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	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NOBLE SENIOR LIVING AT FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00376038, IN00377129, IN00377576, IN00377585, IN003781355, and IN00381592. Complaint IN00376038 Substantiated no deficiencies related to the allegations are cited. Complaint IN00377129 Substaniated deficiencies related to the allegations are cited at R0243 Complaint IN00377576 Substaniated no deficiencies related to the allegations are cited Complaint IN00377585 Substantiated related to the allegations are cited at R0040 Complaint IN00381355 Substantiated related to the allegations are cited at R0243 Complaint IN00381592 Substntiated no deficiencies realted to the allegations are cited. Survey dates: May 31, June 1 and 2, 2022 Facility number: 012288 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quallity review completed June 6, 2022.	R 0000		
R 0040 Bldg. 00	410 IAC 16.2-5-1.2(o)(1-3) Residents' Rights - Noncompliance (o) Residents have the right to form and			

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

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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	participate in a resident council, and families of residents have the right to form a family council, to discuss alleged grievances, facility operation, residents ' rights, or other problems and to participate in the resolution of these matters as follows: (1) Participation is voluntary. (2) During resident or family council meetings, privacy shall be afforded to the extent practicable unless a member of the staff is invited by the resident council to be present. (3) The licensee shall provide space within the facility for meetings and assistance to residents or families who desire to attend meetings.			
	Based on observation, interview, and record review the facility failed to resolve concerns related to elevator safety for 1 of 5 resident council minutes reviewed. Findings include: An interview with Maintenance Director, on 5/31/22 at 9:16 AM, indicated two elevators were not operable. The Maintenance Director indicated the company they had contracted came out on Friday and repaired elevator two but an order was required to obtan a part for elevator one. The maintenance director further indicated the service elevator was not operating at this time. The Maintenance director indicated the service elevator had been inoperable for 2 months. All services, residents, visitors, and emergency personnel were using elevator two. This resulted in some extended wait times. An interview with QMA 2, on 5/31/22 at 11:10 AM, indicated the elevators were rarely both in operation at the same time, one or the other was	R 0040	Elevator operation will be discussed daily in the morning meeting Educated staff and residents to report to the ED/Maintenance Director/DON when the elevator/s are down Educated resident on the need to adhere to the stipulated number of people riding the elevator when we are down to one elevator. Staff will be assigned to monitor residents for safety during riding of the elevator when only one elevator is operational, and document on a monitor sheet for observations and compliance When elevators are down, visual check will be completed to monitor the elevator daily for 4 weeks, then weekly for 4 months or until both elevators are in full operation. All staff will be educated on the process.	07/01/2022

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	broken. Currently elevator one and the service elevator were not working. QMA 2 indicated the residents have difficulty being patient as many were trying to come for meds, meals, and going to smoke at the same time of day. In an interview on 5/31/22 at 10:56 AM, QMA 4 indicated she was physically shoved at one time causing back pain. QMA 4 further indicated there were several behaviors while waiting for an elevator. QMA 2 and QMA 4 indicated it was difficult to pass medications in a timely fashion waiting for an elevator took up to 45mins and there were several floors to go to administer medications. The med cart cannot take the stairs. An observation, on 5/31/22 at 9:22 AM, indicated elevator one's numbers were moving and showing the same number as elevator number 2. There was signage on each floor indicating only one motorized chair could be on elevator at a time, one manual wheelchair, and a total of four people at once. No staff were present on elevator to ensure safety. An observation on 5/31/22 at 9:20 AM indicated four residents were waiting on floor 3 for the elevator. No staff was present on the elevator to ensure safety. An observation on 5/31/22 at 10:10AM indicated three residents were waiting on floor 8 for the elevator, one being a motorized wheelchair. No staff were present on the elevator to ensure safety. An observation on 5/31/22 at 10:32 indicated the same resident in a motorized wheelchair was waiting for the elevator Since the 10:10 AM observation. No staff were present on elevator to		The ED/Designee will audit the monitor sheet when the elevator/s is down every day until the elevator function is restored Results will be sent to Continuous Quality Product Management (CQPM) monthly for the next six months for review and recommendations until compliance is achieved	

