STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155807	A. BUILDING 00 B. WING	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

(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 the Investigation of Complaint IN00414456. Complaint IN00414456 - Federal/State deficiencies related to the allegations are cited at F755, F807, F921, and F925. Survey dates: August 16 and 17, 2023 Facility number: 000388 Provider number: 155807 AIM number: 100454140 Census bed type: SNF/NF: 30 Total: 30 Census payor type: Medicaid: 28 Other: 2 Total: 30 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 21, 2023	F 0000	**Disclaimer: this plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.**	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer			

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

Matt Shafer | HFA | 10/04/2023

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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	drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to timely acquire medications from the pharmacy and provide medications, as ordered, for 4 of 4 residents whose medications were reviewed. (Residents B, D, F, and G) Findings include: 1. The clinical record for Resident B was reviewed on 8/16/23 at 2:46 p.m. Her diagnoses included, but were not limited to, type 2 diabetes mellitus and paranoid schizophrenia.	F 0755	**Deficiency F755 S/S E Pharmacy Services/Procedures/Pharmacist/Records** **1. Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** a. DON/designee will make a thorough audit of the medication carts to verify all medications for residents B, D, F, G are present.	08/31/2023

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	The paranoid schizophrenia care plan, last reviewed 8/2/23, indicated an intervention, initiated, 10/4/22, was to give her medications as ordered. The diabetes mellitus care plan, last reviewed 8/2/23, indicated an intervention, initiated 12/13/27, was to provide her diabetes medication as ordered by her physician. The physician's orders indicated to administer one Calcium-Vitamin D tablet twice daily, stating 4/9/23; one Metformin 1000 mg tablet twice daily, starting 4/9/23; apply Nystatin-Triamcinolone Cream twice daily through 8/3/23; one 4 mg tablet of Risperdal twice daily, starting 4/9/23; one 10 mg tablet of Saphris every evening, starting 4/9/23. The July, 2023 MAR (medication administration record) indicated the the Calcium-Vitamin D was not administered once on 7/13/23 and once on 7/30/23 due to pending arrival from pharmacy. The Metformin was not administered once on 7/13/23 due to pending arrival from pharmacy. The Nystatin cream was not applied twice on 7/9/23, twice on 7/10/23, once on 7/15/23, and once on 7/16/23 due to pending arrival from pharmacy. The Risperdal was not administered once on 7/13/23 due to pending arrival from pharmacy. The 10 mg tablet of Saphris was not administered on 7/6/23 due to pending arrival from pharmacy. 2. The clinical record for Resident D was reviewed on 8/17/23 at 11:23 a.m. Her diagnoses included, but were not limited to, major depressive disorder and seizure disorder. The depression care plan, last reviewed 8/2/23, indicated an intervention, initiated 12/13/22, was to give her antidepressant medications as ordered		b. DON/designee will in-service all nurses/QMA's on pharmacy services and how to order medications and obtain newly ordered medications from the EDK. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. DON/designee will audit all medication orders with medications on hand to ensure all ordered medications are in the facility. b. Any missing medications will be immediately ordered from the pharmacy and obtained from the EDK if necessary. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practices will not occur.** a. DON/designee will audit 5 random residents medication orders with medications on hand to ensure that all medications are accounted for. b. This random audit will be conducted: i. QD (M-F) X 4 weeks ii. 2x/week X 4 weeks iii. Weekly X 4 weeks iv. Monthly x 4 months	

