STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RETREAT AT THE STRATFORD, THE	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 9, 10, 13 and 14, 2023 Facility number: 011151 Provider number: 155794 Census Bed Type: SNF/NF: 13 Residential: 22 Total: 35 Census Payor Type: Medicare: 4 Other: 9 Total: 13 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 20, 2023.	F 0000	This Plan of Correction represents The Retreat at the Stratford allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorna Ray	Care Services Administrator	04/03/2023

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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	medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on interview and record review, the facility failed to update advanced directives upon admission for 1 of 4 residents reviewed for advanced directives. (Resident 13) Finding includes: The Face Sheet for Resident 13 indicated the	F 0578	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident 13 no longer lives in the community. How the facility will identify other residents having the potential to	04/28/2023

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	resident was a Full Code for advance directive status. A care plan indicated Resident 13 had a Full code status on admission to the facility. An "Internal Medicine Progress Note," dated 10/26/22 at 12:06 p.m., indicated Resident 13's code status was DNR (do not resuscitate), and DNI (do not intubate). During an interview, on 03/14/23 at 11:05 a.m., the Executive Director (ED) indicated upon admission normally the social worker would update the code status. During an interview, on 03/14/23 at 11:19 a.m., the Social Worker indicated the facility did not have the updated code status in the record. The family and Resident 13 had changed Resident 13's code status during the last hospital visit. During an interview, on 03/14/23 at 1:34 p.m., the ED indicated upon admission to the skilled nursing center Resident 13's code status was not addressed. A current policy, titled "Advance Directives," received from the ED on 3/14/23 at 2:34 p.m., indicated "...The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment...Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his legal representative, about the existence of any written advance directives...." 3.1-4(f)(5)		be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. SSD audited all resident medical records for accuracy of documented code status. Resident records found to be accurate. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: SSD will meet with all new admission/return admission to obtain code status and add any updates. SSD will discuss code status during care plans. Any update will require new POST form. POST forms will be uploaded into medical records to ensure accuracy. SSD will be educated on Advance Directive policy. Don or designee will audit new admission medical records within 72 hours of admission to ensure medical record has code status entered. Audits will continue weekly x 4 weeks, then every 2 weeks x 2 months, then monthly until 100% compliance is achieved. Review will be ongoing. SNF nursing staff including but not limited to LPN, RN, CNA will be educated on Advance Directive and CPR policy. How the corrective actions will be	

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			monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The SSD or designee will record any changes in code status and discuss in monthly QAPI Committee for review and recommendation until 100% compliance is met. Any recommendation made by the committee will be followed up by the SSD or designee.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer.			

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	At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to provide documentation to show the bed-hold policy was provided to 1 of 1 resident reviewed for bed-hold policy notification. (Resident 11) Finding includes: The record for Resident 11 was reviewed on 03/09/23 at 12:00 p.m. Diagnoses included, but were not limited to, heart failure, anemia, and hypertension. A nursing note, dated 12/21/22, indicated Resident 11 was sent to the hospital for intravenous therapy (IV fluids). There was no note or assessment found in the record indicating the resident or responsible party was provided a bed hold policy at the time of transfer or within 24 hours of the transfer. A nursing note, dated 01/24/23, indicated Resident 11 was sent to the emergency room for the evaluation and treatment of a low hemoglobin (a protein in the red blood cells which carries oxygen to the organs and tissues of the body). There was no note or assessment found in the record indicating the resident or responsible party was provided a bed hold policy at the time of transfer or within 24 hours of the transfer. During an interview, on 03/09/23 at 9:18 a.m., LPN	F 0625	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident 11 returned to the community. No corrective actions needed at this time. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. SSD was educated on bed-hold policy on 3-14-23. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: SSD or designee will provide written information regarding bed-hold policy to residents and family members at admission. SSD or designee will provide written information regarding bed-hold policy to residents and family members within 24 hours of transfer. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be	04/28/2023

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	2 indicated when a resident was sent out of the facility, they were to be provided with the bed hold policy. A facility policy, titled "Bed-Holds and Returns," dated as revised in October 2022 and provided by the Executive Director on 03/14/23 at 1:30 p.m., indicated "...All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence...Residents regardless of payer source, are provided written notice about these policies...notice...well in advance of any transfer (e.g., in the admission packet); and...notice...at the time of transfer (or, if the transfer was an emergency, within 24 hours)...." 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)		put into place Don or designee will audit weekly, medical records of all transfers to ensure documentation of bed-hold review is documented in the medical record. Audits will be conducted weekly x 4 weeks, then every 2 weeks x 2 months, then monthly until 100% compliance is met. Results of audits will be brought and discussed in monthly QAPI Committee for review and recommendation until 100% compliance is met. Any recommendation made by the committee will be followed up by the SSD or designee.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and			