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	ensure safety. An observation on 5/31/22 at 12:18 PM indicated six residents were waiting near the elevator on the 1st floor, 2 men were disagreeing loudly in regard to who was going to get onto elevator. One of the gentlemen was complaining due to waiting an extended period and could not continue to wait there with his walker while the other gentleman was sitting in a wheelchair and therefore could wait with less difficulty. The gentleman with the manual wheelchair indicated he was there first and therefore he was getting on first. The loud dicussion continued and the man with the manual wheelchair entered the elevator when it arrived. The man with the walker was not able to enter at the time due to the elevator was full. There was no staff intervention during this loud discussion, although three staff were at the desk within hearing distance. No staff was present on the elevator to ensure safety. A record review of coordination between the company contracted to service the elevators and the facility provided by the Administrator on 6/1/22 at 1:10PM indicated there were eleven visits in the month of May for elevator repairs. The Administrator indicated it was difficult to keep elevators in operation due to their age and difficulty obtaining parts by the company. A record review of grievances from the last 60 days, on 6/2/22 at 10:10AM provided by Social Services 6 indicated no grievances had been filed directly related to the elevators. A record review of resident council minutes for the last 6 months, on 6/2/22 at 10:28 AM provided by Social Services 6, indicated two specific discussions regarding the elevator.One was a			

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	specific request for a staff member to be on the elevator to keep residents safe. The community follow up did not have a date. The follow up indicated it was a good idea and they would have staff on the elevator the following day as well, additionally they would ask people with motorized wheelchairs to park them on the first floor and use manual wheelchairs. The follow up was signed by the Administrator. The second specific mention of elevators in resident council was the following month on 5/10/22, The form indicated old business; elevator- one was broken down. The resolution listed was the Administrator wrote a follow up regarding suggestions for the elevator. There was no indication or documentation the problem was resolved. A policy, titled "Grievances 8:26-4 provided by DON on 6/2/22 at 1:28PM, indicated to provide a structure and forum for residents to voice complaints and seek their resolution without fear of reprisal .... encourages residents and families to express their complaints about Spring Oak and to suggest remedies or improvements ...Spring Oaks shall try to be responsive to reasonable concerns and suggestions .... B. if the Administrator is unable to effect the desired change to resolve the matter to the resident's satisfaction, and/or the Board of Directors/Owner .... This State citation is relaated to complaint IN00377585.			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:			

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	(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review the facility failed to ensure fire drills were conducted quarterly on second and third shift for a 6 month time period . Findings include: A record review began on 5/31/2022 at 11:16 AM, fire drill report form. The form indicated a fire drill was conducted on 1/4/2022 at 10:50 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. Record review on 5/31/2022 at 11:25 AM, fire drill report form. The form indicated a fire drill was conducted on 2/9/2022 at 11:00 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift.	R 0092	Scheduled fire drill for the year that includes each shift for each quarter Educated the maintenance Director on the need to conduct a fire drill on each shift, once a month for the whole calendar year and documented on the fire drill sheet and CQPM for tracking The ED/designee will audit the fire drill logs every month for the next six months until 100 % compliance is achieved Results will be sent to the Continuous Quality Product Management (CQPM) monthly for the next six months for review and recommendations until compliance and recommendations	07/01/2022

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	Record review on 5/31/2022 at 11:35 AM, fire drill report form. The form indicated a fire drill was conducted on 3/10/2022 at 10:45 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. Record review on 5/31/2022 at 11:45 AM, fire drill report form. The form indicated a fire drill was conducted on 4/5/2022 at 11:00 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. Record review on 5/31/2022 at 11:50 AM, fire drill report form. The form indicated a fire drill was conducted on 5/10/2022 at 9:00 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. In an interview on 5/31/2022 at 9:16 AM, the Maintenance Director indicated this was all the fire drills that had been completed in the past year. A current facility policy, Fire Drill Schedule, was provided by Social Services on 6/2/2022 at 10:47 AM. The policy indicated..."Fire drills will occur on a monthly basis. They will be rotated on each shift so there are 4 drills per year on each shift...."			
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			

