STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Complaints IN00441570, IN00441712, IN00442755, and IN00442598. This visit was in conjunction with the Post-Survey revisit (PSR) to Complaint IN00435623 completed on June 27, 2024 and the PSR to Complaints IN00439316, IN00439663, and IN00439706 completed on August 15, 2024. Complaint IN00441570 - No deficiencies related to the allegations are cited. Complaint IN00441712 - No deficiencies related to the allegations are cited. Complaint IN00442755 - No deficiencies related to the allegations are cited. Complaint IN00444298 - No deficiencies related to the allegations are cited. Complaint IN00435623 - Corrected Complaint IN00439316 - Corrected Complaint IN00439663 - Corrected Complaint IN00439706 - Corrected Survey dates: September 5, 6, 9, 10, 11, and 12, 2024 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 118 Residential: 9 Total: 127	F 0000	Allegation of Compliance Please accept the following plan of correction for the annual survey that was completed on 9/12/2024. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jesse	Ray	09/20/2024

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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	Census Payor Type: Medicare: 11 Medicaid: 65 Other: 42 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 17, 2024.			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, interview and record review, the facility failed to ensure a resident was provided a bed and mattress that could accommodate his height comfortably for 1 of 69 resident beds observed for accommodation of needs. (Resident 60). Findings include: During an observation on 9/6/24 at 9:16 a.m., Resident 60 did not have enough room in the bed to move up, and his feet were touching the footboard. His head was all the way to the top of the mattress. During an observation on 9/10/24 at 9:50 a.m., the resident's feet were touching the foot of the bed. The resident indicated he could not even turn over in this bed. RN 5 was present in the resident's room and observed the resident's feet touching the footboard. RN 5 indicated the blisters to the resident's feet were healed and proceeded to uncover the resident's feet and assessed the skin. No blisters were observed. She indicated she did not know if the resident's bed could be extended, but his feet definitely touched	F 0558	1 On 9/11/24, the Maintenance Director adjusted the footboard to extend the bed length and provide the resident 60 with more space and comfort. 2 Residents that are taller than 72 inches have the potential to be affected by the alleged deficient practice. On 9/16/24, the Maintenance Director and Unit Manager interviewed residents that were 72 inches or taller and audited their respective beds to verify that the standard 80-inch beds in each residents' room provided sufficient space at the head and footboard. Any bed adjustments needed were corrected immediately. 3 On 9/17/24, the Executive Director provided education to the maintenance staff to maintain sufficient space for residents in facility beds and make accommodations to lengthen or widen beds as needed.	09/18/2024

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	the foot board. During an observation on 9/11/24 at 10:46 a.m., the resident's feet were observed touching the foot board of the bed. The record for Resident 60 was reviewed on 9/7/24 at 1:32 p.m. The resident's diagnoses included, but were not limited to, abnormal posture, pain in the right shoulder, muscle weakness, low back pain, abnormal gait and mobility and paraplegia. The Quarterly MDS (Minimum Data Set) assessment, dated 3/17/24, indicated the resident was cognitively intact. The nurse's note, dated 8/15/23 at 3:43 p.m., indicated while staff helped with repositioning the resident there was a discolored area to the resident's outer right foot. The measurements were obtained at 2 cm (centimeters) by 4 cm by 0 cm. The wound appeared to be red and white skin over the area. The wound had a blood blister like appearance. Resident 60's feet were pressed against the foot board of the bed and the resident was all the way up in the bed. Immediately a foam wedge was placed under the resident's knees and lower extremities which raised the foot of the bed to remove his feet off the foot board. The nurse notified the immediate supervisor and the NP (Nurse Practitioner). During an interview on 9/6/24 at 9:18 a.m., Resident 60 indicated his bed was too small and his feet touched the footboard. He had told the staff, but nothing had been done. During an interview on 9/10/24 at 9:45 a.m., the Maintenance Director indicated he thought the resident's bed could be switched out for another		4 The Executive Director and/or Maintenance Director will audit at least five (5) resident beds to verify sufficient space is maintained for residents needing reasonable accommodations weekly for four (4) weeks and then at least weekly for no less than two (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	bed. He was not aware there was a problem with the size of the bed. 3.1-3(v)(1)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review, and interview, the facility failed to ensure documentation on the Controlled Drug Receipt/Record/Disposition Form of administered narcotics for 12 of 64 residents observed for medication storage in the 500, 400, and 800 Hall medication carts. (Residents 32, 76, 96, 45, 20, 58, 219, 87, 218, 43, 15, and 77) Findings include: 1. During an observation on 9/9/24 at 8:56 a.m. of the 500 Hall medication cart, the following were identified: Resident 32's tramadol 50 mg (milligrams) Controlled Drug Receipt/Record/Disposition Form had a count of 6 tablets left. The resident's medication card contained 5 tablets of the tramadol. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 9:15 a.m. The record review on 9/10/24 at 1:20 p.m., the physician's order, dated 8/28/24, indicated the resident received the tramadol 50 mg daily for pain. The review of the resident's September MAR (Medication Administration Record) indicated the resident's last dose of tramadol 50 mg was administered on 9/9/24 at 8:00 a.m., by LPN	F 0755	1. Residents 32, 76, 96, 45, 20, 58, 219, 87, 218, 43, 15, and 77 continue to reside at the facility and controlled medications continue to be administered as ordered. There were no negative outcomes resulting from the alleged deficient practice. 2. Residents that receive controlled medications have the potential to be affected by the alleged deficient practice. On 9/16/24, Nursing Administration reviewed and reconciled controlled medication count sheets to the medication administration record to determine if any other residents had been affected by the alleged deficient practice for a 30 day look back period. 3. Beginning on 9/13/24, licensed nurses and qualified medication assistants were educated by the Staff Development Coordinator regarding the 9 Rights of Medication Administration, with emphasis on the required documentation of controlled medications at the time of administration. 4. The Director of Nursing and/or Unit Managers will complete	09/18/2024