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	(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on interview and record review, the facility failed to develop a comprehensive care plan related discharge planning and the use of psychoactive medications for 2 of 6 residents reviewed for comprehensive care plans. (Resident 9 and 11) Findings include:	F 0656	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident 9 no longer resides in the community. Resident 11 had comprehensive care plan updated on 3-15-23. How the facility will identify other	04/28/2023

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	1. The record for Resident 9 was reviewed on 03/10/23 at 3:36 p.m. Diagnoses included, but were not limited to, impaired mobility, and Parkinson's disease. The resident did not have a discharge goal care planned as part of the comprehensive care. During an interview, on 03/14/23 at 10:37 a.m., the Executive Director indicated Resident 9 discharged to another facility due to financial reasons, initially Resident 9 was to be long term care. During an interview, on 03/14/23 at 3:27 p.m., the Vice President of Clinical (VPC) indicated a care plan should have been developed anticipating the resident's needs after a Medicare Part A (care in a skilled nursing facility, hospice care, and some home health care) stay was completed. 2. The record for Resident 11 was reviewed on 03/10/23 at 1:25 p.m. Diagnosis included, but were not limited to, mild protein malnutrition, cognitive communication deficit, and dysphagia (difficulty swallowing). A physician's order, initiated on 02/24/23, indicated to give mirtazapine (an antidepressant) 30 milligrams (mg) once a day for anorexia (an abnormal loss of the appetite for food). There was no care plan addressing the use of the antidepressant mirtazapine off label use for anorexia, or the side effects to monitor for during the use of the medication. During an interview, on 03/14/23 at 3:33 p.m., the VPC indicated a care plan should have been developed for the use of an antidepressant for		residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Audit of all residents residing on skilled nursing was conducted for discharge care plans and psychotropic care plans. Residents without discharge care plan had one initiated. No other concerns noted for psychotropic care plans. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: DON and MDS coordinator will be educated on policy “Care Plans, Comprehensive Person-Centered” How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place DON or designee will audit residents’ medical records weekly for discharge care plans. DON or designee will audit medical records of residents on psychotropic medication for psychotropic care plan. Audits will be conducted weekly x 4 weeks, then every 2 weeks x 2 months, then monthly until 100% compliance is met. Administrator or designee will review audits weekly to ensure	

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	anorexia. A facility policy, titled "Care Plans, Comprehensive Person-Centered," dated as revised March 2022 and provided by the Executive Director on 03/14/23 at 3:32 p.m., indicated "...The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...The comprehensive, person-centered care plan...describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing...includes the resident's state goals upon admission and desired outcomes...Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change...." 3.1-35(a)		compliance. Results of audits will be brought and discussed in monthly QAPI Committee for review and recommendation until 100% compliance is met. Any recommendation made by the committee will be followed up by the SSD or designee.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to maintain and store oxygen equipment for 1 of 3 residents reviewed for oxygen use. (Resident 10)	F 0695	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:	04/28/2023

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	Finding includes: During an observation, on 03/09/23 at 10:18 a.m., Resident 10's nasal cannula (device for putting oxygen into the nasal passage) and tubing was lying on top of the oxygen concentrator in Resident 10's room and dated 3/3. During an observation, on 03/10/23 at 8:24 a.m., Resident 10's nasal cannula and tubing was lying on top of the oxygen concentrator in Resident 10's room and dated 3/3. During an observation, on 03/10/23 at 2:37 p.m., Resident 10's nasal cannula and tubing was lying on top of the oxygen concentrator in Resident 10's room and dated 3/3. During an observation, on 03/13/23 at 8:33 a.m., Resident 10's nasal cannula and tubing was lying on top of the oxygen concentrator in Resident 10's room and dated 3/3. During an observation and interview, on 03/13/23 at 8:39 a.m., Licensed Practical Nurse (LPN) 1 observed Resident 10's oxygen tubing and nasal cannula lying on the oxygen concentrator and indicated it was just sitting on the oxygen concentrator. The oxygen tubing and nasal cannula had not been changed and the date on the tubing was 3/3 and it was greater than 1 week after date. The oxygen tubing and cannula should be changed weekly. The record for Resident 10 was reviewed. Diagnoses included, but were not limited to, respiratory failure unspecified with hypoxia (low oxygen level in blood).		Resident 10 no longer resides in the community. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. All residents receiving oxygen had nasal cannula and tubing replaced. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: DON, RCD and nursing staff will be educated on policy "Department (Respiratory Therapy) -Prevention of Infection" How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place DON or designee will audit weekly the oxygen tubing on all residents requiring oxygen. Audit will include location of tubing and date of changing. Audits will be conducted weekly x 4 weeks, then every 2 weeks x 2 months, then monthly until 100% compliance is met. Any items found to be out of compliance will be immediately changed and education will be provided to staff. Administrator or designee will	

