DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE PARK RESIDENTIAL CARE	2075 RIPLEY ST LAKE STATION, IN 46405

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00352446. Complaint IN00352446 - Substantiated. No State Residential Findings related to the allegations were cited. Survey dates: May 18 and 19, 2021 Facility number: 001136 Residential Census: 95 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/21/21.	R 0000		
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred and gouged walls, peeling wallpaper and floor tiles, water damaged drywall, dirty floors, dusty ceiling vents and overhead sprinkler piping, black substances around bath tubs, brown substances around toilets, and missing base boards for 2 of 2 floors. (The First and Second Floors) Findings include:	R 0144	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? First Floor a. Room 112- Brown Substance around the base of the toilet caulking will be removed. b. Room 118- the running water issue in the bathtub has been resolved. Both residents have access to running water in their	06/19/2021

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

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

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	During the Environmental Tour on 5/19/21 at 3:30 p.m., with the Maintenance Supervisor, the following was observed: 1. The First Floor a. Room 112, there was a brown substance around the base of the toilet caulking. Two residents resided in the room. b. Room 118, there was no running water coming from the bath tub faucet. Two residents resided in the room. c. Room 135, there was an accumulation of dirt along the floor bases and corners in the room and bathroom. Two residents resided in the room. 2. The Second Floor a. The walls in the common area near the stairs were marred and gouged. b. The overhead sprinkler piping had an accumulation of dust throughout the unit. c. There was an accumulation of dirt and debris along the floor bases and corners of the main hallway. d. Room 206, there was a black substance around the bathtub. The bathroom drywall near the tub had water damage. The bedroom walls were marred and gouged. One resident resided in the room. e. Room 209, the bathroom ceiling vent was dusty and the floor tile was peeling. Two residents resided in the room.		bathtubs. c. Room 135- the accumulation of dirt along the bases and corners in the room will be cleaned thoroughly. Second Floor a. The walls in the common area near the stairs marred and gouged will be repaired. b. The overhead sprinkler piping where the accumulation of dust throughout the unit will be cleaned. c. The accumulation of dirt and debris along the floor bases and corners of the main hallway will be cleaned. d. Room 206- Black Substance around the bathtub will be cleaned. The bathroom drywall near the tub will be replaced. The bedroom walls marred and gouged will be repaired. e. The bathroom ceiling vent will be cleaned and the floor tile will be replaced. f. Room 217- The bedroom walls marred will be repaired. The missing section of the baseboard will be replaced. The holes in the bathroom wall above the toilet will be repaired. The floors will be cleaned and the wallpaper above the light fixture will be repaired. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what	

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	f. Room 217, the bedroom walls were marred. There was a missing section of the base board. There were holes in the bathroom wall above the toilet. The floors were dirty and the wallpaper above the light fixture was peeling. Two residents resided in the room. Interview with the Maintenance Supervisor at that time, indicated the above was in need of cleaning and/or repair.		corrective action will be taken. All the residents have the potential to be affected by the alleged deficient practice. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Regional Facilities Director will review current work order process with Lake Park Facilities Supervisor , Housekeeping Staff and Maintenance staff to ensure that all repairs, and specialized cleaning needing to be done and other environmental concerns are completed in a timely manner and that facility is in a state of good repair, both inside and outside and shall provide reasonable comfort for all residents. All staff will be re-Inserviced one reporting any repairs, special cleaning needed or other concerns through a work order provided by Lake Park Facilities Supervisor. The Facilities Supervisor will inservice housekeeping staff on completing a daily and/ or weekly cleaning checklist/ inspection form after cleaning rooms and common areas of facility . The Facilities Supervisor will re inservice housekeeping staff on current cleaning or resident rooms	

