled "Medication Administration: General Policies & Procedures," undated and received on 08/10/2022 at 3:55 p.m., indicated "...The nurse or approved designee should always remain with the resident to observe that the medication is swallowed...If a dose of regularly scheduled medication is withheld, refused or spit out, the nurse or approved designee is to initial and circle the initials in the resident's MAR (Medication Administration Record), or electronically document, in the space provided for that dosage administration. An explanatory note is then to be entered on the reverse side of the record in the space provided for e (when necessary) documentation...Residents are not allowed to self-administer any medication unless specifically authorized to do so by the interdisciplinary team (IDT) and the attending physician...." 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition			

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	(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, interview and record review, the facility failed to label the enteral feeding bag with the feeding type and amount for 1 of 1 resident reviewed for tube feeding. (Resident 89) Finding includes: During an observation, on 08/02/22 at 10:09 a.m., the resident's feeding bag did not have a label indicating the feeding type or amount of feeding poured into the bag. The feeding was in a water bag instead of an enteral feeding bag. 800 mls (milliliters) of feeding was in the water bag. The record for Resident 89 was reviewed on 08/02/22 at 11:30 a.m. Diagnoses included, but were not limited to, intracranial injury with loss of	F 0693	**F693: The facility failed to label the enteral feeding bag with the feeding type and amount for 1 of 1 resident reviewed for tube feeding.** **1. What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i. Resident 89 without ill effect. ii. Proper Label was placed on the enteral feeding. **2. how other residents having the potential to be**	08/26/2022

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	consciousness of unspecified duration, sequela, gastrostomy status and abdominal distension (gaseous). A physician's order, dated 05/09/2022, indicated to administer Kate Farms Peptide 1.5 through the feeding pump at a rate of 55 ml/hr (milliliters/hour), flush with water at 45 ml/hr and run for 20 hours (off from 1:00 p.m., to 5:00 p.m.) During an interview, on 08/02/22 at 10:11 a.m., the MDS (Minimum Data Set) Coordinator and the 400/500 Unit Manager were present and indicated the nurse was supposed to label the feeding bag with the formula name, write the amount to be administered, date and time the bag was hung because the feeding was not in the original container. The MDS Coordinator indicated the resident took Kate Farms Peptide 1.5 cal/ml (calories/milliliter) and there was 325 ml in a container. An undated document, titled "Administering an enteral feeding through a GT/OG/NG Tube Skills Validations," provided by the Director of Nursing (DON) on 08/10/2022 at 1:12 p.m., indicated "...Label bag and/or tubing with the date, time, and initials...." During an interview, on 08/10/2022 at 1:12 p.m., the DON indicated the document she provided was the facility's G-Tube Policy which was given to her by the corporate office. There was no other documentation or policy provided at the time of exit. 3.1-44(a)(2)		**affected by the same deficient practice will be identified and what corrective action(s) will be taken;** **iii.** All residents with enteral feeding have the potential to be affected. House wide audit was conducted for all tube feeding containers, no other deficiencies were notified **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** **iv.** All Licensed nursing staff will be educated on medication administration to include enteral feedings and proper labeling. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of	

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			the audits. **5. by what date the systemic changes for each deficiency will be completed.** i. Compliance Date: 8/26/22	
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 observation, interview and record review, the facility failed to label medications with open dates, failed to ensure mediations were	F 0761	**F761: The facility failed to label medications were stored in their original containers, failed**	08/26/2022

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	stored in their original containers, failed to ensure an insulin pen had a legible label and failed to discard a discontinued medication for 4 of 4 medication carts and 2 of 3 medication storage refrigerators reviewed for medication storage. (700 unit, 500 unit, Memory Care unit and the 400 unit) Findings include: 1. During an observation, of the 700-unit front side medication cart, on 08/03/22 at 2:20 p.m., with RN 6 the following were noted: a. One open 5 milliliter (ml) bottle of Tuberculin (a solution used for tuberculosis testing) was found in the top drawer. The bottle was not observed to have an open date on the container. 2. In the 700-unit medication storage refrigerator the following were noted: a. Two open 5 ml bottles of Tuberculin were found stored in the medication refrigerator. The bottles did not have open dates on the containers. b. An open bottle of Ativan (an anti-anxiety medication) was found in the medication storage refrigerator for Resident 63. The bottle did not have an open date on the container. 3. During an observation, of the 500-unit medication cart, on 08/02/22 at 2:33 p.m., with RN 4 the following were noted: a. There were nine single dose packets of metoprolol 100 milligrams (mg) found in the medication cart drawer. The medications did not have a resident name and were not stored in their original container/box.		**to ensure an insulin pen had a legible label and failed to discard a discontinued medication for 4 of 4 medication carts and 2 of 3 medication storage refrigerators reviewed for medication storage.** **1. What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i. All un-dated , discontinued, unlabeled medications were removed from the medication storage areas. **2. 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;** i. All residents have the potential to be affected ii. All medication carts were observed, cleaned out appropriately and all medications were reviewed to ensure proper labeling/dating. Any deficiencies found with medications were properly disposed. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	