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	A physician's order, dated 2/25/23, indicated oxygen (O2) at 1 L/min (liter per minute) per nasal cannula 3 times daily. A care plan, dated 2/26/23, indicated Resident 10 was unable to maintain O2 (oxygen) saturation, and received oxygen at 1 L/min. During an interview, on 03/13/23 at 2:11 p.m., the Vice President of Clinical indicated the oxygen tubing and cannula needed to be dated, bagged, and changed weekly. A current policy, titled "Department (Respiratory Therapy)- Prevention of Infection," received from the Executive Director (ED) on 3/13/23 at 3:42 p.m., indicated "...The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff...Change the oxygen cannula and tubing every seven (7) days, or as needed...Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use...." 3.1-47(a)(6)		review audits weekly to ensure compliance. Results of audits will be brought and discussed in monthly QAPI Committee for review and recommendation until 100% compliance is met. Any recommendation made by the committee will be followed up by the SSD or designee.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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RETREAT AT THE STRATFORD, THE	2460 GLEBE ST CARMEL, IN 46032

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	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in the potential for food borne illness for all residents who consume food from the kitchen. Findings include: 1. During an initial kitchen tour, on 03/09/23 at 9:48 a.m., with the Director of Dining Services (DDS) the following were observed: a) a large bin of yellow cornmeal like substance was noted with no open date on the bin. b) a large bin of bread crumb like substance was noted with no open date on the bin. c) a large bin of white sugar like substance was noted with no open date on bin. During an interview, on 03/09/23 at 9:48 a.m., the DDS indicated he did not know when the food was placed in the large bins without an open date on the bins. 2. A review of the "Dish Machine Temperature Log," dated March 2023, indicated there was no documentation of dishwasher temperatures after 3/9/23 at dinner through 3/13/23.	F 0812	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Executive Chef and team members of Dining Services were educated on 3/30/2023 regarding policies “Dishwashing Machine Use”, “Sanitization”, and “Food Receiving and Storage”. Items in large bins were labeled with open dates. All other items listed in SOD were thrown out. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Executive Chef and or designee will audit dishwasher log for completion, all food storage areas to ensure all items are labeled and dated, and QAC solution for proper PPM. What measures will be put in place or what systemic changes	04/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	03/14/2023

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	During an interview, on 03/13/23 at 11:02 a.m., the Executive Chef (EC) reviewed the dish machine temperature log and indicated nobody documented the dishwasher temperatures. It was not known if the dishwasher was at the proper temperature to know if the dishes were sanitized without the documentation on the dishwasher log. 3. A review of the sanitizing logs indicated there was no documented sanitizer concentration checks after 3/9/23 at 11:30 a.m., through 3/13/23. During an interview, on 03/13/23 at 11:30 a.m., the EC indicated there was no sanitizing log documentation for the sanitizer concentration after 3/9/23 at 11:30 a.m., until the present day and time. 4. During an observation of the 3 (three) compartment sink, on 03/13/23 at 11:33 a.m., the quaternary ammonium compound (QAC) solution was checked for concentration by the EC. The observed result of the QAC was 300 ppm (parts per million). 5. During an observation and interview with EC, on 03/13/23, the following was observed: a) 11:10 a.m., a plastic wrapped open bag of crispy onions was noted. The EC indicated it was an open food item without an open date. b) 11:12 a.m., an open 5-pound bag of long grain rice was noted. The EC indicated it was not dated and it was open. c) 11:14 a.m., an open 10-pound bag of spaghetti noodles was noted with no date. The EC indicated there was no date on the open bag of spaghetti noodles. d) 11:16 a.m., an open 1 liter of club soda was noted with no open date on the bottle. The EC indicated the soda was open, but no date was on		the facility will makes to ensure that the deficient practice does not occur: Executive Chef or designee will review all logs weekly to ensure compliance. They will conduct storage walkthrough audit of food storage, refrigerator, and freezer to ensure all items are labeled and dated. QAC will be checked daily to ensure proper PPM. Any items found out of compliance will be corrected and staff will be educated. Audits will be conducted weekly x 4 weeks, then every 2 weeks for 2 months, then monthly until 100% compliance is achieved. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Administrator or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the Executive Chef or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue until 100% compliance is achieved.	