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	by her physician. The seizure disorder care plan, last reviewed 8/2/23, indicated an intervention, initiated 12/13/22, was to give her seizure medication as ordered by her physician. The physician's orders indicated to administer one 30 mg capsule of Cymbalta once daily for major depressive disorder, starting 4/10/23; one 25 mg tablet of Topiramate one time a day for seizures, starting 5/18/23; and one 50 mg tablet of Topiramate one time a day for seizures, starting 5/18/23. The July and August, 2023 MARs indicated the Cymbalta was not administered on 7/3/23 due to pending arrival from pharmacy or on 8/10/23 and 8/12/23 due to on order from pharmacy. The 25 mg tablet of Topiramate was not administered on 7/28/23, 7/29/23 and 8/3/23 due to pending arrival from pharmacy. The 50 mg tablet of Topiramate was not administered on 7/29/23 due to awaiting arrival from pharmacy. 3. The clinical record for Resident F was reviewed on 8/17/23 at 11:12 a.m. Her diagnoses included, but were not limited to: convulsions, seizure disorder, hyperlipidemia, Vitamin D deficiency, and restless leg syndrome. The seizure disorder care plan, last reviewed 6/14/23, indicated an intervention, initiated 11/10/21, was to give her medications, as ordered. The hyperlipidemia care plan, last reviewed 6/14/23, indicated an intervention, initiated 11/12/21, was to give her medications as ordered. The physician's orders indicated to administer one		**4. Indicate how the facility plans to monitor its performance to make sure that the solutions are lasting.** a. Any negative trends will be reviewed in monthly QAPI meetings. After 6 months, the IDT will determine the need and/or frequency of continued monitoring. b. DON/designee will continue the above audit process once quarterly as an ongoing practice. **5. Date of completion**. a. August 31, 2023 **Disclaimer: this plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted.to meet requirements established by state and federal law.**	

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	250 mg tablet of Depakote ER (extended release) at bedtime related to convulsions, starting 6/2/23; to administer one 500 mg caplet of Depakote ER at bedtime related to convulsions, starting 6/2/23; to administer one 500 mg tablet of Keppra in the morning for seizures, starting 4/10/23; to administer one 750 mg tablet of Keppra at bedtime for seizures, starting 4/9/23; to administer one 10 mg tablet of Lipitor for hyperlipidemia at bedtime, starting 4/9/23; to administer one 5 mg tablet of Requip at bedtime for restless leg syndrome, starting 4/9/23; and to administer one 50000 Unit capsule of Vitamin D every Wednesday for vitamin deficiency, starting 4/12/23. The July and August, 2023 MARs indicated the 250 mg tablet of Depakote ER was not administered on 7/8/23 and 7/9/23 due to pending arrival from pharmacy. The 500 mg tablet of Depakote ER was not administered on 7/29/23 due to pending arrival from pharmacy. The 500 mg tablet of Keppra was not administered on 7/8/23 and 7/30/23 due to pending arrival from pharmacy. The 750 mg tablet of Keppra was not administered on 7/22/23 and 8/12/23 due to pending arrival from pharmacy. The Vitamin D capsule was not administered on Wednesday, 8/16/23, due to pending arrival from pharmacy. The Requip tablet was not administered on 7/8/23, 7/9/23, 7/19/23, 7/23/23, and 7/29/23 due to pending arrival from pharmacy. The Lipitor was not administered on 7/2/23 due pending arrival from pharmacy. An interview was conducted with Resident F on 8/17/23 at 11:59 a.m. She indicated she thought she was getting her medications, as ordered, but received them as a cupful of pills, so she couldn't be completely sure. Her biggest concern would be not getting her seizure medications, because she did not want to have another seizure.			

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	4. The clinical record for Resident G was reviewed on 8/17/23 at 1:15 p.m. Her diagnoses included, but were not limited to: hypertension, dysuria, fibromyalgia, dermatitis, anxiety, and Vitamin D deficiency. The physician's orders indicated to administer one 100 mg capsule of Elmiron 3 times a day for dysuria, starting 4/9/23; to administer one 0.5 mg tablet of Lorazepam 3 times daily related to anxiety disorder, starting 5/22/23; to administer one spray of Fluticasone 50 mcg/act into both nostrils one time a day, starting 4/10/23; to administer one tablet of Lisinopril one time a day for hypertension, starting 5/12/23; to administer one 75 mg capsule of Lyrica 3 times a day related to fibromyalgia, staring 4/7/23; one 0.625 mg tablet of Premarin one time a day every Monday and Wednesday for hormones, starting 4/10/23; and one 1.25 mg capsule of Vitamin D3 one time a day every Monday and Saturday for vitamin deficiency, starting 4/10/23. The July and August, 2023 MARs indicated the Elmiron was not administered twice on 7/10/23, once on 7/26/23, and once on 7/12/23 due to pending arrival from pharmacy. The Lorazepam was not administered once on 7/17/23 and twice on 7/18/23 due to pending arrival from pharmacy. The Fluticasone was not administered on 7/3/23 and 7/12/23 due to pending arrival from pharmacy. The Lisinopril was not administered on 7/13/23 due to pending arrival from pharmacy. The Premarin was not administered on 7/10/23, 7/17/23, 7/19/23, and 7/24/23 due to pending arrival from pharmacy. The Vitamin D was not administered on 7/10/23, 7/24/23, and 7/29/23 due to pending arrival from pharmacy. The Lyrica was not administered twice on 7/10/23 due to pending			

