STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155291	A. BUILDING 00 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 13, 14, 15, 16, 17 and 20, 2023. Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census Bed Type: SNF/NF: 72 Total: 72 Census Payor Type: Medicare: 3 Medicaid: 55 Other: 14 Total: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 30, 2023.	F 0000		
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Holder	Executive Director	04/13/2023

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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	treatment or medical services deemed 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 observation, interview and record review, the facility failed to ensure a resident's, (Resident 31) comprehensive care plan was updated to reflect the change of his Advance Directive status and wishes, and failed to ensure a physician's order was obtained for a resident (Resident 66) who received hospice care and had	F 0578	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the	04/20/2023

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	an Out of Hospital Do Not Resuscitate (DNR) form for 1 of 3 residents reviewed for Advance Directives. Findings include: 1. On 3/14/23 at 11:52 a.m., Resident 31 was initially observed. He sat upright on the edge of his bed; he was alert and oriented. During the interview he was asked if he had advance directive plans and he indicated that there was a recent meeting where he decided to change his status like his brother to a Do Not Resuscitate (DNR). On 3/14/23 at 12:00 p.m., Resident 31's medical record was reviewed for advance directive status. He had a Physician Order for Scope of Treatment (POST) which indicated he was a DNR status, while his comprehensive care plan indicated Resident 31 preferred to be a full code. During a follow up interview, on 3/15/23 at 11:10 a.m., Resident 31 was observed. He laid on top of his bed, neat clean and odor free. When asked about his advance directive preference, since his physician order and care plan did not match, Resident 31 indicated he would like to be a full code, "I want them to do everything they can do," and he motioned with his hands up and down in a fist, mimicking CPR compressions. On 3/15/23 11:00 a.m., Resident 31's medical record was reviewed. He was a long-term care resident with active diagnoses which included, but were not limited to, unspecified dementia, vascular dementia and mild intellectual disabilities. A quarterly Minimum Data Set (MDS) assessment		Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 31 comprehensive care plan was updated to reflect the change of his Advance Directive status. A physician's order was obtained for Resident 66 who received hospice care and had an Out of Hospital Do Not Resuscitate (DNR) form to reflect most current wishes of Resident and POA. Both families were made aware of the updates in their respective records. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. Audit was completed for all resident care plans, code status and orders to ensure accurate documentation. Code status of new admissions and re-admissions to be reviewed during clinical meeting daily for accuracy. DNS/Designee to	

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	was dated 12/13/22 and indicated Resident 31 was moderately cognitively impaired. His POST form was dated 10/21/22 and indicated DNR status. A corresponding physician's order, dated, 10/21/23 also reflected his DNR wishes. Resident 31 had a comprehensive care plan, initiated 11/17/21, which indicated he preferred to have a full code status. During an interview on 3/15/23 at 11:28 a.m., Resident 31's POA (power of attorney) indicated, Resident 31 had good and bad days with his mentality, and changed his mind a lot. It was part of his disease process related to his dementia. The family, and Resident 31 had a care plan meeting a while back where his code status had been changed, with Resident 31 present and agreeable, to a DNR status. The POST form was signed at that time, and it was the POA's expectation that his care plan would be updated to match the order. During an interview on 3/15/23 at 11:34 a.m., the Social Service Regional Support (SSRS) indicated, when a resident's code status changed, and a new POST form indicated something different than the previous wish, the social service department would need to be notified and the care plan revised to reflect the resident's change of status. On 3/15/23 at 12:08 p.m., the SSRS provided a copy of current facility policy titled, "Physician's Order for Scope of Treatment (POST), revised 3/2022. The policy indicated, " ...reviewing [POST]: A patient's POST should ne reviewed in the following circumstances: ...the resident's		conduct an in-service with all licensed nursing staff and social services staff regarding code status and POST forms. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Inservice all licensed nurses and social services staff on code status and POST forms to be completed by DNS/Designee. Code status of new admissions and re-admissions to be reviewed during clinical meeting daily for accuracy. Code status, POST forms, and orders to be reviewed quarterly by IDT team and as needed with a new admission event or with a change of condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ø POC QAPI tools will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director Ø If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	treatment preferences change ... initiating a POST form: a POST form may be reviewed with the resident as a part of the advance care planning process ... If a resident (or if the resident lacks decision making capacity, the legally recognized healthcare decision maker) wishes to complete a POST form during the resident's stay, provide a POST form for the physician, advance practice nurse or physician assistant and the resident/legally designated health care decision maker to discuss, fill out and sign ... Implementing/Maintaining a POST form: ... ensure that the resident's wishes are accurately reflected in the plan of care ...." 2. On 3/14/23 at 11:35 a.m., Resident 66's medical record was reviewed. The diagnoses included, but was not limited to, chronic respiratory failure with hypoxia (low oxygen levels), chronic obstructive pulmonary disease, and diabetes. Resident 66's medical profile indicated he was a hospice care recipient and was a DNR. A completed Out of Hospital Do Not Resuscitate Declaration document, dated 2/10/23, was in the resident's hard/paper chart. This document indicated the resident's choice was not to be resuscitated. It was signed by the resident, and had 2 witness signatures. It was also signed by an attending physician. Resident 66's care plan, dated 2/2/23 and last revised 2/24/23, indicated "Resident/legal representative prefers a DNR code status. The physician's order set did not contain an order for any code status. On 3/14/23 at 2:44 p.m., during an interview, the Director of Nursing Services (DNS) indicated Resident 66 did not have a code status order in			