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	the bottle. e) 11:22 a.m., a large open bag of mixed greens was noted with no date. The EC indicated the open bag of mixed greens was supposed to be dated when opened. f) 11:23 a.m., a bag of broccoli was noted without an open date. The EC indicated there was no open date on the broccoli. g) 11:25 a.m., an open bag of quinoa (edible seeds) was wrapped in plastic with no open date. The EC indicated it was open without a date. h) 11:25 a.m., multiple pieces of corn bread were noted with a missing piece of corn bread covered in plastic with no open date on the cornbread. The EC indicated the open cornbread was not dated. A current policy, titled "Dishwashing Machine Use," received from the Executive Director (ED) on 3/13/23 at 1:15 p.m., indicated "...The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log...." A current policy, titled "Sanitization," received from the ED on 3/13/23 at 1:15 p.m., indicated "...The food service area shall be maintained in a clean and sanitary manner...Sanitizing of environmental surfaces must be performed with one of the following solutions: 150 - 200 ppm (parts per million) of quaternary ammonium compound (QAC)...." A current policy, titled "Food Receiving and Storage," received from the ED on 3/13/23 at 1:15 p.m., indicated "...Food shall be received and stored in a manner that complies with safe food handling practices...Dry foods that are stored in bins will be removed from original packaging, labeled, and dated ("use by" date) ...Other opened containers must be dated and sealed or covered			

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	during storage...." 3.1-21(i)(3)			
F 9999 Bldg. 00	3.1-14 Personnel (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test. (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a 2-step tuberculosis test was administered to 2 of 5 new employees. (CNA 5 and CNA 6) Findings include: The employee records were reviewed on 03/13/23 and 03/14/23.	F 9999	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing, Resident Care Director, and HR Director were educated on policy titled "Tuberculosis, Employee Screening for" on 3/29/2023. C.N.A 5: missing Initial TB questionnaire was located. C.N.A had 1st step on 12/24/22 and 2nd step on 1/9/23. C.NA 6: had 2nd step TB on 3/9/23. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. HRD or designee will audit all employee records to identify non-compliance with initial TB testing. Any staff identified as not having completed the initial TB testing will be required to immediately complete to be compliant. What measures will be put in place or what systemic changes the facility will makes to ensure	04/28/2023

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	The records indicated CNA 5, who had a start date of 09/19/22, had no documentation to show she had started the 2-step tuberculosis testing. The facility was unable to provide documentation to show the testing had been completed. The records indicated CNA 6, who had a start date of 12/07/22, had received the first skin test on 02/21/23. The facility was unable to provide documentation to show the testing has been completed. During an interview, on 03/14/23 at 1:31 p.m., the Executive Director indicated the facility did not have any documentation to show CNA 5 received a 2-step tuberculosis test and CNA 6 had only received the first skin test of the 2-step tuberculosis testing. She indicated the 2-step tuberculosis testing should have been completed. A facility policy, titled "Tuberculosis, Employee Screening for," dated as revised in March 2021 and provided by the Executive Director on 03/14/23 at 9:00 a.m., indicated "...Each newly hired employee is screened for LTBI (latent tuberculosis infection) and active TB (tuberculosis) after an employment offer has been made but prior to the employee's duty assignment...."		that the deficient practice does not occur: HRD will audit each new employee record weekly x 1 month to ensure TB skin tests and health assessments have been completed. DON or designee will maintain a calendar with hire dates of all employees and due date of 1st and 2nd step TB testing. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The HR Director or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the HR Director or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue until 100% compliance is achieved. Review will be ongoing.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 9, 10, 13, and 14, 2023	R 0000	This Plan of Correction represents The Retreat at the Stratford allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists	

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	Facility number: 011151 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.		or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
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: (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			