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			and common areas. The facility will contract an outside vendor to repair areas in the facility , i.e. Mixing valves ,intensive plumbing issues etc, that in house Maintenance Staff is unable to repair. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what the quality assurance program will be put into place. The Facilities Supervisor and/or designee will make random rounds 5-7 days a week to ensure housekeeping staff is cleaning resident rooms and common areas properly and completing Cleaning checklist/inspection forms. Facilities Supervisor and/or designee will make random rounds 5 -7 days a week to resident rooms and common areas to ensure that repairs are completed per work orders completed by Maintenance Staff. Regional Facilities Director will make Quarterly random rounds to facility rooms and common areas to ensure ongoing compliance and will report any findings to Facility Supervisor and Administrator. Monitoring by Facilities	

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			Supervisor will be 5-7 days for the first 60 days, then 3-4 days thereafter . Findings will be reported to Administrator ongoing. 5. By what date the systemic changes will be completed. June 19, 2021	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.			
	Based on observation and interview, the facility failed to ensure the kitchen was clean and in good repair related to an accumulation of dust underneath the oven hood, on top of the convection oven, and on fan blades for 1 of 1 kitchen areas. (The Main Kitchen) Finding includes: During the initial tour of the kitchen, on 5/18/21 at 9:30 a.m. with the Dietary Food Manager (DFM), the following was observed: a. An accumulation of dust was observed underneath the oven hood located above the stove. b. An accumulation of dust and grease was observed on top of the convection oven. c. There was a large fan in the dish room. There	R 0154	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? a. The accumulation of dust underneath the oven hood located above the stove was cleaned during the survey process and the surveyor was notified. b. The accumulation of dust and grease on top of the convection oven was cleaned during the survey process by the Dietary Manager. The surveyor was informed during the survey process that the top of the convection oven was cleaned. c. The large fan in the dish room that had an accumulation of dust on the fan blades and grate were	06/19/2021

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	was an accumulation of dust on the fan blades and fan grate. Interview with the DFM at that time, indicated the top of the convection oven, the oven hood, and the fan needed to be cleaned.		cleaned during the survey process and the Dietary Manager informed the surveyor. 2. 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 of the residents in the facility have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Dietary Manager and/or Cook will monitor the kitchen on a daily basis to ensure that cleaning of equipment is done as scheduled. The Dietary Manager will review and re-inservice Dietary Staff on the Cleaning schedules for all equipment in the kitchen and dishroom to ensure equipment is clean and in good repair. The Dietitian will make random checks quarterly to ensure that Dietary Staff is following scheduled cleaning and will report findings quarterly to Dietary Manager and Administrator. Dietary Manager will discipline Dietary Staff for noncompliance with following cleaning schedules. 4. How will the corrective action	

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			will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place. The Dietary Supervisor will make random rounds in the kitchen and dishroom to check equipment weekly to ensure that Dietary Staff is adhering to cleaning schedules that are assigned during the scheduled shift. 5. By what date the systemic changes will be completed. June 19, 2021	
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.			

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	(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 record review and interview, the facility failed to ensure Service Plans were reviewed and revised after a condition change for 2 of 7 records reviewed. (Residents 3 and 6) Findings include: 1. The record for Resident 3 was reviewed on 5/18/21 at 1:20 p.m. Diagnoses included, but were not limited to, depression, anxiety, bipolar, and borderline personality disorder. Nurses' Notes, dated 4/22/21 at 11:29 a.m., indicated the resident was found outside sitting against the wall of the building. The resident's ankle was swollen and she was complaining of pain. She was sent to the emergency room for evaluation. The resident returned from the hospital with a diagnosis of a right sprained ankle. She was also using crutches for mobility. The Service Plan, dated 2/3/21, had not been revised to address the resident's sprained ankle. Interview with the Director of Nursing on 5/18/21 at 4:00 p.m., indicated the resident's Service Plan should have been reviewed and updated after she sprained her ankle. 2. The record for Resident 6 was reviewed on 5/18/21 at 2:59 p.m. Diagnoses included, but were	R 0217	1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? a. On 5/18/2021, Resident#3's Service Plan was revised by Nursing Staff to address sprained ankle. Service Plan was revised again on 6/1/2021 indicating resident no longer needed assistive devices related to Sprained ankle. b. On 5/18/2021 Resident#6's Service Plan was revised to address resident leaving facility for long periods of time. 2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected by alleged deficient practice. 3. What measures will be put into place or what systemic changes	06/19/2021