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	(Licensed Practical Nurse) 6. During an interview on 9/9/24 at 8:57 p.m., LPN 6 indicated she should sign out narcotics when she pulled them. 2. During an observation on 9/9/24 at 9:09 a.m. of the 400 Hall medication cart, the following was observed: a. Resident 76's oxycodone/APAP (acetaminophen) oxycodone/APAP 10/325 mg Controlled Drug Receipt/Record/Disposition Form had a count of 4 tablets left. The resident's medication card contained 3 tablets of the oxycodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 9:00 p.m. The record review on 9/10/24 at 1:26 p.m., the physician's order, dated 8/26/24, indicated the resident received the oxycodone/APAP 10/325 mg two times daily for back pain. The resident's September MAR indicated the resident's last dose of the oxycodone/APAP 10/325 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. Resident 76's diazepam 5 mg Controlled Drug Receipt/Record/Disposition Form had a count of 6 tablets left. The resident's medication card contained 5 tablets of the diazepam left. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 9:00 p.m. The record review on 9/10/24 at 1:26 p.m., the physician's order, dated 8/26/24, indicated the resident received the diazepam 5 mg two times		medication competencies with at least five (5) licensed nurses and/or qualified medication assistants to verify completion of required documentation of controlled medications at the time of administration. These audits will be completed weekly for four (4) weeks and then at least weekly for no less than two (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	daily for anxiety. The resident's September MAR indicated the resident's last dose of the diazepam 5 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. b. Resident 96's hydrocodone/APAP 5/325 mg Controlled Drug Receipt/Record/Disposition Form had a count of 22 tablets left. The resident's medication card contained 21 tablets of the oxycodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 9:00 p.m. The record review on 9/10/24 at 1:29 p.m., the physician's order, dated 8/30/24, indicated the resident received the oxycodone/APAP two times daily for pain. The resident's September MAR indicated the resident's last dose of the oxycodone/APAP 5/325 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. c. Resident 45's hydrocodone/APAP 5/325 mg Controlled Drug Receipt/Record/Disposition Form had a count of 30 tablets left. The resident's medication card contained 29 tablets of the oxycodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was not documented. The record review on 9/10/24 at 1:34 p.m., the physician's order, dated 8/26/24, indicated the resident received the oxycodone/APAP 5/325 mg two times daily for pain. The resident's September MAR indicated the resident's last dose of the oxycodone/APAP 5/325 mg was administered on 9/8/24 at 9:08 a.m., by			