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	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 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 have a certified first aid staff member on site at all times for 11 of 21 shifts reviewed. Findings included: A record review of the facility nursing staff schedules, began on 6/1/2022 at 2:51 PM. The scchedules indicated on 5/30/2022, there was not a certified first aid staff member for first shift, second shift and third shift. Review of the facility nursing staff schedule, indicated on 5/30/2022, there was not a staff member who was Cardiopulmonary resuscitation (CPR) certified working on second shift. Review of the facility nursing staff schedule, indicated on 5/31/2022, indicated there was not a certified first aid staff member for second shift and	R 0117	Audited the employee files for CPR and 1st Aid Instituted a tracker for CPR and 1st Aid renewal and will also be tracked on the CQPM sheet Set up an event on the outlook calendar to remind BMO/DON/ADON and staff about CPR and 1st aid renewal Scheduled training for CPR Upon hiring all nursing and administration must possess the BLS Certification prior to completion of hire to ensure 100% compliance is achieved. The ED/BOM/DON/ADON/Designee will audit the employee files for CPR and 1st Aid currency every month for the next six months	07/01/2022

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	third shift. Review of the facility nursing staff schedule, indicated on 6/1/2022, indicated there was not a certified first aid staff member for second shift and third shift. Review of the facility nursing staff schedule, indicated on 6/1/2022, there was not a staff member who was CPR certified working on second shift and third shift. Review of the facility nursing staff schedule, indicated on 6/2/2022, indicated there was not a certified first aid staff member for second shift and third shift. Review of the facility nursing staff schedule, indicated on 6/2/2022, there was not a staff member who was CPR certified working on second shift and third shift. In an interview on 6/1/2022 at 2:45 PM the Administrator indicated the schedules were the only documentation available for review. He indicated thes facility does not have a policy, and they followed the state guidelines.		until 100 % compliance is achieved Results will be sent to the Continuous Quality Product Management (CQPM)for compliance and recommendations	
R 0147 Bldg. 00	410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on interview and record review the facility failed to ensure fire drills were conducted quarterly on second and third shift for a 6 month time period .	R 0147	Scheduled fire drill for the year that includes each shift for each quarter Educated the maintenance Director on the need to conduct a	07/01/2022

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	Findings include: A record review began on 5/31/2022 at 11:16 AM, fire drill report form. The form indicated a fire drill was conducted on 1/4/2022 at 10:50 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. Record review on 5/31/2022 at 11:25 AM, fire drill report form. The form indicated a fire drill was conducted on 2/9/2022 at 11:00 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. Record review on 5/31/2022 at 11:35 AM, fire drill report form. The form indicated a fire drill was conducted on 3/10/2022 at 10:45 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. Record review on 5/31/2022 at 11:45 AM, fire drill report form. The form indicated a fire drill was conducted on 4/5/2022 at 11:00 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. Record review on 5/31/2022 at 11:50 AM, fire drill report form. The form indicated a fire drill was conducted on 5/10/2022 at 9:00 AM on first shift. There was no other fire drill documentation available for review to indicated fire drill had been conducted on second or third shift. In an interview on 5/31/2022 at 9:16 AM, the Maintenance Director indicated this was all the fire drills that had been completed in the past year.		fire drill on each shift, once a month for the whole calendar year and documented on the fire drill sheet and CQPM for tracking The ED/designee will audit the fire drill logs every month for the next six months until 100 % compliance is achieved Results will be sent to the Continuous Quality Product Management (CQPM) monthly for the next six months for review and recommendations until compliance and recommendations	