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	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 conduct a fire drill for 5 of 12 months reviewed for fire drills. (June, July, August, October, and December 2022) Finding includes: The documentation for fire drills was reviewed on 03/13/23. The facility was unable to provide documentation to show fire drills were held in the following months: June, July, August, October, and December 2022. During an interview, on 3/13/23 at 9:49 a.m., the Executive Director indicated she was not able to say why the facility was missing fire drills and the information provided was accurate. A facility policy, titled "Fire and Safety Training and Drills," dated as last revised in January 2019 and provided by the Executive Director on 03/13/23 at 9:32 a.m., indicated "...Fire and life safety drills are conducted at least monthly...The area fire Department will participate in at least two (2) fire and life safety drills annually...."	R 0092	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The facilities team was re-educated on fire drill policy and procedure on 3/16/2023. The community currently does not have a Director of Facilities. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Director of Facilities or designee will create a yearlong calendar that will state fire drill to be done and what shift it will occur in that month. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Facilities or designee will audit Fire Drill compliance weekly to ensure drills have been completed. The Director of Facilities or designee will identify any issues and educate staff on corrective action. How the corrective actions will be monitored to ensure the deficient	04/28/2023

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			practice will not recur, I,e., what quality assurance program will be put into place The Care Services Administrator or designee will conduct audits of fire drill monthly to ensure proper procedure is followed. Audits will continue monthly until 100% compliance is achieved. Review will be ongoing. Any concerns/deficient practice will be corrected immediately. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease or discontinue the auditing.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services 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			

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	administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure 21 of 21 shifts were covered with an employee certified in first aid and 3 of 21 shifts were covered with an employee certified in cardiopulmonary resuscitation (CPR) between 03/03/23 to 03/09/23. Findings include: The employee schedules were reviewed alongside with the certifications for CPR and first-aid. The following shifts were found to be missing staff with CPR, first aid, or both: On 03/03/23, there were no staff members found on any shift to have been certified in first aid. On 03/04/23, there were no staff members found on any shift to have been certified in first aid. The facility was also found to be without a staff member certified in CPR from 7:00 a.m. to 7:00 p.m. On 03/05/23, there were no staff members found on any shift to have been certified in first aid. On 03/06/23, there were no staff members found on any shift to have been certified in first aid. The facility was also found to be without a staff member certified in CPR from 7:30 a.m. to 7:00 a.m. On 03/07/23, there were no staff members found on any shift to have been certified in first aid. On 03/08/23, there were no staff members found on any shift to have been certified in first aid. On 03/09/23, there were no staff members found on any shift to have been certified in first aid.	R 0117	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing and Resident Care Director were educated on the requirement to the Indiana State Guidelines for CPR/First Aid on 3/29/2023. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. All nurses will be certified in CPR and First Aid. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Director of Nursing or designee will audit all LPN, RN, and QMA files to ensure that everyone has current CPR and First Aid. Anyone found to not be current will be required to take BLS CPR and First Aid by April 28, 2023. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what	04/28/2023

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	155794	A. BUILDING 00 B. WING	03/14/2023

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	During an interview, on 03/14/23 at 11:09 a.m., the Executive Director indicated the facility did not have any first aid certifications. During an interview, on 03/14/23 at 3:38 p.m., the Executive Director indicated the facility did not have a policy addressing CPR and first aid coverage on all shifts and the facility followed the Indiana State Regulations.		quality assurance program will be put into place The Care Services Administrator or designee will conduct audits of the schedule weekly to ensure there is 1 person on each shift that is CPR and First Aid certified. Audits will then continue monthly until 100% compliance is achieved. Review will be ongoing. Any concerns/deficient practice will be corrected immediately. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease or discontinue the auditing.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing			

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	should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure a 2-step tuberculosis test was administered to 2 of 5 new employees. (CNA 5 and CNA 6) Findings include: The employee records were reviewed on 03/13/23 and 03/14/23. The records indicated CNA 5, who had a start date of 09/19/22, had no documentation to show she had started the 2-step tuberculosis testing. The facility was unable to provide documentation to show the testing had been completed. The records indicated CNA 6, who had a start date of 12/07/22, had received the first skin test on 02/21/23. The facility was unable to provide documentation to show the testing has been	R 0121	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing, Resident Care Director, and HR Director were educated on policy titled "Tuberculosis, Employee Screening for" on 3/29/2023. C.N.A 5: missing Initial TB questionnaire was located. C.N.A had 1st step on 12/24/22 and 2nd step on 1/9/23. C.NA 6: had 2nd step TB on 3/9/23. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:	04/28/2023