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	his physician's orders, it should have been entered on 2/13/23. On 3/16/23 at 11:05 a.m., the DNS provided a policy, dated as revised 2/23, titled "Advanced Directives." This current policy indicated,"...Out of Hospital Do Not Resuscitate Declaration and order form...A physician's order indicating the resident's decision regarding CPR [cardiopulmonary resuscitation] will be added to the physician's orders...." 3.1-4(d) 3.1-4((l)(4) 3.1-38(f)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.			

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	(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to ensure a resident's care plan was updated after removal of a nephrostomy tube for 1 of 1 residents reviewed for urinary catheters (Resident 21). Findings include: On 3/13/23 at 11:28 a.m., during a random interview and observation, Resident 21 was seated in a wheelchair, in her room. She wore a hospital gown and a blue sweater. A small catheter bag, which contained clear yellow liquid, was observed on the resident's lap. A larger urinary catheter bag, which was covered for dignity, was attached underneath her wheelchair. Resident 21 indicated she had a suprapubic (catheter inserted through the abdomen to the bladder) fastened under her chair, the smaller bag was a drain to her kidney. She did have two drains, one to each kidney but the urologist was able to remove one. On 3/16/23 at 10:14 a.m., Resident 21's medical record was reviewed. The diagnoses included but were not limited to sepsis (severe systemic infection), chronic kidney disease, neuromuscular dysfunction of bladder, and adult failure to thrive. A nurse's progress note, dated 2/13/23 at 3:51 p.m., indicated Resident 21 had returned from a follow-up appointment with new orders and	F 0657	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 21 care plan was immediately updated to reflect the removal of a nephrostomy tube. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident with a removal or addition of medical devices have the potential to be affected. Audit to be completed of care plans by MDSC/Designee current	04/20/2023

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	follow-up appointments. One nephrostomy tube was removed from her left back. Continue to flush other tube twice a day as directed. Appointments and orders noted as directed. A care plan, with a start date of 8/27/22, and edited 3/13/23, indicated Resident 21 required bilateral nephrostomy tubes. The diagnoses included history of sepsis, likely urinary, adult failure to thrive, CKD (chronic kidney disease) stage 3 (advanced), malnutrition, neurogenic bladder requiring suprapubic, paraplegia below the waist, and impaired mobility. The goal, with a target date of 5/14/23, indicated Resident 21 would have nephrostomy tubes managed appropriately as evidenced by: not exhibiting signs of infection or trauma. On 3/17/23 at 9:24 a.m., during an interview, the Director of Nursing Services (DNS) indicated Resident 21's care plan should have been updated after one of the nephrostomy tubes had been removed. On 3/15/23 at 11:24 a.m., the DNS provided a policy, dated as revised on 10/19, titled "IDT [interdisciplinary] Comprehensive Care Plan Policy." This current policy indicated, "...Care plan problems, goals, and interventions will be updated on changes in resident assessment/condition, resident preferences or family input...." 3.1-35(d)(2)(B)		residents with doctor's appointments and change in condition in the last thirty (30) days. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** IDT has been in-serviced on updating care plans by RAI Specialist 4/10/23. IDT to complete daily audit tool to ensure that resident care plans are updated with daily orders/weekly plan of care review. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ø MDSC/Designee will complete a Care Plan Updating QA tool weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director Ø If 95% is not achieved an action plan will be developed for compliance for six months by the QAPI team.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observations, interview, and record review, the facility failed to identify change in condition and ensure timely transfer to the hospital after residents experienced change of condition for 2 of 3 residents reviewed for hospitalizations (Residents 16 and 26). Findings include: 1. On 3/14/23 at 10:22 a.m., Resident 16 was initially observed. He laid in his bed which was in a raised position, slightly higher than regular height. Although the head of his bed was elevated, he asked that it be raised higher to make it easier for him to speak. There was a long flexible arm device attached to the left side bedrail and positioned directly near his mouth. He was observed to be overweight, and indicated he was unable to move due to being "quadriplegic." He wore a nasal cannula (NC) which was hooked up to a concentrator beside his bed set at 4 liters (L). He indicated he had gotten an infection in his spine which gradually paralyzed him, most recently he had lost even more control of his hands and arms. He was soft spoken, and hard to understand which he also indicated was a part of his paralysis. When asked how he got the staffs' attention if he needed assistance since he could not use a traditional call light or call out for help, he indicated the arm device beside his face was a call light and demonstrated by placing his mouth over the open mouthpiece and blew into the tube,	F 0684	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 16 and Resident 26 are no longer at facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving care had the potential to be affected by the alleged deficient practice. Audit to be completed by DNS/Designee for residents with	04/20/2023