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	LPN 4. d. Resident 20's hydrocodone/APAP 7.5/325 mg Controlled Drug Receipt/Record/Disposition Form had a count of 26 tablets left. The resident's medication card contained 25 tablets of the oxycodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 9:00 p.m. The record review on 9/10/24 at 1:37 p.m., the physician's order, dated 9/6/24, indicated the resident received the oxycodone/APAP 7.5/325 mg two times daily for pain. The resident's September MAR indicated the resident's last dose of the oxycodone/APAP 7.5/325 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. Resident 20's lacosamide 200 mg Controlled Drug Receipt/Record/Disposition Form had a count of 7 tablets left. The resident's medication card contained 6 tablets of the oxycodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 9:00 p.m. The record review on 9/10/24 at 1:39 p.m., the physician's order, dated 8/9/24, indicated the resident received the lacosamide 200 mg two times daily for seizures. The resident's September MAR indicated the resident's last dose of the lacosamide 200 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. e. Resident 58's hydrocodone/APAP 10/325 mg Controlled Drug Receipt/Record/Disposition Form had a count of 1 tablet left. The resident's			

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	medication card contained 0 tablets of the hydrocodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/6/24 at 8:00 a.m. The record review on 9/10/24 at 1:37 p.m., the physician's order, dated 8/9/24, indicated the resident received the hydrocodone/APAP 10/325 mg every 6 hours as needed for chronic pain. The resident's September MAR indicated the resident's last dose of the hydrocodone/APAP 10/325 mg was discontinued on 8/9/24 and the last dose given was on 9/7/24 at 10:30 a.m., by LPN 11. Resident 58's hydrocodone/APAP 10/325 mg Controlled Drug Receipt/Record/Disposition Form had a count of 25 tablets left. The resident's medication card contained 24 tablets of the hydrocodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 9:00 p.m. The record review on 9/10/24 at 1:40 p.m., the physician's order, dated 8/9/24, indicated the resident received the hydrocodone/APAP 10/325 mg every 6 hours as needed for chronic pain. The resident's September MAR indicated the resident's last dose of the hydrocodone/APAP 10/325 mg was administered on 9/8/24 at 9:11 p.m., by LPN 12. The medication was later discontinued on 9/10/24, but continued to be administered on 9/10/24 at 6:05 a.m., 9/11/24 at 6:00 a.m., and 7:46 p.m. f. Resident 219's tramadol 50 mg (milligrams) Controlled Drug Receipt/Record/Disposition Form had a count of 27 tablets left. The resident's medication card contained 26 tablets of the			

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	tramadol. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 8:00 p.m. The record review on 9/10/24 at 1:46 p.m., the physician's order, dated 9/6/24, indicated the resident received the tramadol 50 mg two times daily for pain. The review of the resident's September MAR indicated the resident's last dose of tramadol 50 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. g. Resident 87's tramadol 50 mg Controlled Drug Receipt/Record/Disposition Form had a count of 8 tablets left. The resident' medication card contained 7 tablets of the tramadol. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 5:00 p.m. The record review on 9/10/24 at 1:48 p.m., the physician's order, dated 7/2/23, indicated the resident received the tramadol 50 mg two times daily for pain. The review of the resident's September MAR indicated the resident's last dose of tramadol 50 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. h. Resident 218's oxycodone/APAP 7.5/325 mg Controlled Drug Receipt/Record/Disposition Form had a count of 16 tablets left. The resident's medication card contained 15 tablets of the oxycodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/9/24 at 4:00 a.m.			

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	The record review on 9/10/24 at 1:51 p.m., the physician's order, dated 9/3/24, indicated the resident received the oxycodone/APAP 7.5/325 mg every 4 hours for pain. The resident's September MAR indicated the resident's last dose of the oxycodone/APAP 7.5/325 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. i. Resident 43's tramadol 50 mg Controlled Drug Receipt/Record/Disposition Form had a count of 10 tablets left. The resident' medication card contained 8 tablets of the tramadol. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 8:00 p.m. The record review on 9/10/24 at 1:48 p.m., the physician's order, dated 9/19/23, indicated the resident received the tramadol 50 mg two tablets three times daily for pain. The review of the resident's September MAR indicated the resident's last dose of two tablets of tramadol 50 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. j. Resident 15's tramadol 50 mg Controlled Drug Receipt/Record/Disposition Form had a count of 28 tablets left. The resident' medication card contained 26 tablets of the tramadol. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 8:00 p.m. The record review on 9/10/24 at 1:53 p.m., the physician's order, dated 8/26/24, indicated the resident received the tramadol 50 mg two tablets two times daily for pain.			

