STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELLENIC SENIOR LIVING OF MISHAWAKA	1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00428787 & IN00428869. Complaint IN00428787 - No deficiencies related to the allegations are cited. Complaint IN00428869 - No deficiencies related to the allegations are cited. Survey dates: March 5 & 6, 2024 Facility number: 014224 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/11/24.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Huttel	Executive Director	04/17/2024

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

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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to complete a fire drill every quarter on each shift. This had the potential to affect all 120 residents residing in the facility. Finding includes: On 3/6/2024, the Administrator provided 12 months of fire drills completed for the past year. The Fire Drill Report Sheets lacked the documentation to show a Fire Drill had been conducted on all shifts for the first quarter (January, February & March) in 2023 and for the third quarter (July, August, & September), and lacked the documentation for the evening shift during the second quarter (April, May & June) in 2023. The Fire Drill Reports Sheets lacked the documentation to show a Fire Drill had been conducted in the fourth quarter on evening and night shift in the year 2023. During an interview, on 3/6/2024, at 10:57 A.M., the Maintenance Director indicated he had not completed a fire drill each quarter on a different shift but should have. On 3/6/2024 at 2:58 P.M., a policy on Fire Drills was requested but one was not provided prior to	R 0092	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Preventative maintenance will be followed and fire drills conducted when stated per PM program (TELS). 4. Maintenance/designee will complete audit form, review with the ED/Designee and bring to monthly managers meeting for review or recommendations for six months. Completion date 3-7-24	03/07/2024

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	the survey exit.			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure dementia training was completed	R 0119	1. Corrections of previous timeframes cannot be made. No	04/01/2024

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	for 2 of 5 employees whose records were reviewed. (Server 3 and CNA 8) Findings include: 1. An employee record review was completed, on 3/6/2024 at 11:40 A.M., for server 3. The record lacked the documentation indicating the completion of dementia training upon hire. 2. An employee record review was completed, on 3/6/2024 at 11:48 A.M., for CNA 8. The record lacked the documentation indicating the completion dementia training upon hire. During an interview, on 3/6/2024 at 11:50 P.M., the Executive Director indicated the employee files did not contain the dementia training and it should have been done. A policy was requested on 3/6/2024 for the documentation of employee files. On 3/6/2024 at 2:10 P.M., the Administrator indicated the facility follows the State Guidelines for dementia training.		residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. A complete audit is being conducted. Any staff member found out of compliance will be removed from the schedule until training is completed. 4. At completion of all orientations, and monthly thereafter, BOM/Designee will review files to ensure that all training has been completed as assigned. Any incomplete assignment will be completed at that time. Results will be brought to the manager's monthly meeting for review and/or recommendations for six months. 5. Initial audit will be completed by 4-1-24	
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation and interview, the facility failed to ensure dryer vents were free from a build up of lint in 2 of 6 dryers reviewed for fire hazards. (2nd floor laundry room) Finding includes: On 3/5/2024, at 10:07 A.M., an observation of the 2nd floor laundry room was completed. The	R 0145	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Dryer vent cleaning has been added to the housekeepers	03/07/2024

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	following was observed: The laundry room held 2 washers and 2 dryers. Both dryers had removable lint screens on the front of the dryer where the door closes. Both lint screen holding areas had a large build up of lint on the bottom of the holding area. During an interview, on 3/5/2024 at 10:08 A.M., CNA 5 indicated the dryer lint screen should be cleaned after each use. On 3/6/2024 at 2:04 P.M., a policy regarding laundry use was requested but one was not provided prior to the survey exit.		assignment daily to ensure no excess lint built up is noted on and below each lint trap. 4. Director of Maintenance/Designee will complete spot checks weekly X 3 weeks and monthly thereafter to ensure that lint traps are being cleaned. Any staff found deficient in this practice will be re-educated and discipled per facility protocol. Results of the inspections with be brought to managers meeting monthly for review and or recommendations for six months. 5. Completed 3-7-24	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure admission weights were completed for 4 of 8 residents reviewed for weights. (Residents 2, 3, 4, and 5) Findings include:	R 0216	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no	03/22/2024

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	1. A record review for Resident 2 was completed on 3/5/2024 at 12:00 P.M. The clinical record lacked an admission weight for 3/27/2023 and/or documentation of weight refusals by the resident. 2. A record review for Resident 3 was completed on 3/5/2024 at 2:50 P.M. The clinical record lacked an admission weight on 12/30/2022 and/or documentation of weight refusals by the resident. 3. A record review for Resident 4 was completed on 3/5/2024 at 2:50 P.M. The record lacked the documentation to indicate Resident 4 had a weight taken upon admission. 4. A record review for Resident 5 was completed on 3/5/2024 at 3:20 P.M. The record lacked the documentation to indicate Resident 5 had a weight taken upon admission. During an interview, on 3/6/2024 at 2:15 P.M., the Director of Nursing indicated there was no documentation of any admission weights and there should have been. A policy for admission weights was requested on 3/6/2024, but one was not provided prior to the survey exit.		residents were affected. 3. Audit has been completed to ensure all current residents have documented admission weights. Admission audit forms will be updated to include admission weights. Admission forms will be reviewed within 3 days of each new admit. 4. DON/Designee will complete audit form. Results of the audit forms will be brought to managers meeting monthly for review and or recommendations for six months. 5. Compliance date 3-22-24.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was labeled/dated and stored in a sanitary manner, failed to ensure the walk-in freezer, dishwasher,	R 0273	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice.	03/21/2024