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	which illuminated his call light. Resident 16 indicated he wanted to get up out of bed, it was harder for staff to help him up since he was bigger and needed 2-3 people sometimes to get him into his chair. Then after he was up for a while he needed to be laid back down when his back started to hurt, and he sometimes had to wait a long time. During the interview, Housekeeper (HK) 17 entered Resident 16's room to answer his call light (which he had illuminated a few minutes earlier). He told he would like to get up and HK 17 indicated she would go inform the nursing staff. Shortly after, less than 5 minutes, Certified Nursing Assistant (CNA) 16 entered the room and turn off the call light. Resident 16 indicated he would like to try to get up in his chair. CNA 16 indicated she would go and get supplies and additional staff assistance and return as soon as she could. She did not offer Resident 16 any fluids at that time. On 3/14/23 at 1:39 p.m., Resident 16 was observed. He remained in bed, but at this time received a visit from a Speech Therapist (ST) but they would be done in about 10 minutes. On 3/14/23 at 1:49 p.m., Resident 16 remained in bed and indicated he was unable to finish with his ST as he was very tired and had trouble answering her questions, "I couldn't say what I wanted to." He indicated he was still waiting for assistance to get up out of bed. During an interview on 3/14/23 at 1:50 p.m., CNA 18 indicated she and another CNA attempted to get him up a little earlier, but he had been asleep. It was difficult to wake him, and when they did, he		change in condition in the last 4 weeks to ensure appropriate procedures completed and MD and family notification present as required. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Inservice all nursing staff on Quality of Care to be completed by DNS/Designee. DNS/Designee will complete an inservice with nursing staff across shifts for all staff to ensure staff education on customer service and change in condition to be completed by 4/19/23. Any resident who experiences a change in level of functioning will be reviewed in morning meeting to ensure care needs are addressed as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ø DNS/Designee will be responsible for Accommodation of Needs QA tool weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director Ø If a threshold of 95% is not	

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	said he did not want to get up. On 3/14/23 at 2:00 p.m., Resident 16 remained in bed and indicated he was thirsty and asked for a drink of his Ensure, which was on his bedside table. When asked if Resident 16 had eaten lunch, and/or what it had been, he struggled to keep his eyes open, and struggled to find words to answer. He nodded off asleep. He aroused easily to his name, and when asked if was tired, he indicated he was. His speech was observed to be at a much slower pace than earlier in the morning and as he spoke it was in and out of consciousness as he continued to nod off but woke himself back up to continue. Resident 16 indicated he thought he may be more tired through the day since he was awake a lot during the night, and instead of helping him sleep, staff preferred it so that he was less of a burden during the day. Resident 16 indicated he felt like maybe he had too much medicine, recently his Gabapentin, which can make him sleepy, was doubled. On 3/14/24 at 2:06 p.m., CNA 19 entered Resident 16's room and indicated his call light was on and asked what he needed. Resident 16 indicated he did not remember turning it on, but he would like to get up. When CNA 19 was asked, if Resident 16 appeared and sounded normal, she indicated, "no, he seems too sleepy." CNA 19 indicated she would let him nap and check on him later. CNA 19 exited the room after turning off his call light. She did not offer him any fluids at that time and did not indicate she would inform the nurse of his excessive drowsiness. On 3/14/23 at 2:07 p.m., CNA 19 was observed as she exited Resident 16's room and entered another resident's room and closed the door.		achieved, an action plan will be developed to ensure compliance.	