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	not limited to, depression and schizoaffective disorder. Nurses' Notes, dated 3/2/21 at 1:22 p.m., indicated the resident had left the facility without telling any staff or other residents. The resident had a history of leaving the building but not for long periods of time. The resident was located in a restaurant near the facility and returned. The Service Plan, dated 1/30/21, had not been revised to address the resident's leaving the facility for long periods of time. Interview with the Director of Nursing on 5/18/21 at 4:00 p.m., indicated the resident's Service Plan should have been reviewed after she left the facility for an extended period of time.		the facility will make to ensure that the deficient practice does not recur. Director of Nursing will inservice all nursing Staff on Policy with regards to completing Service Plans on all residents. Director of Nursing will inservice Nursing Staff on updating Service Plans when residents have change of condition, emergency room visits, and readmissions. 4. How will the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Director of Nursing and/or Designee will monitor service plans completion and revisions weekly to ensure the servie plans are accurate. Director of Nursing will make random audits monthly to ensure service plans are accurate. Nursing Staff will be subject to discipline if Service Plans are not completed or revised when necessary. 5. By what date the systemic changes will be completed. June 19, 2021	
R 0243	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency			

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Bldg. 00	(3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.			
	Based on record review and interview, the facility failed to ensure residents received medications as ordered for 2 of 7 records reviewed. (Residents 4 and 5) Findings include: 1. The record for Resident 4 was reviewed on 5/19/21 at 11:14 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, urinary retention, supra pubic catheter, and major depression. The Admission Nursing assessment, dated 4/27/21, indicated the resident was alert and oriented. Physician's Orders, dated 4/27/21, indicated Tamsulosin (a medication for urinary retention) 0.4 mg (milligrams) every evening, Vitamin C 500 mg daily, Vitamin D3 125 mcg (micrograms) daily, Wellbutrin (an antidepressant) 100 mg daily, Zinc 220 mg daily, Metolazone (a diuretic) 5 mg daily, Aspirin 81 mg daily, Brio Ellipta (an inhaler) 2 puffs daily, and Colace (a stool softener) 100 mg daily. Blood glucose monitoring was to be completed twice daily and Humalog Regular insulin per a sliding scale was to be administered twice daily at 6:00 a.m. and 8:00 p.m. for the following blood	R 0243	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Resident#4 - the physician was notified that there was no documentation to indicate the resident receiving oral medications prior to May 4, 2021 and that insulin dosage was administered incorrectly. b. Resident#5- the physician was notified that there was no documentation to indicate blood sugar or insulin coverage for 4/02/21, 4/12/21, 4/18/21, and 4/23/21. The physician was also notified that on the following dates the blood sugar was done but no insulin given- 4/8/21 and 4/19/21. The physician was notified that incorrect dosages were given on 4/9/21,4/10/21,and 4/21/21. the physican had no new orders and indciated to continue with present orders. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what	06/19/2021