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	floors, and walls were clean, and failed to serve meals in a sanitary manor. (Kitchen & Dining room) This had the potential to affect all 120 residents residing in the facility who received food from the kitchen. Findings include: 1. During an observation of the kitchen with the Culinary Service Director (CSD), on 3/5/2024 at 9:45 A.M., the following was observed: a. A food prep table had opened and undated taco seasoning, ground thyme, Italian spaghetti seasoning, cinnamon sticks, rubbed sage seasoning, onion powder, garlic powder, dried parsley flakes, and black pepper. b. The walk-in cooler contained left over shredded beef that was not tabled with a prepared-on date or an expiration date, and one bag of opened parmesan cheese was not labeled with an opened-on date. c. The walk-in freezer had a buildup of ice below the fan. d. The dishwasher and the stainless-steel tables connecting to the front and back of the dishwasher had a large buildup of lime. e. The floor drain below the dishwasher had a large amount of black sludge on the wall, floor grate, and floor surrounding the floor grate. f. The floor drain below the hand sink had a large amount of black sludge on the floor grate. An interview with the CSD was completed on 3/5/2024 at 10:15 A.M. The CSD indicated the		2. All residents could have been affected, however in this case, no residents were affected. 1. For the kitchen observation, the following are the measures to be implemented to correct any deficiencies. A. Training for the proper dating of opened items, such as seasonings has been completed on 3/20/24 (attachment #1) B. Training for the proper dating left over products in the cooler to include prepared on date/expiration date and product labeling. This was completed on 3/20/24. C. Working with maintenance to fix buildup of ice below freezer fan. completion 3/21/24. D. De-limed the dishwasher and stainless-steel tables on both sides of the dishwasher to eliminate lime buildup. Completed 3/6/24. E. Deep cleaned the area below the dishwasher including the wall, floor grate, and floor surrounding the floor grate. Completed on 3/7/24. F. Cleaned the floor drain and floor surrounding the floor drain under the hand sink. Completed on 3/7/24. 2. For the meal service observation cooks, the following are the measures to be implemented to correct any deficiencies. Cook 4	

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	spices were open and should have had an opened-on date. The left-over shredded beef did not have a label with date prepared or expiration date, but should have had a preparation and expiration date. The parmesan cheese did not have an opened-on date, but should have had an opened-on date. The walk-in freezer had an ice buildup under the fan, but should not have had an ice buildup. The dishwasher had a buildup of lime, but should not have had a buildup of lime. The floor drains had a buildup of black sludge, but the floor drains should not have a buildup of black sludge. 2. During a meal service observation, on 3/5/2024 at 11:17 A.M., Cook 4 was observed thumbing plates with gloved hands. He was observed touching the food cart, papers, and lids of trays in between serving food, without changing gloves. During an interview, on 3/5/2024 at 11:20 A.M., Cook 4 indicated he should have changed his gloves and not put thumbs on the plates. 3. During a meal service observation, on 3/5/2024 at 11:22 A.M., Server 3 was observed holding 3 cups against her uniform. During an interview, on 3/5/2024 at 11:23 A.M., Server 3 indicated she should not have carried the cups against her uniform. On 3/5/2024 at 2:30 P.M., a policy, dated 3/2/2021 and titled, "Our Food: Food Safety", was received from the Administrator. The Administrator indicated it was the current policy used by the facility. The policy indicated, "...Labeling: If an item is not being served, it shall be covered, labeled and dated...." On 3/5/2024 at 2:30 P.M., an undated policy, titled,		Training for all cooks on proper glove usage and when to change gloves as well as how to properly handle plates and food contact areas. No thumbing. Completed on 3/20/24 3. For the meal service observation, the following are the measures to be implemented to correct any deficiencies. Server 3 Training for all servers on proper handlining of dishes, cups, glasses, and eating utensils. Completed on 3/20/24. 4. Assigned cleaning schedule/s has been developed to ensure specific individuals are assigned cleaning tasks to be followed up by management/supervisors. This will be an ongoing process in order to ensure the cleanliness of the operations. The Culinary Service Director will be the primary monitor. All alleged deficiencies have been brought into compliance. Management/designee will monitor areas to ensure continued compliance. Any future deficiencies will be brought to managers meetings for suggestions to ensure no other alleged deficiencies will occur for 6 months or further as issues arise. Manager will monitor for patterns and re-educate and discipline per facility protocol. Completed 3-21-24	