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	On 3/14/23 at 2:08 p.m. Licensed Practical Nurse (LPN) 20 was informed Resident 16 was having trouble staying awake. On 3/14/23 at 2:11 p.m., LPN 20 entered Resident 16's room. He called the resident's name, and he woke slowly, he asked why he was so sleepy, and Resident 16 indicated he did not know, and "it feels like I'm in suspended animation." LPN 20 left the room to get a rolling vitals machine. On 3/14/23 at 2:13 p.m., LPN 20 re-entered Resident 16's room and began by checking his blood pressure (BP). LPN 20 had to fully lift and manipulate the resident's right arm and placed the BP cuff. The initial BP reading was: 86/41, LPN 20 indicated that it was too low. He moved the BP cuff to the resident's left arm and the reading was: 110/51. LPN 20 indicated it was a little better but still low. LPN 20 placed a pulse/oxygen (O2) oximeter (a medical device that measure pulse and blood oxygen saturation levels) on Resident 16's left pointer finger. LPN 20 had to uncurl the resident's fingers, as Resident 16 could not open his palm. His initial oxygen level was 85%. LPN 20 adjusted the O2 NC and raised the resident's head of bed, and Resident 16's O2 level came up to 96%. Resident 16 indicated his blood pressure readings were usually in the 130's over 80's, and as he spoke, he continued to struggle to find words and stay awake, he requested some water. On 3/14/23 at 2:30 p.m., LPN 20 came back with a Styrofoam cup of water and a straw and assisted Resident 16 to take a drink. He took a long drink. LPN 20 rechecked his BP and the reading was 84/39. LPN 20 indicated he did not know why the BP was so low, but Resident 16 did not seem at his baseline and this excessive sleepiness and lethargy was not normal, so he was going to go			

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	call the on-call doctor or NP (Nurse Practitioner). On 3/14/23 at 2:48 p.m., LPN 20 was at the nurses' station and indicated the NP had given a new order to send Resident 16 to the hospital for further eval since his BP was low and he had an elevated carbon dioxide level from a recent lab. A copy of the lab results was requested at that time. On 2/15/23 at 2:00 p.m., Resident 16's medical record was reviewed. He was a long-term care resident with active diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD), shortness of breath (SOB), acute and chronic respiratory failure with hypoxia, acute on chronic congestive heart failure, dependency on supplemental oxygen, paraplegia, muscle weakness, and morbid obesity. He admitted on 11/17/22 after an earlier acute hospital stay on 11/3/22 when he was found to have severe volume overload, severe hypercarbia, and there were also likely components of an opioid overdose (summarized below in an initial NP H&P). Shortly after his admission he was transferred back to the hospital (summarized below) and re-admitted on 11/22/23. At that time, the social service director visited with him and indicated he had lost all control of his arms and hands. The Social Service Director offered him emotional support and a referral for a psychological consult, but he declined at that time. A nursing progress note, dated 1/17/23 at 1:08 a.m., indicated Resident 16 was alert and oriented with below the neck paralysis. The record lacked documentation of MD/NP or			

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	IDT (interdisciplinary team) follow up to address Resident 16 progressive paraplegia. An initial visit from the NP was conducted on 12/2/22 at 6:11 p.m., (the NP note was recorded late on 1/15/23 at 6:11 p.m.). The NP note indicated, " ...Resident was seen for physician Initial H&P [history and physical]. Resident was seen for physician multiple co-morbidities at high risk., Resident is a new patient to provider ... Hospital History: Patient is highly complex, originally admitted to [St. Vincent] with volume overload, severe hypercarbia [elevated carbon dioxide] and opioid overdose. Diuresed [to lower volume overload] and titrated [measured/deliberate decreased) down on narcotics and on BiPap support. Patient then arrived to Eagle Valley Meadows 11/16/22 and sent out 11/17/22 to [local hospital] for acute BOS, positive DVT [deep vein thrombosis, a medical condition that occurs when a blood clot forms in a deep vein] on Eliquis [an anticoagulant medication] with concern for respiratory distress and PE [pulmonary Embolism, a sudden blockage in your pulmonary arteries, the blood vessels that send blood to your lungs]. He was treated for UTI [urinary tract infection], CHF and PE/DVT. He returned to facility 11/22/22 and was sent out same day per patient demand and stated he did not like the bed and wanted to return to hospital. Returned to facility with new LAL [low air loss] mattress and larger bed ordered and in place ...." A nursing progress note, dated 2/25/23 at 12:06 a.m., indicated Resident 16 was resting in bed with his eyes closed. Patient was somnolent (excess sleepiness) and was not easily aroused. The nurse had gone to him his pills and noted that he was confused, cursed at the writer and held the pills in mouth and was unable to follow one step			