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	The review of the resident's September MAR indicated the resident's last dose of two tablets of tramadol 50 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. k. Resident 77's oxycodone 5 mg Controlled Drug Receipt/Record/Disposition Form had a count of 14 tablets left. The resident's medication card contained 13 tablets of the oxycodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 8:00 p.m. The record review on 9/10/24 at 1:51 p.m., the physician's order, dated 8/30/24, indicated the resident received the oxycodone 5 mg two times daily for back pain. The resident's September MAR indicated the resident's last dose of the oxycodone 5 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4. During an interview on 9/9/24 at 9:30 a.m., LPN 4 indicated he had not signed out the narcotics upon administration. He should mark the narcotics as he gave the medications. During an interview on 9/9/24 at 9:53 a.m., QMA (Qualified Medication Aide) 7 indicated she should sign out narcotics as she gave them. During an interview on 9/10/24 at 11:10 a.m., the DON (Director of Nursing) indicated the nurse should sign out the narcotic on the sheet once the medication was given. They do that to keep track of the number of narcotics remaining. The Controlled Substances policy, revised April 2019, included, but was not limited to, " ... 5.			

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	Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift ... 9. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together ..." 3.1-25(b)(1)(c)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure discontinued and expired medications were promptly disposed of during 4 of 7 observations of medication storage. (Medication Carts 300, 400, 800, and Medication Room 900) Findings include: 1. During an observation on 9/9/24 at 9:35 a.m. of the 300 Hall medication cart, 2 unused boxes of naloxone hydrochloride with an expiration date of September 2023 were in a drawer in the cart. The boxes had no resident name on them. 2. During an observation on 9/9/24 at 9:09 a.m. of the 400 Hall medication cart, the following concerns were identified: a. Resident 2's discontinued lubricating plus eye drops, with an expiration date of August 2024 were in the drawer. b. Resident 36's Lantus flexpen indicated no open date. There was only 80 units of insulin in the pen. During an interview on 9/9/24 at 9:10 a.m., LPN	F 0761	1 1. The Director of Nursing properly discarded the medication that was identified during the survey on that was past the expiration date and the medication that was discontinued was discarded appropriately. 2 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. Medication carts and medication storage rooms were audited for proper labeling and storage by Nursing Administration on 9/13/24. Any corrective action needed was completed immediately. 3 3. Beginning on 9/13/24, licensed nurses and qualified medication assistants were educated by the Staff Development Coordinator on properly storing and labeling medications and the procedure for discarding improperly stored, labeled and expired supplies. This education is also to be reviewed	09/18/2024

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	155668	A. BUILDING 00 B. WING	09/12/2024

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	(Licensed Practical Nurse) 4 indicated the nurse probably forgot to mark the open date, they should write the date on the pen when it was opened. 3. During an observation on 9/9/24 at 10:04 a.m. of the 800 Hall medication cart, the following concerns were identified: a. Resident 80's tiotropium bromide 2.5 mcg (micrograms) per actuation indicated to discard after 10/19/23. b. An unlabeled vial of Spiriva 2.5 mcg was sitting in a drawer without a box. c. An unlabeled vial of Albuterol 2.5 mg (milligrams) was sitting in a drawer without a box. d. An unlabeled vial of Spiriva 2.5 mcg was sitting in a drawer without a box. e. Resident 86's 2 boxes of Symbicort had no label on the box or vial to indicate the expiration date. f. Resident 25's Lispro flexpen indicated an open date of June 2024 on the bag. There was 55 units of insulin left in the pen. The Lispro flexpen was expired 28 days after opening. 4. During an observation on 9/9/24 at 11:24 a.m. of the 900 Hall medication room, the following concerns were identified: a. Resident 47's formoterol inhalant, received November 13, 2023, for 7 days of administration was located in the refrigerator. The medication had an expiration date of July 31, 2024. b. Resident 78's 2 bags of micafungin 150 mg per		during new hire job specific training. 4 4. The Assistant Director of Nursing and/or Unit Manager will audit medication rooms and medication carts for proper labeling and storage of medications and validate the removal of expired medications three (3) times a week for four (4) weeks and continue weekly for no less than two (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	100 mL intravenous medication were located in the refrigerator. They were received on 8/30/24 and had a use by date of 9/3/24. The resident no longer received this medication. During an interview on 9/9/24 at 9:10 a.m., LPN 4 indicated expired or discontinued medications were usually taken to the manager and they were picked up by the pharmacy company. During an interview on 9/9/24 at 9:37 a.m., LPN 5 indicated the nurse or QMA (Qualified Medication Aide) should return discontinued medications to the pharmacy before they expired. During an interview on 9/9/24 at 10:07 a.m., QMA 9 indicated she got the RN to administer insulin to the residents. At this time, RN 10 indicated she should look at the open date on the insulin before administering it. During an interview on 9/9/24 at 11:29 a.m., LPN 8 indicated the expired or discontinued medications should be sent back to pharmacy at the time of completion of the medication or the ADON (Assistant Director of Nursing) or DON (Director of Nursing) should be given the medication to destroy if it was expired. During an interview on 9/10/24 at 10:30 a.m., the DON indicated the medication carts, and the medication room refrigerators were checked for expired or discontinued medications two to three times weekly for the need for removal. During an interview on 9/10/14 at 10:45 a.m., the DON indicated the naloxone was dropped off by the health department, so it didn't have a name. They still should have been removed from the medication cart due to the expiration date.			