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	"Hellenic Senior Living of Mishawaka Cool Down and Leftover policy" was received from the Administrator and identified as the policy currently used by the facility. The policy indicated, "...All leftovers must be dated with both prep date and used by date...." On 3/5/2024 at 2:30 P.M., an undated cleaning checklist, titled, "Back of House Duties Prep Service Shift" was received from the Administrator and identified as the cleaning checklist currently used by the facility. The cleaning checklist indicated, "...Sweep and mop floors from reach-in cooler to mop area..." On 3/5/2024 at 2:30 P.M., an undated cleaning checklist titled, "Help clean, organize and restock", was received from the Administrator and identified as the cleaning checklist currently used by the facility. The cleaning checklist indicated, "...Empty and clean dish machine surface, clean dish load surface area and back splash, clean dish unload surface area and back splash, clean dish-machine handles and panels...." On 3/06/2024 at 1:42 P.M., the Culinary Service Director (CSD) provided a policy detailing culinary services operating standards. The policy indicated..."1. Food Contact Surfaces and Utensils: Associates shall handle dishes, cups, glasses, and eating utensils in such a way that their hands do not touch the eating surfaces...."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview, and record	R 0295	1. Corrections of previous	03/22/2024

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	review, the facility failed to properly secure medications in a resident's room, for 2 of 4 residents who were reviewed for medication storage. (Residents 5 & 12) Findings include: 1. During an observation, on 3/5/2024 at 1:30 P.M., Resident 5 had the following medication bottles unsecured and sitting on a table next to his recliner: a. metolazone (water pill) b. bumetanide (water pill) c. Senna Plus (stool softener) d. guaifenesin (cough/congestion) e. aspirin (blood thinner) f. hydrocodone/acetaminophen (pain reliever) g. escitalopram oxalate (antidepressant/antianxiety) During an interview, on 3/6/2024 at 9:24 A.M., the Director of Nursing indicated Resident 5's medications should have been locked in his cabinet in his room. 2. During an observation of medication pass, on 3/6/2024 at 8:46 A.M., Resident 12's medication cabinet lock was broken and the medications were not secured in her room. During an interview, on 3/6/2024 at 8:46 A.M., QMA 6 indicated the cabinet should be locked and the broken lock has been reported for repair. During an interview, on 3/6/2024 at 11:45 A.M.,		timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Every resident room in the facility have been checked to ensure all medication cabinets have working locks and no medication is left outside of locked cabinets. Any cabinet without a functioning lock will be replaced by the maintenance department. All self medication residents will be re-educated on proper medication storage. (Attachment #2) 4. DON/Designee has completed the audit to ensure all medication cabinet have functioning locks and no medication is left outside of the cabinet . Audit will be completed weekly x4 weeks then monthly. Results of the inspections with be brought to managers meeting monthly for review and/or recommendations for six months, will monitored on-going moving forward. 5. Completed 3-22-24	

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	the Maintenance Director indicated he did not have a work order for a broken medication cabinet lock. During an interview, on 3/6/2024 at 1:30 P.M., the DON indicated medications should be locked in the cabinet in the resident's room. If the lock was broken, maintenance was to be notified and the medications were locked in the medication cart so they were secure, but staff did not follow this process for Resident 12. A current policy, dated 11/1/2023, provided by the Executive Director on 3/6/2024 at 11 A.M., indicated, "...Medications will be securely stored at all times in the medication box or cabinet under lock and key...."			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on record review and interview, the facility failed to ensure medications were available for administration for 1 of 2 residents reviewed for medications. (Resident 3) Finding includes: During an interview, on 3/6/2024 at 8:40 A.M., Resident 3 indicated he had a hard time getting his medications sometimes. He had missed his medications 3 - 4 weeks ago. A record review was completed on 3/5/2024 at 2:50	R 0297	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Audit was conducted. All providers have been notified regarding residents' unavailable medications. Medication orders have been updated per providers. All staff in-service completed	03/22/2024

