STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 19, 20, 21, 22, and 23, 2022 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: NF: 36 Total: 36 Census Payor Type: Medicaid: 35 Other: 1 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/28/22.	F 0000		
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that 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.	F 0684	The filing of the plan of correction	10/21/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamey Kleva	HFA	10/30/2022

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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	Based on record review and interview, the facility failed to administer insulin as ordered for 2 of 5 residents reviewed for unnecessary medication review. (Residents 9 and 20) Findings include: 1. The clinical record for Resident 9 was reviewed on 9/22/22 at 9:17 a.m. Diagnoses included, but were not limited to, diabetes mellitus and peripheral vascular disease. Review of the resident's electronic Medication Administration Record (eMAR) indicated the following current, signed physician's orders and lack of blood sugars for the resident: a. Novolog (insulin to treat diabetes) solution, inject four units before meals related to diabetes mellitus. The order was dated 4/9/22. The eMAR was blank for administration or blood sugar value for the 11:30 a.m. doses on 8/16/22, 8/20/22, 8/30/22, 8/31/22, and 9/10/22; and for the 5:00 p.m. dose on 9/18/22. b. Novolog solution, inject per sliding scale for blood sugar results before meals: If 150-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units. Call MD with blood sugar greater than 401. The order was dated 4/9/22. The eMAR was blank for administration or blood sugar value for the 11:30 a.m. doses on 8/16/22, 8/30/22, 8/31/22 and 9/10/22; and for the 5:00 p.m. dose on 9/18/22. c. Levemir solution (insulin to treat diabetes), inject 55 units at bedtime related to diabetes mellitus. The order was dated 9/5/22. The eMAR was blank for administration of ordered dose on 8/18/22.		does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** Review of documentation on resident #9 & #20 by nursing team resulted in findings that insulin was administered to both residents however there lacked documentation on the EMAR. *All Nursing staff in-service on proper administering of Insulin and documentation to support actions. (Exhibit A) *ADON to implement a routine check of EMAR to ensure proper administering and documentation of Insulins to the appropriate residents. This daily routine check was implemented in medical records as a red triggered alert on Oct. 1, 2022 and is part of the ADON checklist. The outcome of this tool will be reviewed during the facility's Quality Assurance Performance Improvements meetings monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The results of the review and any corrective actions will be discussed at the quarterly QA meetings and current plan revised as warranted	

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	2. The clinical record for Resident 20 was reviewed on 9/21/22 at 9:43 a.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus and unspecified intellectual disabilities. Review of the resident's eMAR indicated the following current, signed physician's orders and lack of blood sugars for the resident: a. Novolog solution, inject 5 units with meals related to type 1 diabetes mellitus. The order was dated 8/21/22. The eMAR was blank for administration for the 11:30 a.m. dose on 8/31/22 and 9/10/22; and for the 5:00 p.m. dose on 9/18/22. b. Novolog solution, inject per sliding scale for blood sugar results before meals: If 181-220 = 1 units; 221-260 = 2 units; 261-300 = 3 units; 301-340 = 4 units; 341-380 = 5 units; 381-420 = 6 units; 421-550 = 7 units. The order was dated 8/21/22. The eMAR was blank for administration or blood sugar value for the 11:30 a.m. doses on 8/31/22 and 9/10/22; and the 5:00 p.m. dose on 9/18/22. c. Lantus SoloStar solution (insulin to treat diabetes), inject 6 units at bedtime related to type 1 diabetes mellitus. The order was dated 8/16/22. The eMAR was blank for administration on 9/18/22. During an interview on 9/23/22 at 3:37 p.m., the Assistant Director of Nursing (ADON) indicated the administration of medications, including insulin, should be recorded in the eMAR when administered. If the administration was not entered on the eMAR, the administration of that medication would not be confirmed.		ADON will monitor EMAR insulin administration for 100% of resident within facility for that day. If any resident did not receive their insulin, administration code will be documented in EMAR and on monitoring sheet. Disciplinary action noted and provided at finding. Monitoring will be completed 5x weekly for 6 months, and evaluated during the quartile QAPI meeting. (Exhibit 7)	