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	b. A Humalog insulin pen was found in the medication cart. The label of the insulin pen was not legible and did not contain an open date. c. A Humalog insulin pen for Resident 99 was found open without a date to indicate when the medication had been opened/started. d. A single dose packet of aspirin 81 mg was found in the drawer. The medication did not have a resident's name on it and was not stored in its original container/box. e. A single dose packet of Eliquis (an anti-clotting medication) 5 mg was found in the drawer. The medication did not have a resident's name on it and was not stored in its original container/box. f. A bottle of morphine solution (a narcotic pain reliever) for Resident 53 was found with 18 of 30 ml left in the bottle, open and without a date to indicated when the bottle had been opened. g. A bottle of hydromorphone liquid (a narcotic pain reliever) 1 mg/ml, for Resident 43 was found open without a date to indicated when it had been opened. 4. In the 500-unit medication storage refrigerator the following were noted: a. One bottle of lansoprazole suspension (a medication used for gastric reflux) 3 mg/ml, with 6 ounces remaining, for Resident 89, was found without an open date. b. One bottle of Ativan for Resident 100 was found open without a date to indicated when it had been opened.		i. All licensed nursing staff was educated on medication administration to include medication storage, drug labeling and a clean med cart. Signage will be placed in medication storage areas on proper medication storage protocols. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audits. **5. by what date the systemic changes for each deficiency will be completed.** i. Completed 8/26/22	

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	During an interview, on 08/02/22 at 2:49 p.m., RN 4 indicated medications should have been dated when opened. 5. During an observation of the Memory Care Unit medication cart, on 08/03/22 at 4:33 p.m., with QMA 7 the following were noted: a. A box of glucose control solution, opened, was found stored with the eye drops in the top drawer of the medication cart. b. A round pink pill, without packaging, was found in the bottom of the drawer. c. A small white oval pill, without packaging, was found in the bottom of a drawer. d. A single dose package of clopidogrel 75 mg was found in the drawer. The medication did not have a resident's name and was not stored in its original container/box. e. A single dose package of melatonin 3 mg was found in the drawer. The medication did not have a resident's name and was not stored in its original container/box. During an interview, on 08/03/22 at 10:38 a.m., the Director of Nursing indicated the glucose control solution should have been stored with the glucometer, not the eye drops. 6. During an observation of the 400-unit medication cart, on 08/03/22 at 4:33 p.m., with RN 8 the following were noted: a. A red capsule was found, unpackaged, in the bottom of the drawer.			

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	b. Two single dose packages of Divalproex Delayed Release 250 mg were found in the drawer. The medication did not have a resident's name and were not stored in its original container/box. c. Two single dose package of amitriptyline hydrochloride 25 mg were found in the drawer. The medication did not have a resident's name and was not stored in its original container/box. d. A single dose package of acetaminophen 325 mg was found in the drawer. The medication did not have a resident's name and was not stored in its original container/box. e. Two single dose packages of Meloxicam 15 mg were found in the drawer. The medication did not have a resident's name and was not stored in its original container/box. f. A 5 ml bottle of prednisolone eye drops for Resident 48 was found open. It did not have a date to indicated when the medication had been opened. g. An open bottle of morphine solution 100 mg/5 ml containing 21 ml, for Resident 14 was found open in the narcotic drawer. The bottle did not have a date to indicated when it had been opened. During an interview, on 08/05/22 at 10:40 a.m., the Director of Nursing indicated when liquid medications were opened, they were to be labeled with an open date and discontinued medications were to be discarded. An undated facility policy, titled "Drug Storage," provided by the Director of Nursing on 08/05/22 at 11:05 a.m., indicated "...Medications are to remain in the container in which they are			