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	sugars: 151-200, give 2 units 201-250, give 4 units 251-300, give 6 units 301-350, give 8 units 351-400, give 10 units if less than 60 or more than 400 call the Physician. There was no documentation to indicate the resident received the above oral medications prior to 5/4/21. The April 2021 Medication Administration Record (MAR), indicated the resident did not receive his insulin on 4/27 at 8:00 p.m., 4/28 at 6:00 a.m. and 8:00 p.m., and 4/29/21 at 6:00 a.m. The May 2021 MAR, indicated the resident received the incorrect doses of insulin on the following days: 5/1/21 at 8:00 p.m., the resident's blood sugar (bs) was 209. He received 2 units of insulin. 5/4/21 at 8:00 p.m., the bs was 192. He received no insulin. 5/5/21 at 8:00 p.m., the bs was 262. He received 4 units of insulin. 5/17/21 at 8:00 p.m., the bs was 188. He received no insulin. Interview with the Director of Nursing on 5/19/21 at 1:05 p.m., indicated when the resident was admitted on 4/27/21 the nurse did not put the medication orders into the computer. The order for the insulin was recognized on 4/29/21, the other medications were not noted until 5/4/21. She further indicated the nursing staff should have administered the correct doses of insulin as ordered.		corrective action will be taken. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deificent practice does not recur. Director of Nursing will re-inservice nursing staff on Blood Glucose and Insulin Coverage. Director of Nursing re-inservice nursing staff on completion of Medication Administration Records for residents upn admission and readmission. Director of Nursing revised Shift Change Checkoff Sheet and will inservice staff on revision. 4. How will the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Director of Nursing and/or designee will monitor Blood Glucose and insulin coverage documentation twice weekly for one month, on second month monitoring will be done weekly, and thereafter monthly. Director of Nursing and/or designee will ensure that all residents have Medication Administration Records either electronically or paper for all	

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	2. The record for Resident 5 was reviewed on 5/18/21 at 11:32 a.m. Diagnoses included, but were not limited to, bipolar affective disorder, diabetes, Bell's palsy, schizoaffective disorder, personality disorder, and sleep apnea. The 6 Month or Yearly Nursing assessment, dated 1/6/21, indicated the resident was alert and oriented. Physician's Orders, dated 3/29/21, indicated Levemir insulin 30 units twice daily at 6:00 a.m. and 8:00 p.m. Blood glucose monitoring three times daily, and Novolog R per sliding scale at 6:00 a.m., 11:00 a.m., and 4:00 p.m. based on the following blood sugars: 151-200, give 2 units 201-250, give 4 units 251-300, give 6 units 301-350, give 8 units 351-400, give 10 units if less than 60 or more than 400 call the Physician. The April 2021 Medication Administration Record (MAR), indicated the resident did not receive her 8:00 p.m., Levemir insulin on 4/19, 4/20, 4/26, and 4/29/21. The April 2021 MAR, indicated the resident received the incorrect doses of Novolog insulin on the following days: 4/2/21 at 11:00 a.m., there was no documentation to indicate the blood sugar (bs) or insulin coverage. 4/8/21 at 11:00 a.m., the bs was 248, she received no insulin. 4/9/21 at 11:00 a.m., the bs was 239, she received 8		residents by monitoring resident charts weekly for the first month, thereafter monitoring will be done monthly. 5. By what date the systemic changes will be completed. June 19, 2021	

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	units of insulin. 4/10/21 at 6:00 a.m., the bs was 185, she received 4 units of insulin. 4/12/21 at 4:00 p.m., there was no documentation to indicate the bs or insulin coverage. 4/18/21 at 6:00 a.m., there was no documentation to indicate the bs or insulin coverage. 4/19/21 at 4:00 p.m., the bs was 191, she received no insulin. 4/21/21 at 11:00 a.m., the bs was 340, she received 6 units of insulin. 4/23/21 at 4:00 p.m., there was no documentation to indicate the bs or insulin coverage. Interview with the Director of Nursing on 4/18/21 at 12:50 p.m., indicated the resident should have received her insulin as ordered.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			
	Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to as needed (prn) medication orders, prn medication administration, and treatment administration for 3 of 7 records reviewed. (Residents 2, 3, and 5) Findings include: 1. The record for Resident 2 was reviewed on	R 0349	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident#2 -Physician notified of PRN medication administered without documentation of resident assessment before or after administration on 4/11-4/14/21, 4/16/21,4/17/21 and	06/19/2021

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		A. BUILDING 00 B. WING	05/19/2021