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	A current facility policy, Fire Drill Schedule, was provided by Social Services on 6/2/2022 at 10:47 AM. The policy indicated..."Fire drills will occur on a monthly basis. They will be rotated on each shift so there are 4 drills per year on each shift...."			
R 0149 Bldg. 00	410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on record review and interview the facility failed to ensure adequate pest control in 19 rooms and one common area affecting 19 of 84 residents residing in the facility. Findings include: A review of the maintenance work order log from January 2022 to present, received from the SSD (social service director) on 5/31/22 at 2:03PM, indicated the following work orders: Regarding Bed Bugs on the following dates: 1/3/22 room 615. 1/12/22 room 909 1/12/22 room 1209 1/13/22 room 704 1/24/22 room 505 2/1/22 room 710 2/2/22 room 1218 2/2/22 room 704 2/8/22 room 505 2/21/22 room 906 2/23/22 room 609 3/29/22 room 81`2 4/20/22 room 416	R 0149	Retained the extermination services to routinely inspect and treat for bed bugs and roaches – treatment set for 6/22/2022 Maintenance department will monthly inspect all apartments and common areas, document all inspections and requests for exterminations. Setup a resident treatment request for bed bugs/roaches Exterminator will continue to maintain the treatment log Educated nursing staff and housekeeping staff on the need to report beg bug/Roaches/roaches activity and document in the treatment request log. The ED/designee will audit the maintenance inspection log, extermination request log and the extermination log every month for the next 6 months until 100 % compliance is achieved Results will be sent to the Continuous Quality Product Management (CQPM) every month	07/01/2022

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	5/24/22 room 1220 Regarding Roaches on the following dates: 1/3/22 room 711 1/21/22 room 717 1/23/22 room 914 2/8/22 room 1218 2/9/22 room 901 2/14/22 room 1007 2/14/22 room 9th floor sitting area A review of the records from professional pest control company, received on 6/1/22 at 4:28 PM from Maintenance Director, indicated in the past year the company treated the facility on the following dates 11/12/21, 11/26/21, 11/30/21, 12/9/21, 12/22/21, 1/14/21, and 1/28/21. In an interview with the Maintenance Director on 6/1/22 at 4:32 PM, he indicated these were the only professional services that have been given in the last year. The maintenance director indicated prior to 11/12/21 the maintenance department was doing all the pest control. The maintenance director indicated they did have a company specific to bed bug treatment come out one time in the last year to heat treat 4 rooms. The maintenance director did not have a copy of the invoice or any documentation of the visit. A policy titled "Insect Infestation Control" B-460, provided by Maintenance Director on 6/1/22 at 4:28 PM, indicated... Policy statement: A contracted professional exterminator is retained for routine treatment monthly basis .... If unusual insects (roaches or bed bugs) are sighted, staff should immediately report the location to maintenance..maintenance staff is responsible for contacting the exterminator for a visit to treat and		for the next 6 months for review and recommendations until compliance is achieved	

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	or identify the type of insect. Maintenance staff, and other staff directed by maintenance, will follow the instructions provided by the exterminator			
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 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 interview and record review, the facility failed to ensure signed service plans were completed for 5 of 5 residents. Residents B, C, 2, 3,	R 0217	Service provider will be increasing the speed of the internet services to ensure continuous connectivity	07/01/2022

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		A. BUILDING 00 B. WING	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NOBLE SENIOR LIVING AT FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

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	and 4. Findings include: 1. Resident B's record review began on 5/31/2022 at 10:15 AM. Diagnoses included acute bronchitis. There were no signed service plan available for review. 2. Resident C's record review began on 5/31/2022 at 10:30 AM. Diagnoses included, type 2 diabetes mellitus with hyperglycemia. There was no signed service plan available for review. 3. Resident 2's record review began on 5/31/2022 at 10:45 AM. Diagnoses included, type 2 diabetes mellitus with diabetic neuropathy.There was no signed service plan available for review. 4. Resident 3's record review began on 5/31/2022 at 11:25 AM. Diagnoses included , essential primary hypertension. There was no signed service plan available for review. 5. Resident 4's record review began on 5/31/2022 at 11:45 AM. Diagnoses included, major depressive disorder, recurrent mild. There was no signed service plan available for review. In an interview on 6/1/2022 at 4:28 PM, the Director of Nursing, indicated the facility did not have any of the service plans signed by residents. A current facility policy, Resident Service Plans, was provided by the Director of Nursing on 6/22/2022 at 1:29 PM. The policy indicated..."The resident shall participate in and, if the resident agrees, family members shall be invited to participate in, the development of the resident service plan, if plans are needed. Participation		– appointment set for 6/23/2022 Service plans for all residents will be reviewed by resident/representative review and signed by 7/1/2022 Educated the DON/ADON on the need to have services plans reviewed and signed when there is a change in condition and every month for the next 6 months in order to meet the state guide lines, until 100 % compliance is achieved Results will be sent to the Continuous Quality Product Management (CQPM) for compliance and recommendations	