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	arrival from pharmacy. An interview was conducted with the DON (Director of Nursing) on 8/17/23 at 11:55 a.m. She indicated they hadn't had many issues with their pharmacy. Sometimes nursing staff just didn't realize they may need a physician signature to get a medication refilled, causing a delay in getting the medications in timely. The Ordering and Receiving Non-Controlled Medications policy was provided by ED (Executive Director) 2 on 8/17/23 at 12:56 p.m. It read, "Reordering of medications is done in accordance with the order and delivery schedule developed by the pharmacy provider(s). Quantities of medications sent from the pharmacy may vary in accordance with payer status, insurance plan, or law. Examples include Medicare A vs. medicaid, plan limitations on quantities under Medicare Part D, and quantity ordered by the prescriber. Reorder medication based on the reorder date on the Pharmacy Rx label, to assure an adequate supply is on hand." The Mediation administration general Guidelines was provided by ED 2 on 8/17/23 at 12:56 p.m. It read, "Administration...2. Medications are administered in accordance with written orders of the prescriber....4. Medications are administered without unnecessary interruptions." This Federal Tag relates to Complaints IN00414456. 3.1-25(a) 3.1-25(b)			
F 0807 SS=E	483.60(d)(6) Drinks Avail to Meet Needs/Prefs/Hydration			

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Bldg. 00	§483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, interview, and record review, the facility failed to provide ice, as preferenced, to 4 of 4 residents in the facility reviewed for hydration. (Residents B, D, F, and G) Findings include: An interview was conducted with the Maintenance Director during an environmental tour of the facility on 8/16/23 at 2:10 p.m. He indicated the ice machine was currently not functioning. He was told by corporate that parts were ordered. An interview was conducted with ED (Executive Director) 1 on 8/16/23 at 1:06 p.m. She indicated they'd been having issues with their ice machine. They would get it fixed, then it would break again. It was a bunch of different issues. It had been going on for about a week and a half. The last time she'd checked, it was working and able to make ice. They'd had to go out and get ice from the store, maybe 3 times total. The DM (Dietary Manager) informed her about the broken ice machine when it first happened. An interview and observation of the kitchen was conducted with the DM (Dietary Manager) on 8/16/23 at 1:35 p.m. The ice machine was plugged in and up to half full of ice. The DM pushed the screen to turn on the ice maker. The DM indicated	F 0807	**Deficiency F807 S/S E** **Drinks Available to Meet Needs/Preferences/Hydration** **1. Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** a. Ice is being monitored and purchased daily by the Administrator/designee until the ice machine is functioning properly. b. DON/designee will in-service nursing staff on hydration policy and who to contact if there is no ice. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. DON/designee will audit all residents to ensure they are receiving hydration per their preferences. b. Any resident found to be without proper hydration will have drinks/ice provided to their preference. **3. Address what measures will be put into place or**	08/31/2023