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	5/18/21 at 2:07 p.m. Diagnoses included, but were not limited to, anxiety, borderline personality, bipolar, and major depressive disorder. A Physician's Order, dated 10/16/20, indicated the resident was to receive Hydroxyzine HCL (an antihistamine which could also be used short term for anxiety) 25 milligrams (mg) every 12 hours as needed (prn). The Physician's Order did not indicate why the prn medication was to be given. The April 2021 Medication Administration Record (MAR) was reviewed. The resident received a dose of the Hydroxyzine HCL on 4/1-4/8, 4/11-4/14, 4/16, 4/17, and 4/20-4/30/21. The back of the MAR was blank and there was no documentation indicating why the medication was given and/or the time it was given. Interview with the Director of Nursing on 5/19/21 at 4:00 p.m., indicated the resident was receiving the Hydroxyzine HCL due to anxiety and the order should have indicated that. She also indicated the back of the MAR should have been completed as to when the medication was given and why. 2. The record for Resident 3 was reviewed on 5/18/21 at 1:20 p.m. Diagnoses included, but were not limited to, depression, anxiety, bipolar, and borderline personality disorder. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive Lorazepam (an anti-anxiety medication) 1 milligram (mg) as needed (prn) daily. The Physician's Order did not indicate why the prn medication was to be given. The April 2021 Medication Administration Record (MAR) was reviewed. The resident received the Lorazepam on 4/7, 4/15, 4/19-4/25, and 4/28/21.		4/20-4/30/21. No new orders were given by physician. Resident#3- Physician notified of PRN medication administered without documentation of resident assessment before or after administration on 4/7/21,4/15,4/19/21-4/25/21 and 4/28/21. No new orders were given. Resident#5- Physician notified that resident's dressing for supra pubic catheter was changed daily with no assessment documentation by nursing staff. No new orders were given by physician. 2. 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 alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice not recur. Director of Nursing will in-service Nursing Staff on dressing changes and documentation of signs and symptoms and assessment of wound, infective area and treatment area. Director of Nursing will in-service Nursing Staff on PRN	

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	There was no documentation on the back of the MAR indicating why and when the medication was given. A Physician's Order, dated 1/6/21, indicated the resident was to receive Hydroxyzine (an antihistamine which could also be used short term for anxiety) 50 milligrams (mg) three times a day prn. The Physician's Order did not indicate why the prn medication was to be given. Interview with the Director of Nursing on 5/19/21 at 4:00 p.m., indicated the resident received both medications for anxiety and the order should have reflected that. She also indicated the back of the MAR should have been completed as to when the Lorazepam was given and why.3. The record for Resident 5 was reviewed on 5/19/21 at 11:14 a.m. He was admitted on 4/27/21. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, urinary retention, and a supra pubic catheter. The Admission Nursing assessment, dated 4/27/21, indicated the resident was alert and oriented. A Physician's Order, dated 5/3/21, indicated supra pubic catheter dressing changes daily. The 5/2021 Medication and Treatment Administration Records were reviewed. There was no documentation to indicate the nursing staff changed the resident's dressing to his supra pubic catheter daily since the order on 5/3/21.		Administration requirements which will include diagnosis and documentation of the need for the PRN Medication. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Director of Nursing and/or designee will monitor PRN medication administration and documentation weekly for thirty days, then bi monthly for thirty days, then monthly for thirty days, thereafter quarterly. Director of Nursing will also have Pharmacy Consultant to review PRN Medication administration and Documentation and report findings to Director of Nursing Monthly for Ninety days then quarterly thereafter. Director of Nursing will monitor wound documentation for thirty days, then monthly thereafter. 5. By what date the systemic changes will be completed. June 19, 2021	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following:			