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	completed. During an interview, on 03/14/23 at 1:31 p.m., the Executive Director indicated the facility did not have any documentation to show CNA 5 received a 2-step tuberculosis test and CNA 6 had only received the first skin test of the 2-step tuberculosis testing. She indicated the 2-step tuberculosis testing should have been completed.		All residents have the potential to be affected by the deficient practice. HRD or designee will audit all employee records to identify non-compliance with initial TB testing. Any staff identified as not having completed the initial TB testing will be required to immediately complete to be compliant. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: HRD will audit each new employee record weekly x 1 month to ensure TB skin tests and health assessments have been completed. DON or designee will maintain a calendar with hire dates of all employees and due date of 1st and 2nd step TB testing. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The HR Director or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the HR Director or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue until 100% compliance is	

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	155794	A. BUILDING 00 B. WING	03/14/2023

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			achieved. Review will be ongoing.	
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 service plans were signed and dated by the resident or resident's representative for 6 of 7 residents reviewed for service plans. (Resident 402, 403, 404, 405, 406, and 407)	R 0217	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing and Resident Care Director were	04/28/2023

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	Findings include: 1. The record for Resident 402 was reviewed on 3/13/23 at 12:25 p.m. Diagnoses included, but were not limited to, hypertension. A service plan was not signed and dated by the resident or resident's representative. 2. The record for Resident 403 was reviewed on 3/13/23 at 10:28 a.m. Diagnoses included, but were not limited to, hyperlipidemia, and hypothyroidism. A service plan was not signed and dated by the resident or resident's representative. 3. The record for Resident 404 was reviewed on 3/13/23 at 11:15 a.m. Diagnoses included, but were not limited to, hypertension. A service plan was not signed and dated by the resident or resident's representative. 4. The record for Resident 405 was reviewed on 3/13/23 at 11:27 a.m. Diagnoses included, but were not limited to, hypertension, anemia, anxiety, and encephalopathy. A service plan was not signed and dated by the resident or resident's representative. 5. The record for Resident 406 was reviewed on 3/13/23 at 11:35 a.m. Diagnoses included, but were not limited to, hypertension, depression, anorexia, and dysphagia. A service plan was not signed and dated by the resident or resident's representative.		educated on 3/31/2023 regarding policy related to Resident Service Plans . Residents 402 and 404 no longer reside in the community. Residents 403, 405, 406, and 407 will have service plans signed and dated. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. RCD or designee will audit all resident records for a signed service plan. Any resident that does not have a signed resident service plan on file will have service plan updated and signed. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: DON or designee will audit new resident charts within 1 week of admission to ensure residents have a signed service plan in their medical records. Any medical record that does not have a signed service plan will have one completed and signed within a week of audit. Audits will be conducted weekly x 4 weeks, then every 2 weeks x 2 months, followed by monthly until 100% compliance has been achieved.	

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	6. The record for Resident 407 was reviewed on 3/13/23 at 11:50 a.m. Diagnoses included, but were not limited to, major depressive disorder, hypertension, and insomnia. A service plan was not signed and dated by the resident or resident's representative. During an interview, on 3/13/23 at 2:40 p.m., the Vice President of Clinical indicated service plans should be signed by the resident or the resident's representative and she could not provide signed service plans. A current facility policy, "Assessment/Service Plan," received from the Vice President of Clinical on 3/13/23 at 3:35 p.m., indicated "...Current Service Plan...Service Plan Signature Form...."		Review will be ongoing. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Administrator or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the RCD or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue until 100% compliance is achieved.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in the potential for food borne illness for all residents who consume food from the kitchen. Findings include: 1. During an initial kitchen tour, on 03/09/23 at 9:48 a.m., with the Director of Dining Services (DDS) the following were observed: a) a large bin of yellow cornmeal like substance was noted with no open date on the bin. b) a large bin of bread crumb like substance was	R 0273	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Executive Chef and team members of Dining Services were educated on 3/30/2023 regarding policies “Dishwashing Machine Use”, “Sanitization”, and “Food Receiving and Storage”. Items in large bins were labeled with open dates. All other items listed in SOD were thrown out. How the facility will identify other	04/28/2023