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	the ice machine was currently broken, had been for at least the past week, and management had been bringing in bags of ice and emptying the bags into the ice machine. When the DM came into the kitchen daily, the ice machine was always "tripped off." If you selected to make ice, you could hear it attempt, but the machine would trip off later. The DM pointed to a black box in the corner, connected to the ice machine. The DM indicated the black box was new about 3 weeks ago. She could tell the ice machine was going out then. Their Maintenance Director and Corporate Maintenance Director had come to look at it. An outside company hadn't come in to look at it while she was in the facility. She just wanted to know know who to call so the problem could be eliminated. They checked every shift to make sure they had plenty of ice. They usually went to a gas station down the street to buy ice. Since the ice machine had broken, there may be an issue on the weekends, when management wasn't present, with not having ice in the facility. She called into the facility this past Sunday and spoke with CNA (Certified Nursing Assistant) 5 to make sure there was plenty of ice in the facility. CNA 5 informed her there was only one bag. "I said come on ya'll." CNA 5 informed her she would have another CNA go get some. The DM requested for CNA 5 to "please just make sure there's enough to last until management comes in on Monday." When the DM arrived at work Monday morning, the ice machine was "totally empty." On Monday, one of the residents informed her there was no ice in the facility on Sunday. An interview was conducted with Resident B on 8/16/23 at 3:21 p.m. She indicated there had been "no ice lately." She liked to have ice in her water, but 2 or 3 times, she had to get water from her bathroom sink. She didn't remember what days		**systemic changes made to ensure that the deficient practices will not occur.** a. DON/designee will audit 5 random residents to ensure hydration is being offered. b. This random audit will be conducted: i. QD (M-F) X 4 Weeks ii. 2x/week x 4 weeks iii. Weekly x 4 weeks iv. Monthly x 4 months c. ADMIN/designee will audit the ice level to ensure ice is provided daily until the ice machine is fixed. **4. Indicate how the facility plans to monitor its performance to make sure that the solutions are lasting.** a. Any negative trends will be reviewed in monthly QAPI meetings. After 6 months, the IDT will determine the need and/or frequency of continued monitoring. b. DON/designee will continue the above audit process once quarterly as an ongoing practice. **5. Date of completion.** a. August 31, 2023 **Disclaimer: this plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of**	

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	there was no ice, but there was a day she couldn't get any. An interview was conducted with Resident F on 8/17/23 at 11:59 a.m. She indicated she hadn't been able to get ice lately and "there needs to be a back up plan." She was pounding on the kitchen door for ice 4 or 5 days ago. She'd gone 2 or 3 days with no ice at all, and was drinking water with no ice, "yuck." An interview was conducted with Resident D on 8/17/23 at 12:11 p.m. She indicated the ice machine wasn't working and it was a problem. The staff hadn't been coming around regularly with water and ice since. An interview was conducted with Resident G on 8/17/23 at 12:15 p.m. She indicated no one was regularly coming to pass water and ice. The ice machine had been broken for 6 or 7 weeks. They were given a half a pitcher of ice today. Resident G displayed a small maroon pitcher half full of ice at this time. This Federal Tag relates to Complaints IN00414456.		**this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted.to meet requirements established by state and federal law.**	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain the kitchen and residents' rooms in a cleanly fashion and good repair for 2 of 4 residents whose rooms were observed and 30 of 30 residents in the facility who	F 0921	**Deficiency F921 S/S E Safe/Functional/Sanitary/Comfortable Environment** **1. Address how corrective actions will be accomplished for those residents found to**	08/31/2023

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	eat food from the kitchen. (Residents F and G) Findings include: An observation of the kitchen and interview was conducted with the DM (Dietary Manager) on 8/17/23 at 9:50 a.m. The baseboard behind the 3 compartment sink was hanging off the wall. The outer left leg to the 3 compartment sink was cracked where the leg met the bowl of the sink. There was standing water on the floor underneath the sink and missing floor tile. The DM indicated water leaked out of the leg and onto the floor. They regularly used the 3 compartment sink, and the leg had been like that for the past year. There were 2 green buckets with water inside, catching water leaking from the garbage disposal. The DM indicated the garbage disposal worked, but water leaked out around the edge of the disposal when you used it. There was a gap along the side and bottom of the back kitchen door, leading outside. Light could be seen through these gaps. The DM indicated she spoke with the Dietician several days ago about the door needing weather stripping. There was dirt and debris built up in the corner of the kitchen near the stove, including 4 dried macaaroni noodles. There was debris built up under the freezer and a significant amount along the back wall near the 3 compartment sink, dishwasher, and garbage disposal, including a broken dish, food wrappers, cups, and wadded up foil. The dry storage area had a chocolate syrup bottle, open chip bag, grape jelly packet underneath the shelves. DA (Dietary Aide) 4, upon request, swept out more debris from underneath the dry storage shelves, including 6 black straws, a pepper packet, a wadded up piece of paper, a ketchup packet, an open candy wrapper, a cigarette butt, a jar lid, and a writing pen.		**have been affected by the deficient practice.** a. Residents' rooms will be cleaned and repaired. b. The kitchen will be cleaned and repaired. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents' rooms will be cleaned and repaired. b. All components of the kitchen will be cleaned and repaired. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practices will not occur.** a. ADMIN/designee will audit 5 random residents' rooms to ensure rooms are in a clean fashion and in good repair. b. This random audit will be conducted: i. QD (M-F) X 4 Weeks ii. 2x/week x 4 weeks iii. Weekly x 4 weeks iv. Monthly x 4 months c. ADMIN/designee will inspect the kitchen to ensure the kitchen is a sanitary and clean environment to produce food for the residents in the facility. This	