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	The Discarding and Destroying Medications policy, revised April 2019, included, but was not limited to, "Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances ... 1. All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of ... 3 ... individual resident medications supplied in sealed unopened containers may be returned to the issuing pharmacy for disposition ..." 3.1-25(k)(6) 3.1-25(o)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure kitchen equipment, ceiling vents and the kitchen floor were free from food debris and grease build up for 3 of 3 kitchen observations. This deficiency had the potential to affect 118 residents who received meal trays from the kitchen. Findings include: 1. During the initial tour with the Dietary Manager and the Regional District Manager on 9/5/24 at 8:55 a.m., the following concerns were identified: - One of two ceiling air vents in the dry storage room had gray substance around the vent. The middle slats of the grate cover of the second air vent had a heavy coating of gray dust on the grate.	F 0812	1. On 9/12/24, the equipment and vents in the kitchen identified during the survey were thoroughly cleaned and the two items identified in the walk-in refrigerator were discarded immediately upon identification. 2. All residents have the potential to be affected by the alleged deficient practice. All other dietary equipment and ceiling vents were reviewed by the Executive Director on 9/12/24 to verify sanitation and cleanliness. 3. On 9/16/24, the Dietary Manager provided re-education to dietary staff regarding thorough cleaning and sanitation of equipment and ceiling vents as	09/18/2024

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	- The walk-in refrigerator had a container of hot dogs on the shelf had a 9/1/24 open date with a 9/3/24 use by date. A container of baked apples had an open date of 9/1/24 with a use by date of 9/1/24. Two sandwiches on a tray had a date of 9/1/24 when they were made with a use by date of 9/4/24. - There was a heavy build up of yellow grease streaks which ran down both sides of the fryer and left side of the steamer. - The top and front of both steamers and the shelves underneath them had a heavy build up of yellow grease with food particles. - There were multiple burnt black spots inside the bottom of both ovens. - There was a heavy build up of burnt black food particles on the stove top burners and around them. - The toaster had a heavy build up of crumbs in the tray below the wire rack. - The wall behind the fryer had yellow and white streaks which ran half way down the wall to the floor. - There were two floor tiles against the wall by the steamer and the fryer that had a build up of white and black wet substance on the tiles. 2. During an observation at 11:30 a.m. with the Dietary Manager and the Regional District Manager, the following concerns were identified: - the same areas of concerns identified at 8:55 a.m. were again present. 3. During an observation on 9/9/24 at 2:00 p.m. while accompanied by the Regional Dietary Manager, the following concerns were identified: - One of two ceiling air vents in the dry storage room had gray substance around the vent. The		assigned and proper discarding of food after use by date. 4. The Executive Director and/or Dietary Manager will audit to verify food is properly discarded after use by date and that ceiling vents and kitchen equipment are sanitized and cleaned appropriately at least (3) days a week for (4) weeks and then at least weekly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	middle slats of the grate cover of the second air vent had a heavy coating of gray dust on the grate. - There was a heavy build up of yellow grease streaks, which ran down both sides of the fryer and left side of the steamer. The Regional Dietary Manager indicated that the fryer did make a mess. - The top and front of both steamers and shelves underneath them had a heavy build up of yellow grease with food particles. - There were multiple burnt black spots in the bottom of both ovens. - There was a heavy build up of burnt black food particles on the stove top burners and around them. - The toaster had a heavy build up of crumbs in the tray below the wire rack. - The wall behind the fryer had yellow and white streaks which ran half way down the wall to the floor. - A small pan had hot dogs sitting in water in the closed "Hot Box" that went to the dementia unit for lunch. During an interview with the Regional Dietary Manager on 9/11/24 at 11:30 a.m., he indicated he had been fighting to get those stove burners clean for a very long time. They were hard to clean. The staff usually would eat the hot dogs for lunch after the residents were finished. On 9/11/24 at 11:15 a.m., the Dietary Manager presented a copy of the cleaning schedule for 8/18/24 through 9/8/24 which indicated the following: - Clean fryer (filter/boil out as needed) marked as completed on 9/1/24. - Clean Oven (doors/top/inside) a name was marked on the schedule but was not completed.			