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	A current facility policy, dated 12/1/21, titled, "Insulin Injections," provided by RN 13 on 9/23/22 at 2:32 p.m., included, but was not limited to, the following: "Policy: Daily insulin injections are give {SIC} with a physician's order.... Procedure:...14. Record type, amount, time and site of injection on the MAR." 3.1-37(a)			
F 0689 SS=E 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. Based on observation, interview, and record review, the facility failed to investigate resident falls and assess for additional fall interventions to prevent falls for 3 of 5 residents reviewed for accidents. (Residents 1, 34 and 9) Findings include: 1. During an observation on 9/19/22 at 11:50 a.m., the resident used her hands to propel her high back wheelchair from the nurse's station down the hallway to her room. She was not assisted by a staff member. A discolored bruise was noted to her right posterior hand.	F 0689	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** Plan of Correction: * IDT form created and implemented to review each morning during stand up meeting	10/21/2022

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	During an observation on 9/20/22 at 11:45 a.m., Resident 1 was not in her room. Her room lacked non-skid strips in front of the closet or on the floor at either side of the resident's bed. Resident 1's clinical record was reviewed on 9/20/22 at 2:07 p.m. Diagnoses included, but were not limited to the following: Parkinson's disease, epilepsy, unspecified, essential hypertension, dementia in other diseases classified elsewhere with behavioral disturbance, generalized anxiety disorder, polyneuropathy and polyosteoarthritis. Current physician orders for the resident included, but were not limited to the following: a. Give carbidopa-levodopa (Parkinson's medication)25-100 milligram (mg) 0.5 tablet by mouth two times daily. The order originated on 6/7/21. b. Give amlodipine besylate (blood pressure medication) 10 mg tablet by mouth daily in the morning. The order originated on 6/10/22. c. Give lacosamide (seizure medication) 100 mg tablet by mouth two times daily. The order originated on 6/1/22. d. Give buspirone HCl (anxiety medication) 15 mg tablet by mouth four times daily. The order originated on 3/1/22. e. Give Morphine Sulfate Solution (pain medication on hospice) 20 mg/milliliters (ml) - 0.25 ml by mouth every 3 hours as needed for pain. The order originated on 6/3/22.		the falls that had occurred the prior 24 hours. The form is completed by the IDT team to ensure follow up to the fall has been performed, that the intervention was implemented as well as the care plan is updated to reflect the change. The form will then be scanned to the residents file in medical records. (EXHIBIT B) *Nonskid socks issued for ambulatory residents that are care planned for at risk for falls. *All staff In-service was performed to educate the staff on the proper procedures in reporting a fall, implementation of the falls IDT form.(Exhibit A) *Implemented a Fall Meeting 1x month to review falls and ensure that interventions are successful or determine a new intervention during that meeting. First meeting to be held on Oct 21, 2022. The outcome of this tool will be reviewed during the facility's Quality Assurance Performance Improvements meetings monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The results of the review and any corrective actions will be discussed at the quarterly QA meetings and current plan revised as warranted Monitoring sheet will be utilized every business day by DON/Designee. IDT will assess root cause, and ensure	

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	Review of a post fall Morse Fall Assessment, dated 7/4/22, indicated the resident was at high risk for falls. A Significant Change Minimum Data Set (MDS) assessment, dated 6/16/22, indicated the resident's cognitive status was moderately impaired. Rejection of care behavior was not exhibited. The resident required extensive assistance of 2 staff members for bed mobility, transfers, and toileting. She required supervision and assistance of 1 staff member for locomotion on the unit. The resident was always incontinent of bowel and bladder and had a fall in the last month. A current Care Plan, dated 7/5/22, indicated the resident had impaired safety awareness related to dementia. Interventions included, but were not limited to, redirect as/if needed. A current Care Plan for risk for falls, last revised on 8/24/22, indicated the resident had a history of falls and a recent fall. Interventions included, but were not limited to, non-skid strips in front of closet door, non-skid strips at bedside and seating and positioning evaluation. A Nurse's Note, dated 7/29/22 at 3:40 p.m., indicated the resident was found on the floor face down in the corner of her closet with her wheelchair on top of her. A moon shaped skin tear was noted to the left upper shin area and measured 3.8 centimeters (cm). A Nurse's Note, dated 8/20/22 at 1:26 p.m. indicated the resident was found crying uncontrollably with her head near the bottom edge of the dresser opposite of the wheelchair in her room. She had 2 lacerations on her upper right forehead.		intervention is put in place, care plan adjusted as needed, order for any necessary equipment will be put in place, and MD/POA will be notified in a timely manner. Please see the following Fall sheet that will be used 5x weekly for 6 months, and evaluated at the quartile QAPI meeting. (Exhibit 8)	