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	155807	A. BUILDING 00 B. WING	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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	An observation of Resident D's and G's room and restroom was made on 8/17/23 at 12:15 p.m. The door to their restroom was loose when opened and closed, and made a noise while closing. The toilet rim was elongated, but the toilet seat was round and didn't fit completely over the elongated rim. The baseboard was pulling away from the wall in the restroom. There was a brown bedrail on the floor near a wheel chair. An interview was conducted with Resident G on 8/17/23 at 12:15 p.m. She indicated she told the Maintenance Director about the bathroom door "over and over," but he never came to look at it. The toilet seat swiveled back and forth and would pinch her while sitting on it. She told the Maintenance Director about it a couple months ago, but he never came to look at it either. Her bed rail came off 3 or 4 months ago, and she asked the Maintenance Director to put it back on her bed, but he hadn't. This Federal Tag relates to Complaints IN00414456. 3.1-19(f)		audit will match as above. **4. Indicate how the facility plans to monitor its performance to make sure that the solutions are lasting.** a. Any negative trends will be reviewed in monthly QAPI meetings. After 6 months, the IDT will determine the need and/or frequency of continued monitoring. b. DON/designee will continue the above audit process once quarterly as an ongoing practice. **5. Date of completion.** a. August 31, 2023 **Disclaimer: this plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted.to meet requirements established by state and federal law.**	
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for 30 of 30 residents in the facility.	F 0925	**Deficiency F925 S/S F Maintains an Effective Pest Control Program** **1. Address how corrective actions will be accomplished for those residents found to**	08/31/2023

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	Findings include: An interview and observation was conducted with ED (Executive Director) 1 and ED 2 on 8/16/23 at 1:06 p.m. There was a gnat flying around in the office at this time. ED 1 indicated the facility hadn't really had any issues with pests, other than gnats, but that was due to it being summer. An observation and interview was conducted with Resident B in her room on 8/16/23 at 3:21 p.m. There was a gnat flying in her room during the interview. An observation of the front entrance was made on 08/17/23 at 9:22 a.m. A gnat was flying in the area. An observation and interview was conducted with Resident F in her room on 8/17/23 at 11:59 a.m. Her room was very cool. She indicated they were having issues with gnats in the entire facility. She intentionally kept her room very cool, because "gnats don't like cold." An observation and interview was conducted with Resident D in her room on 8/17/23 at 12:11 p.m. There was a gnat flying near her bed. An observation and interview was conducted with Resident G on 8/17/23 at 12:15 p.m. She indicated the flies and gnats were "all over the place." Her breakfast tray was sitting on her bedside table with an exposed, uncovered bowl of milk and 2 glasses of uncovered drinks. She indicated staff needed to pick up her breakfast tray sooner, but they didn't remove it until her lunch tray was delivered. There was a gnat on one of the cups. An observation of the kitchen and interview was		**have been affected by the deficient practice.** a. Pest control lights are provided in common and notable areas of gnat presence. b. Facility inspected and identified for sources of gnat infestation. **2. Address how the facility will identify other residents who have the potential to be affected by the same deficient practice.** a. Staff in-service on what to do when pests are noticed in the building and who to report it to. b. Pest control company contacted for servicing. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practices will not occur again.** a. ADMIN/designee will audit/inspect all areas of the facility including resident rooms to ensure that there is no presence of gnats. b. This random audit will be conducted: **i.** QD (M-F) X 4 Weeks **ii.** 2x/week x 4 weeks **iii.** Weekly x 4 weeks	