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	- Clean stove (stove eyes and catch tray) a name was on the schedule but was not completed. - Steamer (Delime, Top and Sides) marked as completed on 9/1/24. Review of the facility's current policy dated revised 9/2017 on Equipment, included, but was not limited to, "Policy Statement: All food service equipment will be clean, sanitary, and in proper working order. Procedures: 1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. 2 All staff members will be properly trained in the cleaning and maintenance of all equipment. 3. All food contact equipment will be cleaned and sanitized after every use. 4. All non-food contact equipment will be clean and free of debris..." A second current policy on Equipment also dated revised 9/2017, included, but was not limited to, "Policy Statement: All food preparation areas, food service areas, and dining areas will be maintained in a clean and a sanitary condition. Procedures: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces. 3. All food contact surfaces will be cleaned and sanitized after each use. 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces..." 3.1-21(i)(3)			

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00441570, IN00441712, IN00442755, and IN00442598. This visit was in conjunction with the Post-Survey revisit (PSR) to Complaint IN00435623 completed on June 27, 2024 and the PSR to Complaints IN00439316, IN00439663, and IN00439706 completed on August 15, 2024. Survey dates: September 5, 6, 9, 10, 11, and 12, 2024 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Residential Census: 9 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 17, 2024.	R 0000	Allegation of Compliance Please accept the following plan of correction for the annual survey that was completed on 9/12/2024. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency Based on observation, record review, and interview, the facility failed to ensure documentation on the Controlled Drug Receipt/Record/Disposition Form of administered narcotics for 2 of 2 residents observed for medication storage in the Residential 100 Hall	R 0243	1. Residents 3 and 5 continue to reside at the facility and controlled medications continue to be administered as ordered. There were no negative outcomes resulting from the alleged deficient	09/18/2024

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	medication cart. (Residents 3 and 5) Findings include: During an observation on 9/9/24 at 9:50 a.m., of the 100 Hall medication cart the following concerns were identified: 1. Resident 3's tramadol 25 mg (milligrams) Controlled Drug Receipt/Record/Disposition Form had a count of 28 tablets left. The resident's medication card contained 27 tablets of the tramadol. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 8:00 p.m. The review on 9/10/24 at 2:15 p.m., of the physician's order, dated 6/18/24, indicated the resident received the tramadol 25 mg three times daily for hip pain. The resident's September MAR (Medication Administration Record) indicated the resident's last dose of the tramadol 25 mg was administered on 9/9/24 at 8:00 a.m., by QMA (Qualified Medication Aide) 7. 2. Resident 5's pregabalin 200 mg Controlled Drug Receipt/Record/Disposition Form had a count of 8 tablets left. The resident's medication card contained 7 tablets of the oxycodone/APAP. The last dose signed out on the Controlled Drug Receipt/Record/Disposition Form was on 9/8/24 at 8:00 p.m. The review on 9/10/24 at 2:18 p.m., of the physician's order, dated 8/28/24, indicated the resident received the pregabalin 200 mg two times daily for fibromyalgia.		practice. 2. Residents that receive controlled medications have the potential to be affected by the alleged deficient practice. On 9/16/24, Nursing Administration reviewed and reconciled controlled medication count sheets to the medication administration record to determine if any other residents had been affected by the alleged deficient practice for a 30 day look back period. 3. Beginning on 9/13/24, licensed nurses and qualified medication assistants were educated by the Staff Development Coordinator regarding the 9 Rights of Medication Administration, with emphasis on the required documentation of controlled medications at the time of administration. 4. The Director of Nursing and/or Unit Managers will complete medication competencies with at least five (5) licensed nurses and/or qualified medication assistants to verify completion of required documentation of controlled medications at the time of administration. These audits will be completed weekly for four (4) weeks and then at least weekly for no less than two (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance	