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An Interdisciplinary Team (IDT) Note, dated 8/22/22 at 9:25 a.m., indicated the IDT met to review the resident's falls on 8/18/22 and 8/20/22. Care plans were reviewed and updated.

The clinical record lacked the seating and positioning evaluation intervention noted on the care plan.

A Nurse's Note, dated 8/24/22 at 2:22 p.m., indicated the resident was found on the floor, laying on back with head faced toward the bathroom and feet towards the bed in her room. "Resident was attempting to transfer self. Was told would be a few minutes, staff were weighing another resident. Resident overheard ' I will just do it myself.'"

The clinical record lacked documentation of management notification or IDT meeting documentation for the resident's fall dated 8/24/22.

During an observation on 9/21/22 at 11:30 a.m., the resident was not in her room. Non-skid strips were not on the floor by the resident's bed nor on the floor in front of the resident's closet.

During an interview on 9/21/22 at 3:58 p.m., Temporary Nurse's Aide (TNA) 9 indicated she referenced the Resident Roster for what assistance each resident required and for any specific needs.

Review of the Resident Roster on 9/21/11 at 4:00 p.m., lacked any indication of Resident 1's risk for falls.

During an interview at the time of observation on 9/21/22 at 4:02 p.m., TNA 9 indicated the resident's

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	closet and floor beside the bed did not have any non-skid strips. TNA 9 identified which closet belonged to the resident in her room. During an interview on 9/21/22 at 4:09 p.m., Licensed Practical Nurse (LPN) 6 indicated she was familiar with all of the residents in the facility. Resident 1 was a high fall risk and had several recent falls. Staff were required to notify the provider, POA (power of attorney/resident representative), DON, ADON, and Administrator of the resident's falls along with the details of the fall. Since the facility did not have a DON, they were required to report it to the Administrator and ADON for IDT review and care plan updates. Fall prevention interventions should have been implemented and put into place immediately if the current interventions were not effective to prevent falls. She indicated current fall interventions included 2 person assistance, ensure the resident is clean an dry, frequent checks, ask for assistance from staff to get items from her closet, and non-skid strips in her room because the resident preferred to get things from her closet. During an interview at the time of observation on 9/21/22 at 4:27 p.m., LPN 6 indicated the resident's room did not have any non-skid strips in front of the resident's closet nor at the resident's bedside. She indicated the resident had been moved from another room and the non-skid strips had not been placed on the floor in her current room. Immediate review of the resident's previous room, along with LPN 6, lacked non-skid strips in front of the closet or at beside in the resident's previous room. During an interview on 9/21/22 at 4:29 p.m., LPN 6 indicated a nurse should have notified the Administrator and ADON when fall prevention			

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	interventions were not implemented to prevent falls. During an interview on 9/21/22 at 4:40 p.m., the ADON indicated Resident 1 was a high fall risk and had several recent falls and some resulted in injuries of bruising, skin tear, and abrasions. Current interventions in place included a high back wheel chair and non-skid strips at the closet and bedside. She indicated fall interventions on the care plan should have been implemented immediately. Failure to implement the fall prevention interventions placed the residents at risk for further falls. Fall interventions in place during a room change should have followed the resident and remained in place. During an observation at the time of interview on 9/21/22 at 5:00 p.m., the ADON indicated the resident's current room and the last 2 rooms the resident resided in lacked non-skid strips. She was unsure why the non-skid strips were not in place. 2. Resident 34's clinical record was reviewed on 9/20/22 at 3:07 p.m. She admitted to the facility on 3/16/22. Diagnoses included, but were not limited to the following: schizoaffective disorder, anxiety disorder, unspecified, restless legs syndrome, essential hypertension, atrial fibrillation, primary osteoarthritis, unspecified ankle and foot, insomnia, abnormal posture, and unsteadiness on feet. Current physician orders for the resident included, but were not limited to the following: a. Give digoxin (heart rhythm medication) 125 micrograms (mcg) by mouth each morning. The			