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	commands. Writer asked resident to say his name to which resident replied "Shut the f*** up" repeatedly, which was unusual for resident. His vital signs were within normal limits and his catheter tube was not kinked but was flowing well with amber color urine in bag. On-call contacted and recommends sending resident to ER [Emergency Room] for evaluation. Resident refused to go to ER at this time and the on-call was notified via a voice message. When the nurse went to reassess the resident, he could then state name, location, and year." The record lacked documentation of MD/NP or IDT (interdisciplinary team) follow up related to the 2/25/23 change of condition. On 3/14/23 at 3:00 p.m., LPN 20 provided a copy of Resident 16's lab which noted his carbon dioxide (CO2) levels. The lab was dated 2/28/23 at 4:29 p.m. and indicated his CO2 was elevated at 45 with a normal range of 21-33 and his chloride was at Reporting Limit (this is the lowest concentration that would be reported by the laboratory) at 88, on a range of 98-110. The record lacked documentation of follow-up for these lab results, until the CO2 levels were used as a determining factor to send Resident 16 to the hospital on 3/14/23. A nursing progress note, dated 3/5/23 at 4:31 p.m., indicated Resident 16's C&S (culture and sensitivity test of a urine sample to determine cause of infection) were received this shift. The results were called into the doctor and a new order for Macrobid (an antibiotic medication) 100 mg (milligrams) 3 times a day for 7 days. He was placed in contact isolation due to ESBL in his urine. (Extended-spectrum beta-lactamases			

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	(ESBLs) are enzymes that confer resistance to most beta-lactam antibiotics). A nursing progress note dated 3/14/23 at 3:33 p.m., indicated, Resident 16 was hard to stay aroused, upon assessment resident BP: 90/51, 108/53, NP was aware of resident's condition, order to send resident to the ER to treat and eval. Resident refused to go to ER, this writer educated resident on how important it was to go to ER to get treated and eval resident agreed. Resident 16 had a physician's order for scheduled Hydrocodone-Acetaminophen (a narcotic pain medication) 5-325 mg with instructions to give 2 tablets every 6 hours for pain. Resident 16 was scheduled to receive his narcotic pain medication on the following 6-hour schedule: 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. The March MAR (medication administration record) was reviewed and reconciled with the controlled substance record (CSR) and indicated the following: 3/13/23 MAR 5:00 a.m., administered with no concerns. 11:00 a.m., administered 2 and 26 minutes late at 1:26 p.m. 5:00 p.m., administered 3 hours late at 8:00 p.m. 11:00 p.m., charted late at 12:44 a.m. the following morning, with a note that it was administered on time at 11:00 p.m. 3/13/23 CSR 5:00 a.m., reconciled to MAR with no concern. 11:00 a.m., reconciled to MAR as removed at 11:00 a.m., although above administered at 1:26 p.m. 5:00 p.m., lacked documentation of a 5:00 p.m. administration, but an 8:00 p.m., late			

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	administration of the 5:00 p.m. was recorded. 3/14/23 MAR 12:45 a.m., (as noted above) the previous evening's ee:00 p.m. dose was charted late but administered on time. 5:00 a.m., administered with no concerns. 11:00 a.m., administered with no concerns. 5:00 p.m., LOA (leave of absence) Hospital. 11:00 p.m., LOA Hospital 3/14/23 CSR 5:00 a.m., administered 25 minutes early at 4:35 p.m. 11:00 a.m., administered an hour early at 10:00 a.m. 5:00 p.m., LOA Hospital 11:00 p.m., LOA Hospital Resident 16 had a comprehensive care plan initiated 11/17/22 which indicated he was at risk for pain due to his diagnoses. An intervention for this plan of care included, but was not limited to, "observe for adverse side effects of pain medication including, but not limited to over sedation, constipation, skin rash, nausea/vomiting, loss of appetite, change in mental status, stomach upset. Document abnormal findings and notify MD ...." The comprehensive care plan lacked person-centered revision/interventions to address Resident 16's previous opioid overdose. Further the comprehensive care plan lacked person-centered revision/interventions to address Resident 16's dependence on his adaptive blow-call-light device. Resident 16 remained in the hospital for the until the end of the survey period.			

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	2. On 3/16/23 at 2:00 p.m., Resident 26's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, methicillin-resistant Staphylococcus aureus, (MRSA, a type of bacteria that is resistant to several antibiotics), bilateral above the knee amputation, phantom limb syndrome, type II diabetes mellitus and UTI, peripheral vascular disease and history of stroke. He had an active physician's order for Eliquis (an anticoagulant medication) and received 2.5 mg, twice a day. A nursing progress note dated 2/3/23 at 1:28 a.m., indicated, "Resident earlier experiencing n/v [nausea/vomiting] with coffee ground color emesis in large quantity, he stated he was not feeling ok, and were [was] given PRN [as needed] Zofran ... on-call notified ...." Resident 26's MAR was reviewed and revealed, the PRN Zofran had been administered 2/2/23 at 11:14 p.m., 2 hours and 14 minutes prior to the on-call being notified. A physician notification text threat was provided by the DON on 3/16/23 at 2:45 p.m. The communication was not initiated until 2/3/23 at 1:28 a.m. At that time, the on-call ordered a gastric occult blood test and a CBC (comprehensive blood count). A stool sample and CBC lab were collected on 2/3/23 at 7:07 a.m. The CBC results were received on 2/3/23 at 8:40 p.m. with a critical hemoglobin (HGB) level of 6.2, when the range should be 14-18.			