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	The resident's September MAR indicated the resident's last dose of the pregabalin 200 mg was administered on 9/9/24 at 8:00 a.m., by QMA 7. During an interview on 9/9/24 at 9:53 a.m., QMA 7 indicated she should sign out narcotics as she gave it. During an interview on 9/10/24 at 11:10 a.m., the DON (Director of Nursing) indicated the nurse should sign out the narcotic on the sheet once the medication was given. They do that to keep track of the number of narcotics remaining. The Controlled Substances policy, revised April 2019, included, but was not limited to, " ... 5. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift ... 9. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together ..."		Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to ensure kitchen equipment, ceiling vents and the kitchen floor were free from food debris and grease build up for 3 of 3 kitchen observations. This deficiency had the potential to affect 9 of 9 Residential residents who received meal trays from the kitchen. Findings include: 1. During the initial tour with the Dietary Manager and the Regional District Manager on 9/5/24 at 8:55 a.m., the following concerns were identified:	R 0273	1 On 9/12/24, the equipment and vents in the kitchen identified during the survey were thoroughly cleaned and the two items identified in the walk-in refrigerator were discarded immediately upon identification. 2 All residents have the potential to be affected by the alleged deficient practice. All other dietary equipment and ceiling vents were reviewed by the Executive Director on 9/12/24 to	09/18/2024

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	- One of two ceiling air vents in the dry storage room had gray substance around the vent. The middle slats of the grate cover of the second air vent had a heavy coating of gray dust on the grate. - The walk-in refrigerator had a container of hot dogs on the shelf had a 9/1/24 open date with a 9/3/24 use by date. A container of baked apples had an open date of 9/1/24 with a use by date of 9/1/24. Two sandwiches on a tray had a date of 9/1/24 when they were made with a use by date of 9/4/24. - There was a heavy build up of yellow grease streaks which ran down both sides of the fryer and left side of the steamer. - The top and front of both steamers and the shelves underneath them had a heavy build up of yellow grease with food particles. - There were multiple burnt black spots inside the bottom of both ovens. - There was a heavy build up of burnt black food particles on the stove top burners and around them. - The toaster had a heavy build up of crumbs in the tray below the wire rack. - The wall behind the fryer had yellow and white streaks which ran half way down the wall to the floor. - There were two floor tiles against the wall by the steamer and the fryer that had a build up of white and black wet substance on the tiles. 2. During an observation at 11:30 a.m. with the Dietary Manager and the Regional District Manager, the following concerns were identified: - the same areas of concerns identified at 8:55 a.m. were again present.		verify sanitation and cleanliness. 3 On 9/16/24, the Dietary Manager provided re-education to dietary staff regarding thorough cleaning and sanitation of equipment and ceiling vents as assigned and proper discarding of food after use by date. 4 The Executive Director and/or Dietary Manager will audit to verify food is properly discarded after use by date and that ceiling vents and kitchen equipment are sanitized and cleaned appropriately at least (3) days a week for (4) weeks and then at least weekly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	3. During an observation on 9/9/24 at 2:00 p.m. while accompanied by the Regional Dietary Manager, the following concerns were identified: - One of two ceiling air vents in the dry storage room had gray substance around the vent. The middle slats of the grate cover of the second air vent had a heavy coating of gray dust on the grate. - There was a heavy build up of yellow grease streaks, which ran down both sides of the fryer and left side of the steamer. The Regional Dietary Manager indicated that the fryer did make a mess. - The top and front of both steamers and shelves underneath them had a heavy build up of yellow grease with food particles. - There were multiple burnt black spots in the bottom of both ovens. - There was a heavy build up of burnt black food particles on the stove top burners and around them. - The toaster had a heavy build up of crumbs in the tray below the wire rack. - The wall behind the fryer had yellow and white streaks which ran half way down the wall to the floor. - A small pan had hot dogs sitting in water in the closed "Hot Box" that went to the dementia unit for lunch. During an interview with the Regional Dietary Manager on 9/11/24 at 11:30 a.m., he indicated he had been fighting to get those stove burners clean for a very long time. They were hard to clean. The staff usually would eat the hot dogs for lunch after the residents were finished. On 9/11/24 at 11:15 a.m., the Dietary Manager presented a copy of the cleaning schedule for 8/18/24 through 9/8/24 which indicated the			