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	conducted with the DM (Dietary Manager) on 8/17/23 at 9:50 a.m. There was standing water behind and beside the ice machine. There was a gallon size black pan catching water underneath the ice machine with a gnat flying nearby. There was a trash can near the back kitchen door that was uncovered with food debris inside, half full. There was a gnat flying nearby the trash can. The baseboard behind the 3 compartment sink was hanging off the wall. The outer left leg to the 3 compartment sink was cracked where the leg met the bowl of the sink. There was standing water on the floor underneath the sink and missing floor tile. The DM indicated water leaked out of the leg and onto the floor. They regularly used the 3 compartment sink, and the leg had been like that for the past year. There were 2 green buckets with water inside, catching water leaking from the garbage disposal. The DM indicated the garbage disposal worked, but water leaked out around the edge of the disposal when you used it. There was a gap along the side and bottom of the back kitchen door, leading outside. Light could be seen through these gaps. The DM indicated she spoke with the Dietician several days ago about the door needing weather stripping. There was dirt and debris built up in the corner of the kitchen near the stove, including 4 dried macaroni noodles. There was debris built up under the freezer and a significant amount along the back wall near the 3 compartment sink, dishwasher, and garbage disposal, including a broken dish, food wrappers, cups, and wadded up foil. The dry storage area had a chocolate syrup bottle, open chip bag, grape jelly packet underneath the shelves. DA (Dietary Aide) 4 swept out more debris from underneath the dry storage shelves, including 6 black straws, a pepper packet, a wadded up piece of paper, a ketchup packet, an open candy wrapper, a cigarette butt, a jar lid, and a writing		**iv.** Monthly x 4 months c. ADMIN/designee will inspect the kitchen to ensure the kitchen is a sanitary and clean environment to produce food for the residents in the facility. This audit will match as above. **4. Indicate how the facility plans to monitor its performance to make sure that the solutions are lasting.** a. Any negative trends will be reviewed in monthly QAPI meetings. After 6 months, the IDT will determine the need and/or frequency of continued monitoring. b. ADMIN/designee will continue the above audit process once quarterly as an ongoing practice. **5. Date of completion** a. August 31, 2023 **Disclaimer: this plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted.to meet requirements established by state and federal law.**	

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	pen. An environmental tour of the facility and interview was conducted with the Maintenance Director and ED 2 on 8/16/23 at 2:10 p.m. The Maintenance Director indicated they'd been having issues with flies/gnats. They used a safe spray and "these red apple looking things" to attract and treat for gnats. They usually kept them at the nurse's desk. The nurse's desk was observed, but there were none there. The Maintenance Director indicated when pest control came to the facility, he did not tour with them or discuss any findings or recommendations. The 6/29/23, 7/12/23, 7/27/23, and 8/11/23 pest control invoices were provided by ED 1 on 8/16/23 at 2:31 p.m. They indicated an every other week pest control service and a flylight program service from April through October. They indicated "preventative maintenance" was completed at each visit, but did not specify what the preventative maintenance included. An interview was conducted with owner of the facility's pest control company on 8/17/23 at 8:25 a.m. He indicated they provided pest control services at the facility every other week that included inspection of the facility, inspection of the pest stations, and the exterior of the facility. When they were in the facility, they tried to point out situations that could harbor gnats. The facility had loose floor tile, drains needing cleaned, and loose baseboard stripping in the kitchen, which all had gnat activity. He indicated they kept telling the facility those things needed repaired, as "the flies have been constant." The gnat activity was most prevalent in the kitchen and dining area. There were also gaps in the back kitchen door that needed sealed. He informed them of these issues 3			

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	or 4 months ago, the last time he was in the facility. The Pest Control Program policy was provided by ED 1 on 8/16/23 at 2:31 p.m. It read, "It is the policy of this facility to maintain an effective pest control program to ensure the facility is free of pests and rodents. An 'effective pest control program' is defined as measures to eradicate and contain common household pests (e.g., roaches, ants, mosquitos, flies, mice, and rats)." This Federal Tag relates to Complaints IN00414456. 3.1-19(f)(4)			