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	A nursing progress note, dated 2/4/23 at 2:17 a.m., indicated, the on-call was notified of the critical value of HGB and elevated white blood cell count (WBC). At that time the on-call placed a STAT (immediate) repeat HGB level. A nursing progress note dated 2/4/23 at 7:26 p.m., indicated, the nurse received a call from a lab technician who reported a critical HGB level of 5.5. The on-call was paged, and an order was given to send the resident to the hospital. The corresponding lab was dated 2/4/23 and indicated the STAT HGB critical value was reported to the facility 2/4/23 at 2:48 p.m., A Hospital Transfer Form was dated 2/4/23 at 6:29 p.m., 3 hours and 41 minutes after the lab results were received an order was obtained to send the resident out. The corresponding Hospital Treatment Record was reviewed and indicated, Resident 26 arrived to the ER with complaints of low HGB and dark stool the day before. An abdominal CT (computed tomography, a medical procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body), the right SFA (superficial femoral artery) appeared occluded (blocked) at its origin. There was a significant stenosis (narrowing) of the left SFA near its origin. The right SFA occlusion appeared new when compared to a 2/20/21 and a vascular surgeon was recommended for follow up. Additionally, he received two blood transfusions while in the ER. He was diagnoses with an acute kidney injury, a complicated UTI, and anemia. During an interview on 3/17/23 at 11:26 a.m., a final review of above timeline with conducted with the			

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	Director of Nursing (DON). At that time, the DON indicated ER Transfer forms are opened when the resident is being prepared to leave. Although the record lacked documentation of what time Resident 26 left the building, the closest time would have been recorded on the transfer form, and the DON indicated he should have been sent out sooner than 3 hours and 41 minutes after the lab was received. Further, the DON indicated the MD should have been notified immediately of the coffee ground emesis at the time it happened, and not have waited until more than 2 hours later. On 3/16/23 at 11:10 a.m., the DON provided a copy of current facility policy titled, "Resident Change of Condition), revised 11/2018. The policy indicated, " ...it is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely and effective intervention takes place ... Acute Medical Change: any sudden change in a resident's condition manifested by marked change in physical or mental behavior will be communicated to the physician ...." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, interview, and record review, the facility failed to implement interventions to prevent the potential for falls for a resident who had a history of falls with fracture for 1 of 4 residents reviewed for accidents (Resident 34). Findings include: During an observation on 3/17/23 at 1:12 p.m., Resident 34 was observed lying in bed. She had a low air mattress, regular size with grab bars. The mattress did not have bolsters (build up edges for boundaries) on it. During an observation on 3/20/23 at 12:57 p.m., Resident 34 was observed lying in bed. She had a regular low air loss mattress without bolsters. A comprehensive record review was completed for Resident 34 on 3/20/23 at 9:32 a.m. She had diagnoses which included, but were not limited to, senile degeneration of the brain, fracture of the right femur, protein-calorie malnutrition, dementia, osteoporosis, and muscle weakness. On 8/8/22, Resident had a fall and was sent to the hospital for surgical repair of her right femur. Resident 34 returned to the facility on 8/12/22. An Interdisciplinary Team (IDT) progress note, dated 8/7/22 at 10:45 a.m., indicated Resident 34 slid off of her bed and onto the floor. The progress note indicated a body pillow was placed as the immediate intervention for tactile boundaries. A bari-bed with bolster was ordered to allow resident more space to stretch out while lying in bed.	F 0689	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 34 bed was replaced by Hospice company with appropriate Bari Bed with bolsters. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident that requires a Bari Bed for fall intervention has the potential to be affected. An audit will be completed for all residents with fall interventions that include a Bari Bed to ensure fall interventions are implemented per plan of care. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	04/20/2023

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	Resident 34's comprehensive care plan was reviewed and lacked documentation that the interventions of adding a bari-bed with bolsters was added. During an interview on 3/20/23 at 9:46 a.m., the Director of Nursing Services (DNS) indicated Resident 34's hospice company changed her bed back to a regular size bed. The DNS indicated she notified the hospice company to bring a bari-bed with bolsters. She indicated the bed was ordered. A policy titled, "IDT (interdisciplinary team) Comprehensive Care Plan Policy," dated 1/2010 was provided by the DNS (Director of Nursing Services) on 3/15/23 at 11:42 a.m. The policy indicated, " ...It is the policy of the facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning included medical, nursing, mental and psychosocial needs ...." 3.1-45(a)		Inservice all nursing staff and Care Companions on Fall Interventions to be completed by DNS/Designee. Care companion/Designee will conduct rounds daily to ensure all fall interventions are implemented per plan of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ø Fall Management QAPI will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director Ø If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide treatments/services for a resident who had a diagnosis of Post-Traumatic Stress Disorder (PTSD) for 1 of 1 residents reviewed for PTSD	F 0745	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission	04/20/2023