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	(1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly with resident interaction for 1 of 1 meals observed, monitoring for signs and symptoms of COVID-19 for a resident in Transmission Based Precautions (TBP) and touching pills with bare hands for 1 of 5 residents observed during medication administration. (The lunch meal, Resident 9 and LPN 1) Findings include: 1. On 5/18/21 at 12:03 p.m., 5 staff members were observed in the main dining room passing lunch trays. The staff members were within 6 feet of the residents and they were not wearing eye protection. Interview with the Director of Nursing on 5/19/21 at 4:15 p.m., indicated the facility had face shields and the staff would be educated to wear them when providing direct care within 6 feet of the residents. The current and updated 3/31/21 Long Term Care	R 0407	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. 1. The five staff members in Dietary as well as other staff on duty, that they must wear face shields in addition to masks when providing direct care to resident's within six feet. Face shields were issued to all staff. 2. Resident#9- Vital signs were taken and all were within normal limits. A rapid Covid Test was done on 5/19/21 and results were negative for Covid. 3. LPN#1 was in-serviced by Director of Nursing on same day of survey indicating that all Medication must be administered using infection control guidelines. 4. Resident#9 had electronic physician orders that was completed on May 13, 2021. A paper copy was not in his chart when reviewed by surveyor.	06/19/2021

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	"Use of Face shields or protective eyewear/goggles," indicated during moderate to high community transmission eye protection should be worn by HCP (Health Care Personnel) who provide essential direct care within 6 feet for any resident regardless of COVID status in all levels of care in LTC (long term care) settings. Thanks to a robust supply, face shields are the recommended source of eye protection; if you have access to goggles/safety glasses in your area, those are permitted as well. They must fit close to the face and not have gaps at the side, top and bottom of the glasses/goggles. 2. The record for Resident 9 was reviewed on 5/19/21 at 2:48 p.m. Diagnoses included, but were not limited to, asthma, seasonal allergies, schizophrenia, and major depression. The resident was admitted to the facility on 5/13/21 and placed in Transmission Based Precautions (TBP). No Physician Orders were available for review. Nurses' Notes, dated 5/13/21 at 9:45 a.m., indicated the resident would be in quarantine for 14 days. The resident's vital signs were checked at that time. There was no additional documentation of the resident's vital signs (temperature, pulse, respirations, blood pressure, and oxygen saturation). Interview with the Director of Nursing (DON) on 5/19/21 at 4:00 p.m., indicated the only set of vitals documented for the resident were on 5/13/21 when he was admitted. The DON indicated vital signs should have been obtained daily. 3. On 5/19/21 at 8:50 a.m., during a medication administration		2. How the facility will identify residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Director of Nursing/Infection Control Coordinator will in-service all facility staff on the wearing of face shield or protective eyewear/goggle when providing direct care to any resident within six feet regardless of resident's Covid Status. Director of Nursing will in-service Nursing staff on obtaining vitals and obtaining physician orders upon admission either electronically or manual paper physician orders. Director of Nursing/ Infection Control Coordinator will in-service nursing staff on following infection control guidelines including Transmission Based Precautions. 4. How will the corrective action will be monitored to ensure the deficient practice will not recur,	

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	observation with LPN 1, he was observed dispensing 2 pills into his bare hand prior to placing them into a plastic pill cup. Interview with the LPN at that time, indicated he should not have placed the pills into his bare hand prior to administering them to the resident. Interview with the Director of Nursing on 5/19/21 at 12:50 p.m., indicated the LPN should not have placed the pills into his bare hand prior to placing them into the pill cup, then administering them to the resident.		what quality assurance program will be put into place. Director of Nursing/Infection Control Coordinator and/or Dietary Manager and/or designee will monitor mealtimes daily to ensure that staff is wearing Face Shields or Protective Eyewear when passing meals to residents. Director of Nursing will randomly monitor residents weekly to ensure Nursing staff is following Transmission Based Precautions when passing medications. Director of Nursing and/or designee will audit charts weekly to ensure a copy of electronic physician orders are in every resident's physical chart. 5. By what date the systemic changes will be completed. June 19, 2021	