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	noted with no open date on the bin. c) a large bin of white sugar like substance was noted with no open date on bin. During an interview, on 03/09/23 at 9:48 a.m., the DDS indicated he did not know when the food was placed in the large bins without an open date on the bins. 2. A review of the "Dish Machine Temperature Log," dated March 2023, indicated there was no documentation of dishwasher temperatures after 3/9/23 at dinner through 3/13/23. During an interview, on 03/13/23 at 11:02 a.m., the Executive Chef (EC) reviewed the dish machine temperature log and indicated nobody documented the dishwasher temperatures. It was not known if the dishwasher was at the proper temperature to know if the dishes were sanitized without the documentation on the dishwasher log. 3. A review of the sanitizing logs indicated there was no documented sanitizer concentration checks after 3/9/23 at 11:30 a.m., through 3/13/23. During an interview, on 03/13/23 at 11:30 a.m., the EC indicated there was no sanitizing log documentation for the sanitizer concentration after 3/9/23 at 11:30 a.m., until the present day and time. 4. During an observation of the 3 (three) compartment sink, on 03/13/23 at 11:33 a.m., the quaternary ammonium compound (QAC) solution was checked for concentration by the EC. The observed result of the QAC was 300 ppm (parts per million). 5. During an observation and interview with EC,		residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Executive Chef and or designee will audit dishwasher log for completion, all food storage areas to ensure all items are labeled and dated, and QAC solution for proper PPM. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Executive Chef or designee will review all logs weekly to ensure compliance. They will conduct storage walkthrough audit of food storage, refrigerator, and freezer to ensure all items are labeled and dated. QAC will be checked daily to ensure proper PPM. Any items found out of compliance will be corrected and staff will be educated. Audits will be conducted weekly x 4 weeks, then every 2 weeks for 2 months, then monthly until 100% compliance is achieved. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place The Administrator or designee will bring the results of the audits to the monthly QAPI Committee for	

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	on 03/13/23, the following was observed: a) 11:10 a.m., a plastic wrapped open bag of crispy onions was noted. The EC indicated it was an open food item without an open date. b) 11:12 a.m., an open 5-pound bag of long grain rice was noted. The EC indicated it was not dated and it was open. c) 11:14 a.m., an open 10-pound bag of spaghetti noodles was noted with no date. The EC indicated there was no date on the open bag of spaghetti noodles. d) 11:16 a.m., an open 1 liter of club soda was noted with no open date on the bottle. The EC indicated the soda was open, but no date was on the bottle. e) 11:22 a.m., a large open bag of mixed greens was noted with no date. The EC indicated the open bag of mixed greens was supposed to be dated when opened. f) 11:23 a.m., a bag of broccoli was noted without an open date. The EC indicated there was no open date on the broccoli. g) 11:25 a.m., an open bag of quinoa (edible seeds) was wrapped in plastic with no open date. The EC indicated it was open without a date. h) 11:25 a.m., multiple pieces of corn bread were noted with a missing piece of corn bread covered in plastic with no open date on the cornbread. The EC indicated the open cornbread was not dated. A current policy, titled "Dishwashing Machine Use," received from the Executive Director (ED) on 3/13/23 at 1:15 p.m., indicated "...The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log...." A current policy, titled "Sanitization," received from the ED on 3/13/23 at 1:15 p.m., indicated "...The food service area shall be maintained in a		review and recommendation. Any recommendation made by the committee will be followed up by the Executive Chef or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue until 100% compliance is achieved.	

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	clean and sanitary manner...Sanitizing of environmental surfaces must be performed with one of the following solutions: 150 - 200 ppm (parts per million) of quaternary ammonium compound (QAC)...." A current policy, titled "Food Receiving and Storage," received from the ED on 3/13/23 at 1:15 p.m., indicated "...Food shall be received and stored in a manner that complies with safe food handling practices...Dry foods that are stored in bins will be removed from original packaging, labeled, and dated ("use by" date) ...Other opened containers must be dated and sealed or covered during storage...."			
R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record, the facility failed to ensure a chest x-ray was completed within 6 months of admission for 3 of 7 residents reviewed for chest x-rays. (Resident 403, 405 and 406) Findings include: 1. The record for Resident 403 was reviewed on 3/13/23 at 10:28 a.m. Diagnoses included, but were not limited to, hyperlipidemia, and hypothyroidism. A chest x-ray was not located in the medical record. 2. The record for Resident 405 was reviewed on 3/13/23 at 11:27 a.m. Diagnoses included, but were not limited to, hypertension, anemia, anxiety, and encephalopathy.	R 0408	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing and Resident Care Director were educated on 3/31/2023 on policy titles “Tuberculosis, Screening Resident for” . Residents 406 had Chest X-ray located in medical record. Residents 403 and 405 will be screened for TB as per policy. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to	04/28/2023