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	(Resident 56) Findings include: On 3/14/23 at 9:36 a.m., Resident 56 was observed sitting up in a standard chair with bright tape on the arms of the chair in her room. The door to the room was shut. On 3/15/23 at 10:32 a.m., Resident 56 was observed lying in bed on her right side. Her eyes were closed. On 3/15/23 at 2:34 p.m., Resident 56 was observed sitting up in a chair in her room. The door to her room was shut. On 3/16/23 at 9:23 a.m., Resident 56 was observed sitting up in a chair in her room. The door to the room was shut. On 3/16/23 at 12:16 p.m., Resident 56 was observed sitting up in her wheelchair in the dining room. She was alert and did not display any behaviors. On 3/20/23 at 9:51 a.m., Resident 56 was observed sitting in the lounge area with other residents. She was alert and did not display any behaviors. On 3/15/23 at 2:02 p.m., a comprehensive record review was completed for Resident 56. She had the following diagnoses which included, but were not limited to, Alzheimer's disease, encephalopathy, hypertension, debility, Post-Traumatic Stress Disorder (PTSD), and psychotic disorder with delusions. Resident 56's care plan lacked information pertaining to Resident 56's PTSD to include		or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 56 diagnosis of PTSD was discontinued by the psychiatric provider and family was made aware. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident that had an inaccurate PTSD diagnosis has potential to be affected by the alleged deficient practice. Audit to be completed for all residents with a PTSD diagnosis to ensure appropriate with supporting documentation with accurate care plan. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Inservice all Social Service and nursing staff on PTSD diagnosis to	

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(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
	triggers associated with the diagnosis and interventions to address the PTSD. Her behavior care did not address an intervention to leave resident in her room due to over stimulation when with other residents. Resident 56 was prescribed prazosin (a medication that can be used to treat PTSD-associated nightmares), 1 milligram (mg) at bedtime for PTSD. During an interview with Resident 56's spouse on 3/15/23 at 11:20 a.m., he indicated he was not aware that Resident 56 had been diagnosed with PTSD. During an interview with Licensed Practical Nurse (LPN) 5 on 3/15/23 at 2:22 p.m., she indicated Resident 56 stayed in her room due to overstimulation when she was with others. Resident 56's roommate kept the door to her room shut. Resident 56 was fed in her room due to increased behaviors when she was with other residents. Resident 56 was fed by staff. During an interview with Social Service Director (SSD) 7 on 3/16/23 at 11:12 a.m., she indicated that Resident 56 was followed by a mental health provider. The provider added a diagnosis of PTSD as the resident was often combative when she was provided with care of her peri area. SSD 7 provided a psychiatry progress note on 3/16/23 at 3:25 p.m. The note indicated Resident 56 was stable at baseline continued to display physical aggression with peri care. This was an ongoing behavior as resident was calm and cooperative with care until staff did peri care or attempts to remove Resident 56's clothes. Planned to introduce a low dose of prazosin to address possible PTSD symptoms.		be completed by Social Services/Activity Support/Designee. DNS/Designee will monitor residents with PTSD diagnosis to ensure appropriate care plan completed and documented in the medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ø POC QAPI Tool related to monitoring for PTSD diagnosis will be utilized bi-weekly x 4 weeks then monthly x 4 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director Ø If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	155291	A. BUILDING 00 B. WING	03/20/2023

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	A policy titled, "IDT (interdisciplinary team) Comprehensive Care Plan Policy," dated 1/2010 was provided by the DNS (Director of Nursing Services) on 3/15/23 at 11:42 a.m. The policy indicated, " ...It is the policy of the facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning included medical, nursing, mental and psychosocial needs ...." 3.1-34(a)			
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 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-			

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	§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 record review and interview, the facility failed to reconcile and document the disposition of medications for 4 of 5 discharged residents reviewed for discharge (Residents 64, 67, 68, and 69). Findings include: 1. On 3/20/23 at 10:51 a.m., Resident 64's medical record was reviewed. He had the following diagnoses, which included, but were not limited to, diabetes type II, congestive heart failure, essential hypertension, major depression, anxiety bi-polar disorder, osteoarthritis of the knee, and reduced mobility. Resident 64's medication regimen included acetaminophen, atorvastatin, biofreeze, clopidogrel, cyclobenzaprine, doxycycline, escitalopram oxalate, ferrous sulfate, gabapentin, insulin lispro, Levemir insulin, melatonin, metformin, metoprolol tartrate, nitroglycerin, pantoprazole, quetiapine, ranolazine, tamsulosin, thera-M vitamin, tramadol, and zinc. 2. On 3/20/23 at 10:35 a.m., Resident 67's medical record was reviewed. She had the following	F 0755	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 64, 67, 68 and 69 no longer reside at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	04/20/2023