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	155668	A. BUILDING 00 B. WING	09/12/2024

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	following: - Clean fryer (filter/boil out as needed) marked as completed on 9/1/24. - Clean Oven (doors/top/inside) a name was marked on the schedule but was not completed. - Clean stove (stove eyes and catch tray) a name was on the schedule but was not completed. - Steamer (Delime, Top and Sides) marked as completed on 9/1/24. Review of the facility's current policy dated revised 9/2017 on Equipment, included, but was not limited to, "Policy Statement: All food service equipment will be clean, sanitary, and in proper working order. Procedures: 1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. 2 All staff members will be properly trained in the cleaning and maintenance of all equipment. 3. All food contact equipment will be cleaned and sanitized after every use. 4. All non-food contact equipment will be clean and free of debris..." A second current policy on Equipment also dated revised 9/2017, included, but was not limited to, "Policy Statement: All food preparation areas, food service areas, and dining areas will be maintained in a clean and a sanitary condition. Procedures: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces. 3. All food contact surfaces will be cleaned and sanitized after each use. 4. The			

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	Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces..."			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance Based on observation and interview, the facility failed to ensure discontinued and expired medications (Resident 3) were promptly disposed of during 1 of 5 observations of medication storage. (Residential 100 Hall Medication Cart) Findings include: During an observation on 9/9/24 at 9:50 a.m. of the 100 Hall medication cart, Resident 3's morphine 20 mg (milligrams) per 5 mL (milliliters) was received on 6/10/24. The Controlled Drug Receipt/Record/Disposition Form indicated a D/C (Discontinued). The medication bottle had a discontinuation date of August 2024. The review on 9/10/24 at 2:40 p.m., of the physician's order, dated 7/10/24, indicated morphine sulfate 20 mg/mL 5 mg every 4 hours as needed for pain. The August and September 2024 MAR (Medication Administration Record) indicated the resident had not received the morphine. During an interview on 9/9/24 at 9:37 a.m., LPN (Licensed Practical Nurse) 5 indicated the nurse or QMA (Qualified Medication Aide) should return discontinued medications to the pharmacy before they expire. During an interview on 9/9/24 at 9:50 a.m., QMA 7 indicated the resident's morphine was	R 0306	1. The Director of Nursing properly discarded the medication that was identified during the survey on that was past the expiration date and the medication that was discontinued was discarded appropriately. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. Medication carts and medication storage rooms were audited for proper labeling and storage by Nursing Administration on 9/13/24. Any corrective action needed was completed immediately. 3. Beginning on 9/13/24, licensed nurses and qualified medication assistants were educated by the Staff Development Coordinator on properly storing and labeling medications and the procedure for discarding improperly stored, labeled and expired supplies. This education is also to be reviewed during new hire job specific training. 4. The Assistant Director of Nursing and/or Unit Manager will audit medication rooms and medication carts for proper labeling and storage of	09/18/2024

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	discontinued in August 2024. During an interview on 9/9/24 at 11:29 a.m., LPN 8 indicated expired or discontinued medications should be sent back to pharmacy at the time of completion of the medication or the ADON (Assistant Director of Nursing) or DON (Director of Nursing) should be given the medication to destroy if it was expired. During an interview on 9/10/24 at 10:30 a.m., the DON (Director of Nursing) indicated the medication carts, and the medication room refrigerators were checked for expired or discontinued medications two to three times weekly for the need of medication removal. The Discarding and Destroying Medications policy, revised April 2019, included, but was not limited to, "Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances ... 1. All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of ... 3 ... individual resident medications supplied in sealed unopened containers may be returned to the issuing pharmacy for disposition ..."		medications and validate the removal of expired medications three (3) times a week for four (4) weeks and continue weekly for no less than two (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	