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	A chest x-ray was not located in the medical record. 3. The record for Resident 406 was reviewed on 3/13/23 at 11:35 a.m. Diagnoses included, but were not limited to, hypertension, depression, anorexia, and dysphagia. A chest x-ray was not located in the medical record. During an interview, on 03/13/23 at 3:45 p.m., the Vice President of Clinical indicated the residents should have had a chest x-ray and she could not provide a chest x-ray for Residents 403, 405, and 406. A current facility policy, titled "Resident Tuberculosis Screening," undated and received from the Vice President of Clinical on 3/13/23 at 3:50 p.m., indicated "...All residents will be required to have a diagnostic chest x-ray completed no more than ix (6) months prior to admission...."		be affected by the deficient practice. RCD or designee will audit all resident records for a chest x-ray. Any resident that does not have a chest x-ray in the medical record will have a TB assessment completed as per policy "Tuberculosis, Screening Residents for". What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Administrator or DON will audit new resident charts within 1 week of admission to ensure residents have a completed TB assessment completed. Review will be ongoing. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Administrator or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the RCD or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue until 100% compliance is achieved.	
R 0410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance			

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Bldg. 00	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure a 2-step tuberculosis test was administered to 5 of 7 residents reviewed for tuberculosis testing. (Residents 401, 403, 404, 406, and 407) Findings include: 1. The record for Resident 401 was reviewed on 3/13/23 at 12:05 p.m. Diagnoses included, but were not limited to, dementia, insomnia, and major depressive disorder. The record indicated the resident had a first-step tuberculosis test and the second step was not completed. 2. The record for Resident 403 was reviewed on	R 0410	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing and Resident Care Director were educated on 3/31/2023 on policy titles “Tuberculosis, Screening Resident for” . Residents 403, 406 and 407 had First step PPD initiated on 3/30/23. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to	04/28/2023

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	3/13/23 at 10:28 a.m. Diagnoses included, but were not limited to, hyperlipidemia, and hypothyroidism. A 2-step tuberculosis test was not located in the resident's record. 3. The record for Resident 404 was reviewed on 3/13/23 at 11:15 a.m. Diagnoses included, but were not limited to, hypertension. A 2-step tuberculosis test was not located in the resident's record. 4. The record for Resident 406 was reviewed on 3/13/23 at 11:35 a.m. Diagnoses included, but were not limited to, hypertension, depression, anorexia, and dysphagia. A 2-step tuberculosis test was not located in the resident's record. 5. The record for Resident 407 was reviewed on 3/13/23 at 11:50 a.m. Diagnoses included, but were not limited to, major depressive disorder, hypertension, and insomnia. A 2-step tuberculosis test was not located in the resident's record. During an interview, on 3/13/23 at 3:45 p.m., the Vice President of Clinical indicated the residents should have had a two-step tuberculosis testing completed and she could not provide the documentation. A current policy, titled "Resident Tuberculosis Screening," undated and received from the Vice President of Clinical on 3/13/23 at 3:50 p.m., indicated "...All residents will have a tuberculin skin test accomplished through use of the Mantoux intradermal method (5 TU PPD)		be affected by the deficient practice. RCD or designee will audit all resident records for an initial TB test. Any resident that does not have an up in the medical record will have a TB assessment completed as per policy “Tuberculosis, Screening Residents for”. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: Administrator or DON will audit new resident charts within 1 week of admission to ensure residents have a completed TB assessment. Review will be ongoing. Nurses will be educated on TB assessment and signs and symptoms of TB. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Administrator or designee will bring the results of the audits to the monthly QAPI Committee for review and recommendation. Any recommendation made by the committee will be followed up by the RCD or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue until 100% compliance is achieved.	

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	administered at the time of admission or within three (3) month prior to admission, unless there is a documented history of a positive skin test...The physician will be requested to administer the Mantoux skin test and record the results on the Medical Evaluation...The Mantoux skin test will be administered by qualified nursing staff upon admission if the resident does not have documentation of a test completed within three (3) months prior to admission or a documented history of a positive skin test...The two-step method will be used for the baseline testing...All Mantoux administration and results will be documented on the Resident Tuberculosis Screening Record. This includes test results administered by external clinics or health care providers...."			