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	diagnoses, but not limited to Alzheimer's disease, unspecified dementia, muscle weakness, essential hypertension, difficulty walking, vitamin deficiency and constipation. Resident 67's medication regimen included acetaminophen, calcium, vitamin b-12, lisinopril, and senna. 3. On 3/20/23 at 9:54 a.m., Resident 68's medical record was reviewed. She had the following diagnoses, but not limited to COPD (chronic obstructive pulmonary disease), essential hypertension, and anxiety disorder. Resident 68's medication regimen included acetaminophen, anoro ellipta, budesonide, buspirone, duloxetine, hydroxyzine, ipratropium-albuterol, metoprolol, pantoprazole, prednisone, proair digihaler, and saline nasal mist. 4. On 3/20/23 at 10:17 a.m., Resident 69's medical record was reviewed. He had the following diagnoses, but not limited to fracture of right femur, muscle weakness, difficulty walking, neuropathy, depression, constipation, and pain. Resident 69's medication regimen included acetaminophen, acyclovir, bupropion, calcium, vitamin D, vitamin B-12, Eliquis, fluoxetine, gabapentin, and sennosides-docusate sodium. During an interview with the ED (Executive Director) on 3/20/23 at 11:52 a.m., she indicated the facility was unable to provide documentation of the disposition of medications for Residents 64, 67, 68 and 69. A policy titled, Disposal/Destruction of Expired or Discontinued Medications dated 12/1/07, was provided by the DNS (Director of Nursing Services) on 3/20/23 at 1:00 p.m. The policy		Any resident that was discharged to hospital then to home or expired had the potential to be affected by alleged deficient practice. Audit to be completed for discharged residents to hospital then home or expired in the last 4 weeks to ensure appropriate disposition of medications. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Inservice all nursing staff on Medication Destruction protocol and inventory to be completed by DNS/Designee by 4/20/23. DNS/Designee will conduct weekly audits of medication destruction forms/inventory to ensure proper documentation and follow through. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Nursing staff inservice on Medication Destruction protocol and inventory to be completed by DNS/Designee by 4/20/23. DNS/Designee will conduct weekly audits of medication destruction forms/inventory to ensure proper documentation and follow through for 4 weeks and then monthly for 6 months using	

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	indicated ... "the facility should enter the following information on the drug destruction form when medications are destroyed: resident's name, name and strength of medication, prescription number, amount of medication destroyed, date of destruction, signature of witness and method of destruction, including donation as permitted by applicable law ...." 3.1-25(a) 3.1-25(b)(l) 3.1-25(c)		POC QA tool, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which			

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	the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to properly label medications for 2 of 2 residents randomly observed during a medication storage observation (Residents 21 and Resident 4) . Findings include: 1. During an observation on 3/15/23 at 8:55 a.m., Resident 21 had an order for thera-M 9mg/400mcg by mouth daily. RN 9 removed the bottle of medication from the cart. The bottle lacked a prescription label. It had her name on it. 2. During an observation on 3/16/23 at 11:43 a.m., Resident 4 had a box with her name on it. LPN 5 indicated these medications were stored in the narcotic box. She had two boxes. One was 1:3 releaf oil. The other was social CBD. LPN 5 indicated one goes on her skin and the other was oral. The medications lacked a prescription label. On 3/17/23 at 10:20 a.m., a policy titled, "General Dose Preparation and Medication Administration," was provided by the DNS (Director of Nursing Services). The policy indicated, " ...Facility staff should not administer a medication if the medication or prescription label is missing or illegible. 3.1-25(j) 3.1-25(m) 3.1-25(n)	F 0761	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 21 and 4 medication is appropriately labeled. All medication carts were immediately audited. All licensed nurses and QMAs will be educated on medication storage policy. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. DNS/Designee to conduct an in-service with all licensed nursing	04/20/2023

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			staff and QMAs regarding medication storage policy. All medications were reviewed to ensure all have appropriate label by DNS/Designee **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/Designee to conduct an in-service with all licensed nursing staff and QMAs regarding medication storage policy. Medication labeling and proper storage to be checked weekly using POC rounding tool by DNS/Designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** POC QAPI tool will be utilized weekly for 4 weeks, monthly for 6 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	