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	shall be documented on the resident's record...." 410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.			
R 0243 Bldg. 00	Based on interview, observation and record review the facility failed to administer medications as ordered for 2 of 5 residents reviewed. (Resident B and Resident 2) Findings include: In an observation and interview, on 5/31/22 at 10:54AM, QMA 4 (Qualified Medical Assistant) was preparing to take blood sugars and administer insulin for multiple residents. QMA 4 was unable to pull up the MAR (medication administration record) in the computer due to the internet was not available. QMA 4 indicated they had a sheet with residents' sliding scale insulin orders to go off of when the computer was not available. The orders were typed by a nurse when the computer was available. QMA 4 was unable to determine the date these orders were typed onto this document. In an observation, QMA 2 was administering medication to Resident 2, on 5/31/22 at 11:17AM. She indicated she was unable to verify medication, time the medication was to be given, the route medication was to be administered, and the ordered dose of the medications. The	R 0243	Consulted with the pharmacy consultant to set up an emergency binder that will have updated 60-day medication list and hard copy Mar and Tar, and progress notes sheets in the event of no internet connection Educated DON/ADON and nursing staff on the need to utilize the emergency binder The ED/DON/ADON will audit the emergency binder to ensure that it is up to date every month for the next 6 months until 100% compliance is achieved Results will be sent to the Continuous Quality Product Management (CQPM) for compliance and recommendations	07/01/2022

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	medication packaging had been opened prior to administration. The packaging indicated medication name, dose, and Resident 2's name. There were 2 medications in the package. The medication given to Resident 2 at 11:17AM had been ordered to be given at 1PM. In an interview on 5/31/22 at 11:18 AM, QMA 2 indicated she took a controlled substance from the original package and put it in the routine package. QMA 2 was able to indicate the name of the medication, but she was unable to verify the time the medication was to be given and the dose of the medication. QMA 2 indicated the routine medications were delivered weekly on Thursdays. QMA 2 indicated when they arrived the 3 QMA's on the schedule put them away in the carts. When asked how the medications were verified to be correct medication, correct dose, correct time, and correct resident, QMA 2 indicated the name of the resident was on the top of the card the medication comes on and the medications were separated by morning, afternoon, evening, and bedtime doses. QMA 2 was unable to find a back up MAR in case the computer was not available. QMA 2 indicated the computer was down about 70% of the time. In an interview on 5/31/22 at 11:46AM, QMA 4 indicated there were no MARs printed to check the orders for medications in case the computers were unavailable. QMA 4 indicated she did not work at the facility full time. QMA 4 indicated she had worked on medication delivery day, and the medications were put away by residents' names. QMA 4 indicated they did not check medications in from pharmacy by checking medication in the package with current orders for the medication. 1. Resident B's record review began on 6/1/22 at 3:00PM Diagnosis included acute bronchitis and			

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	encounter for other specified aftercare. A review of Resident B's orders, Lyrica count sheets, and May 2022 MAR provided by DON on 6/1/22 at 4:09 PM. The review indicated Resident B had an order to give Anaspaz every 6 hours as needed. Resident B had 4 medications ordered for pain management, 2 medications ordered for insomnia, and 2 medications ordered for constipation. Resident B's controlled drug use record and MAR were compared. The following was noted: On 5/31/22 The noon and bedtime dose of Lyrica was not signed out on count sheet and was marked as given in MAR. The MAR had no documentation of Lyrica given on following dates and times but had been signed out as given on count sheet: 5/4/22 morning and afternoon (count sheet indicated given at 8am and 2pm) 5/11/22 morning and afternoon (count sheet indicated given at 8am and 2pm) 5/12/22 morning and afternoon (count sheet indicated given at 8am and 2pm) 5/13/22 morning and afternoon (count sheet indicated given at 8am and 2pm) 5/26/22 morning and afternoon (count sheet indicated given at 8am and 2pm) 5/27/22 morning and afternoon (count sheet indicated given at 8am and 2pm) 5/29/22 morning and afternoon (count sheet indicated given at 8am and 2pm) 5/30/22 morning and afternoon (count sheet indicated given at 8am and 2pm) 2. Resident 2's record review began on 6/1/22 at 4:10 PM. Diagnosis included paranoid schizophrenia, anxiety disorder, and chronic pain disorder.			