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	dispensed...Potentially harmful substances...are stored...separately from medications...Discontinued and expired medications should be removed from medication carts and refrigerators...promptly...Return drugs or destroy...Insulin and other multi-dose injectable vials or pens must be discarded after 28 days...Drugs shall be stored in an orderly manner in cabinets, drawers or carts...Insulin and PPD (TB) vaccine...need to be dated when opened...All vials should be discarded within 28 days of the open date...." An undated facility policy, titled "Medication Labeling," provided by the Director of Nursing on 08/05/22 at 11:05 a.m., indicated "...Medication containers having soiled, damaged, incomplete, illegible or confusing labels are returned to the dispensing pharmacy for re-labeling or are destroyed...." 3.1-25(j) 3.1-25(o)			
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 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			

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	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 pans were thoroughly dried before being stored on a shelf unit, failed to ensure food items were labeled/dated with open dates and failed to identify what was in the containers for 1 of 2 kitchens and 3 of 4 units. (main kitchen, 700 unit, 800 unit and 400 unit) Findings include: During an observation of the main kitchen, unit pantries and the Woodland Kitchen, on 08/02/22 beginning at 9:07 a.m., with the Dietary Manager in attendance four rectangular metal pans were found to have clear fluid inside and on the outside. The pans were stacked on a shelf for storage in the main kitchen. In the 700 Unit pantry refrigerator, a nine-ounce container of jalapeno cheddar dip was found open, half full without a name or date on the container and a clear 32 ounce container with 275 milliliters of red fluid was found without a name or date on the container. In the 800-unit refrigerator, a one-gallon container of whole milk, ¾ full, was found open without an open date. There was also a salad with a zip type storage bag containing a substance on top of the container found in the refrigerator without a name	F 0812	**F812: The facility failed to ensure pans were thoroughly dried before being stored on a shelf unit, failed to ensure food items were labeled/dated with open dates and failed to identify what was in the containers for 1 of 2 kitchens and 3 of 4 units.** **1. What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i. Pans with remining water were re-washed and hand dried. ii. Outdated/unlabeled food items were immediately discarded. **2. 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;** i. All residents have the potential to be affected. Audit	08/26/2022

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	or date and the zip storage bag did not contain a name of the substance it contained, a date or a name. In the 400-unit refrigerator, a 16-ounce bottle of Italian dressing was found open without a date or name and one 340 milliliter bottle of a protein shake was also found without an open date. At the end of the observations of the kitchens and unit food storage areas, the Dietary Manager indicated there should have been names and open dates on the items in the refrigerators and staff was not to store their items in those refrigerators. An undated facility policy, titled "Food and Non-Food Storage," provided by the Administrator on 08/05/22 at 4:46 p.m., indicated "...Foods that have been removed from their original containers are clearly marked with contents, date that package was opened...." A facility policy, titled "Food and Non-Food Storage," dated 2012 and provided by the Administrator on 08/05/22 at 4:46 p.m., indicated "...Subject: Storage of Unused Equipment and Dishware...Dishware and utensils are thoroughly air dried prior to storage...." 3.1-21(i)(3)		of food storage areas/dishware storage areas completed to ensure there are no outdated or unlabeled food items. ii. Audit of all dishware completed to ensure there are no pots or pans that were not completely dry prior to being placed on the storage shelf. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i. Dietary Supervisor or designee will educate dining services staff on the Guidelines for Food Storage, Food Safety and Handling to include drying of dishware and storage of dishware and storage of food for consumption. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial	

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			compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audits. **5. by what date the systemic changes for each deficiency will be completed.** i. Completed 8/26/22	
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 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			

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	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 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.			