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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
	P.M. Resident 3's diagnoses included, but were not limited to diabetes chronic kidney disease and hypertension. Current Physician's Orders, dated 1/29/2024, indicated Resident 3 was to receive the following medications: Centrum Silver Med 50 1 tablet daily; CO Q-10 100 mg (milligrams) 3 capsules daily; I-Vite tab 1 daily; and Omega III 1000 mg capsules take 1 capsule twice a day. An Order Administration Note, dated 11/1/2023 at 11:20 A.M., indicated the following medications were not available: Co Q 10, I-Vite tab, Omega III, and the Centrum Silver tablet. An Order Administration Note, dated 11/9/2023 at 6:23 A.M., indicated the I-Vite tablet was not available. An Order Administration Note, dated 11/13/2023 at 11:15 A.M., indicated the following medications were not available: Centrum Silver tablet, Co Q 10, and the Omega III capsule. An Order Administration Note, dated 11/21/2023 at 4:36 P.M., indicated the following medication was not available: Omega III capsule. During an interview, on 3/6/2024 at 2:13 P.M., the Director of Nursing indicated the staff were to notify her when there was a medication missing or not available so she could find out why the medication was not available. On 3/6/2024 at 2:45 P.M., the Director of Nursing provided the policy titled, "Medication Administration", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... 32. The Director of		3-20-24 in regards to community's policy on unavailable medications. Pharmacy provided payment form for residents agreeing to accept charges for non-covered medications. (Attachment #3) 4. DON/Designee will audit on-going to ensure procedure completed per policy for all unavailable medications. Audits will be completed weekly. Results of audits will be brought to managers meeting monthly for review and/or recommendations for six months. Completed 3-22-24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/06/2024

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	Nursing will be notified when prescribed medications are not available to be administered a the scheduled time. The Director of Nursing will be responsible for investigating the reason medication(s) are not available, and for taking corrective actions to ensure medications are available as prescribed...." 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			
R 0349 Bldg. 00	Based on observation and interview, the facility failed to maintain accurate Narcotic Shift-to-Shift count sheets. This had the potential to affect all residents who were prescribed narcotic medications to be administered by facility staff. Finding includes: During an observation, on 8/6/2024 at 8:36 A.M., the narcotic signature sheets for January 2024 and February 2024 were incomplete, and there was no signature sheet for March 2024. The count was correct at the time of observation. During an interview, on 8/6/2024 at 8:36 A.M., QMA 6 indicated she did not know anything about the shift count, as she did not do it today, and someone else did the count with the previous shift.	R 0349	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. All staff in-service completed 3-20-24 in regards to community's policy on shift to shift narcotic count sheets. Staff found non-compliant will be re-educated and disciplined per facility policy. (Attachment #4) 4. DON/Designee will audit on-going to ensure procedure completed per policy for all shift to shift counts. Audit will be completed weekly. Results of audits will be brought to managers	03/22/2024

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	During an interview, on 8/6/2024 at 1:30 P.M., the DON indicated the narcotics should be counted at each shift change and had not been. A policy for counting narcotics was requested and the DON indicated she wasn't sure if there was a specific policy. A policy was not provided prior to exit.		meeting monthly for review and/or recommendations for six months. Completed 3-22-24	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure an emergency information file was accurate and complete with all required resident information for 3 of 9 residents whose emergency information was reviewed. (Residents 3, 5 & 9) Findings include: On 3/5/2024 at 2:45 P.M., the Administrator	R 0356	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Audit was conducted. All residents emergency information	03/22/2024

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	provided 3 Emergency Binders. A review of Residents' 3, 5, and 9's emergency information sheets all lacked the documentation of a hospital preference. During an interview, on 3/6/2024 at 2:20 P.M., the Director of Nursing indicated the emergency sheets were not complete and should have had the hospital listed. On 3/6/2024, a policy was requested for emergency information, but one was not provided by the survey exit.		has been updated and placed in binder 3-7-24. 4. DON/Designee will audit on-going to ensure procedure completed per policy for all Current Residents' emergency information. All new residents will be added and all discharged residents will be removed. Any resident updates will also included. Results of audits will be brought to managers meeting monthly for review and/or recommendations for six months. Audits will continue monthly on-going. 5. Completed 3-22-24	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review, and interview the facility failed to ensure infection control practices were followed during an insulin injection, for 1 of 1 injection observations. (Resident 13) Finding includes: During a medication administration, on 3/6/2024 at 8:15 A.M., LPN 7 entered Resident 13's room and explained what she was going to do. She then moved the sleeve to the right upper arm and swabbed the area to be injected with an alcohol swab and then fanned the area with her hand and	R 0406	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. All staff in-service completed 3-20-24 in regards to community's policy on infection control and proper injection administration. Any staff found non-compliant will be re-educated and disciplined per facility policy.	03/22/2024

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	did not wear gloves to administer the injection. During an interview, on 3/6/2024 at 8:15 A.M., LPN 7 indicated she should not have fanned the area before administering the insulin injection. On 3/6/2024 at 1:30 P.M., a policy for infection control related to injections was requested but one was not provided. before the survey exit.		(Attachment #4) 4. DON/Designee will audit on-going to ensure procedure completed per policy for proper infection control procedures. Each insulin certified QMA and Nurse will be individually observed during insulin administration x3. Results of audits will be brought to managers meeting monthly for review and/or recommendations for six months. Completed 3-22-24.	