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	A copy of Resident 2's MAR dated May 2022 and Lyrica count sheets were provided by the DON on 6/1/22 at 4:09PM. The MAR dated May 2022 had the following dates and times without documentation of the medication given: 5/4/22 8a and 1400 (2pm) 5/5/22 2PM 5/9/22 2000 (8pm) 5/11/22 8am and 2pm 5/12/22 8am and 2pm 5/13/22 8am and 2pm 5/26/22 8am and 2pm 5/27/22 8AM 5/29/22 8am and 2pm 5/30/22 8am and 2pm The controlled drug use record from the pharmacy indicated the following had been signed out: 3/11/22 only 2 doses of Lyrica 1PM and 8PM 3/18/22 only 2 doses of Lyrica 8AM and 8PM 3/21/22 4 doses 8AM, 2PM, 2PM and 8PM (2PM signed out as given twice) 3/26/22 only 1 was documented 8AM (none at 2PM and 8PM) 4/11/22 only 2 were documented 2PM and 8PM 4/18/22 only 8PM 4/21/22 only 8PM 4/27/22 only 8PM 5/13/22 only 8PM A policy provided by the DON on 5/31/22 at 11:10AM, titled "Medication Assistance" did not indicate a process for receiving, documenting, and administering medications. This State citation is related to complaints IN00377129, and IN00381355			

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R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure a pharmacy regimen review was completed for 5 of 5 residents reviewed. Residents B, C, 2, 3, and 4. Findings include: 1. Resident B's record review began on 5/31/2022 at 10:15 AM. Diagnoses included, acute bronchitis. There was no pharmacy regiman review available for review. 2. Resident C's record review began on 5/31/2022 at 10:30 AM. Diagnoses included, type 2 diabetes mellitus with hyperglycemia. There was no pharmacy regiman review available for review. 3. Resident 2's record review began on 5/31/2022 at 10:45 AM. Diagnoses included, type 2 diabetes mellitus with diabetic neuropathy. There was no pharmacy regiman review available for review.	R 0298	Formulated the Pharmacy and Regimen review policy Reviewed the pharmacy products and services agreement to include the frequency of review (every 60 days) The Pharmacy consultant, DON and the ADON will be educated on the pharmacy regime review regulation by 7/2/2022 The pharmacy will provide a regiment review every 60 days with an exception report. The Administrator/DON/ADON/designee will audit all resident pharmacy reviews monthly for the next 6 months until 100% compliance is achieved Results will be sent to the Continuous Quality Product Management (CQPM)for	07/01/2022

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	4. Resident 3's record review on 5/31/2022 at 11:25 AM. Diagnoses included , essential primary hypertension. There was no pharmacy regiman review available for review. 5. Resident 4's record review on 5/31/2022 at 11:45 AM. Diagnoses included, major depressive disorder, recurrent mild. There was no pharmacy regiman review available for review. In an interview on 6/1/2022 at 3:16 PM, the Director of Nursing (DON), indicated she called the pharmacy regarding the pharmacy reviews, the pharmacy told the DON they are suppose to be done every sixty days. But the pharmacy indicated they only came to the facility once. The pharmacy could not give the DON any information about the date they were in the facility, whose review had been completed or what the outcome was. The DON indicated she could not find the pharmacy reviews. In an interview on 6/1/2022 at 4:28 PM, the DON indicated the pharmacy woould be in the facility on 6/7/202. The DON indicated the pharmacy reviews were unable to be located, she could not find any. A current facility policy, Consultant Pharmacist Service, was provided by the DON on 6/2/2022 at 2:09 PM. The policy indicated..."Review the medication regimen of each resident at least quarterly to identify any potential or actual drug-related problems, including, untreated indicated, improper drug selection, sub therapeutic dosage, failure to receive drugs, overdose, adverse drug reactions (ADR's), drug interactions and drug use without indications...."		compliance and recommendations	