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	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 develop and implement written policies and procedures for infection control, to contain the spread of infections and the Covid-19 virus, when the facility failed to ensure staff used the appropriate Personal Protective Equipment (PPE) while in an isolation room for 2 of 2 random observations. (Resident 172 and 69) Findings include: 1. During a random observation, on 08/02/22 at 8:20 a.m., LPN 1 was observed in an isolation room administering medications to Resident 172, wearing a surgical mask only. The room had an isolation bag, stocked, hanging on the door and signs posted on the door indicating PPE to be used when entering the room. Upon her exit from the room, LPN 1 indicated she had asked which residents were in isolation that morning, she did not work on this unit and she was not paying attention. The record for Resident 172 was reviewed on 08/02/22 at 11:21 a.m. Diagnoses included, but were not limited to, weakness, unsteadiness on feet and type 2 diabetes. A physician's order, dated 07/28/22, indicated "...Droplet/contact isolation...." A facility sign posted on Resident 172's door indicated "...STOP...CONTACT PRECAUTIONS EVERYONE MUST...Put on gloves before room entry...Put on gown before room entry...."	F 0880	**F880: The facility failed to develop and implement written policies and procedures for infection control, to contain the spread of infections and the Covid-19 virus, when the facility failed to ensure staff used the appropriate PPE while in an isolation room for 2 of 2 random observations.** **1. What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i. Resident #172, #69 without ill effect. Both residents were on precautionary isolation per CDC guidance. **2. 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;** i. All residents have the potential to be affected. Full house audit was conducted, to include proper signage, orders, care plans. The ED/DON, Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same team will review the Long-Term	08/26/2022

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	A facility sign posted on Resident 172's door indicated "...STOP...DROPLET PRECAUTIONS EVERYONE MUST...Make sure their eyes...are fully covered before room entry...." 2. The record for Resident 69 was reviewed on 08/03/22 at 11:50 a.m. Diagnoses included, but were not limited to, malignant neoplasm of the cervix, chronic obstructive pulmonary disease, anxiety disorder and diarrhea. A physician's order, dated 08/04/2022, indicated contact isolation. All meals, activities, therapy and services must be provided in room with isolation precautions followed. A physician's order, dated 08/05/2022, indicated to obtain stat lab for C-Diff (Clostridium Difficile) and a Urinalysis (UA). A progress note indicated the resident was positive for C-Diff. During an observation, on 08/05/22 at 3:37 p.m., there was a stop sign at the door indicating the resident was on contact isolation. The instruction read, "...Put on gown before room entry, discard gown before room exit...." During an observation, on 08/05/22 at 3:37 p.m., CNA 9 was at the resident's bedside providing peri-care. CNA 9 did not wear a protective gown and her surgical mask was below her nose. During an interview, on 08/05/22 at 3:40 p.m., CNA9 indicated she did not realize the resident was on contact isolation precaution until she entered the room. She should have went back outside and put on a protective gown when she		Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i. All Licensed nursing staff to be educated on infection control practices to include: isolation rooms and appropriate PPE requirements. Nursing leadership to conduct observations on isolation room. ii. Reviewed and or updated infection control practices. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	found out the resident needed peri-care. During an interview, on 08/05/22 at 4:00 p.m., the Executive Director (ED) indicated the only time staff was allowed to go into the resident's room without PPE was if they were in isolation and an emergency would arise. The ED indicated the CNA was supposed to go back outside to put a protective gown on when she realized the resident needed peri-care. During an interview, on 08/08/22 at 11:00 a.m., the Director of Nursing (DON) indicated the resident tested positive for C-Diff, had started treatments and would continue to be on contact isolation precautions. A facility policy, titled "CarDon PPE COVID-19 Quick Reference Guide (ORG)," updated on 02/25/22 and provided by the Director of Nursing on 08/02/22 at 11:33 a.m., indicated "...Admission/Re-Admission/Known Exposure with Contact Tracing...Door Signage: PPE DON/DOF CDC...Contact Precautions Droplet Precautions Yellow Isolation...Wear standard N95...Gown use...Wear Gown, Goggle/Face Shield, Gloves...N95 masks will be utilized in Yellow and Red areas...Face Shield or Goggles must be worn by healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident when...Caring for a Resident in a yellow zone that is a new admission or re-admission...." A facility policy, titled "Cardon Infection Control Precautions," dated as effective 10/2014 and provided by the DON on 08/10/2022 at 1:12 p.m., indicated "...A gown and gloves must be worn at all times while tending to the resident in contact isolation if any contact is going to made with the resident or the environment...."		compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audits. **5. by what date the systemic changes for each deficiency will be completed.** i. Completed 8/26/22	

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	A facility policy, titled "Clostridium Difficile (C-Diff) Policy," dated as effective 6/6/2019 and provided by the DON on 08/10/2022 at 1:12 p.m., indicated "...PPE must be used when handling residents with C-Diff or any environmental object in the resident's room...." This Federal tag relates to Complaint IN00379657. 3.1-18 (b)			