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R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to maintain a current, emergency file for 5 of 5 residents reviewed. Residents B, C, 2, 3, and 4. Findings include: 1. Resident B's record review began on 6/1/2022 at 10:15 AM. Diagnoses included, acute bronchitis. There was no emergency file available for review. 2. Resident C's record review began on 6/1/2022 at 10:30 AM. Diagnoses included, type 2 diabetes mellitus with hyperglycemia. There was no emergency file available for review. 3. Resident 2's record review began on 6/1/2022 at 10:45 AM. Diagnoses included, type 2 diabetes mellitus with diabetic neuropathy. There was no	R 0356	All resident files will be audited for emergency contact information by 7/2/2022 Added the emergency contact list to the admission check list Educated the Sales Director/BOM/DON/ADON/Social Worker/Nursing staff on the emergency contact information and documenting it on the resident chart The Administrator/DON/BOM/designee will audit all resident files for emergency contact information every month for 4 months until 100% compliance is achieved Results will be sent to the	07/01/2022

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	emergency file available for review. 4. Resident 3's record review began on 6/1/2022 at 11:25 AM. Diagnoses included , essential primary hypertension. There was no emergency file available for review. 5. Resident 4's record review on 6/1/2022 at 11:45 AM. Diagnoses included, major depressive disorder, recurrent mild. There was no emergency file available for review. In an interview on 6/1/2022 at 12:07 PM, the Director of Nursing (DON) indicated she did not know what the emergency file was, where it was located, or what it consisted of. She indicated the facility did not have a policy to have one.		Continuous Quality Product Management (CQPM) monthly for the next 4 months for review and recommendations until compliance is achieved	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on record review and interview the facility failed to ensure plans were developed in cooperation with the mental health provider for residents diagnosed with major mental illness for 3	R 0383	Formulated the Mental Health Screening policy All resident files will be audited for mental health diagnosis/screening	07/01/2022

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	of 5 residents reviewed. (Resident C, Resident 4, and Resident 2) Findings include: 1. Resident C's record review began on 6/1/22 at 9:13 AM. Diagnoses included post-traumatic stress disorder, borderline personality disorder, generalized anxiety disorder, major depressive disorder, recurrent severe without psychotic features. No service plan regarding major mental illness was available for reivew. During an interview on 5/31/22 at 1:24 PM, Resident C indicated she met regularly with a case manager from Park Center. No documentation of communication with the resident's mental health provider was found. 2. Resident 4's record review began on 6/1/22 at 10:45 AM. Diagnoses included major depressive disorder, recurrent, mild, unspecified dementia without behavioral disturbances, post-traumatic stress disorder.No service plan regarding major mental illness was available for reivew. No documentation of communication with the resident's mental health provider was found. 3. Resident 2's record review began on 6/1/22 at 11:30 AM. Diagnoses included paranoid schizophrenia.No service plan regarding major mental illness was available for reivew. No documentation of communication with the resident's mental health provider was found. In an interview on 6/2/22 at 1:26 PM, the Director of Nursing (DON) indicated some residents had		and comprehensive care plan by 7/2/2022 Educated DON/ADON/Sales manager/Social Worker on the Mental health Screening Policy, for the need to have a mental health screening pre-admission and a comprehensive care plan upon admission Educated mental health service providers for the need of coordination of care in regards to documentation The ED/DON/designee will audit all files for residents with mental illness for pre-admission Mental Health Screening, admission comprehensive care plans and mental health service providers' communication every month for the next 6 months until 100% compliance is achieved. Results will be sent to the Continuous Quality Product Management (CQPM) for compliance and recommendations	

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	mental health services provided by agencies outside the facility. The DON indicated there was no communication between the facility and the mental health care providers. She indicated no mental health screens were found for any resident in the facility.			