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	order originated on 5/30/22. b. Give melatonin (insomnia medication) 6 mg tablet by mouth daily at bedtime. The order originated on 3/16/22. c. Give ropinirole hcl (restless leg medication) 0.5 mg tablet by mouth daily at bedtime. The order originated on 3/28/22. A Significant Change Minimum Data Set (MDS) assessment, dated 6/10/22, indicated the resident's cognitive status was moderately impaired. Rejection of care behavior was exhibited 4-6 days. The resident required extensive assistance of 2 staff members for bed mobility, transfers, personal hygiene and toileting. She required assistance of 1 staff member for locomotion on the unit. The resident was frequently incontinent of bowel and bladder, had a fall on admission in the last month and a fracture related to a fall in the 6 months prior to admission. A current Care Plan, dated 7/5/22, indicated the resident had impaired safety awareness related to schizoaffective disorder. Interventions included, but were not limited to, redirect as/if needed. A current Care Plan for risk for falls, last revised on 3/19/22, indicated the resident was at risk for falls related to confusion, gait/balance problems, and psychoactive drug use. Interventions included, but were not limited to, anticipate and meet the resident's needs, assist with toileting, assist with transfers, and encourage the resident to wear non-skid footwear. The care plan lacked any revisions related to the fall dated 5/26/22. Review of the admission Morse Fall Assessment, dated 3/17/22, indicated the resident was at			

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	moderate risk for falls. Review of a post fall Morse Fall Assessment, dated 5/26/22, indicated the resident was at moderate risk for falls. A Nurse's Note, dated 5/26/22 at 12:29 p.m. indicated the resident had a witnessed fall secondary to an attempted unassisted transfer from her wheelchair to the toilet before the Certified Nurse's Aide could get to her. The resident loudly screamed, "My leg is broken; and I know it." A Nurse's Note, dated 5/26/22 at 6:03 p.m., indicated the hospital called and the resident was admitted for a right hip fracture. The clinical record lacked and IDT note of the resident's fall and lacked any updated fall interventions/reviews or revisions. During an observation on 9/22/22 at 3:25 p.m., the resident was observed sitting up in bed with a movie on her television. She was talking to someone in words that did not make sense, but no one was there. During an interview on 9/23/22 at 1:43 p.m., Licensed Practical Nurse (LPN) 8 indicated the resident had a fall and fractured her right hip on 5/26/22. The clinical record did not contain an IDT progress note nor implemented care plan interventions related to the resident's fall on the above mentioned date. The residents care plan should have been revised when the resident had a fall with a fracture. During an interview on 9/23/22 at 2:05 p.m., Registered Nurse (RN) 3 indicated Resident 34's			

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	fall on 5/26/22 lacked an Interdisciplinary Team Note because no one was assigned to review falls at that time. The care plan should have been revised when the resident returned from her hospitalization but the fall risk care plan was not updated. A request was made for a copy of the IDT note related to the resident's fall on 5/26/22. Further information was not provided. 3. The clinical record for Resident 9 was reviewed on 9/22/22 at 9:17 a.m. Diagnoses included, but were not limited to, traumatic brain injury, chronic obstructive pulmonary disease, epilepsy, unspecified convulsions and repeated falls. Fall reports were obtained on 9/22/22 at 1:36 p.m. from the Administrator and included, but were not limited to, the following: On 7/6/22, Resident 9 had an unwitnessed fall. She was found on her floor in her room, laying on her back with her feet towards the head of the bed. The resident indicated she was scooting herself back in her wheelchair seat and had forgotten to lock the wheelchair. The resident was assessed to have no injuries. The resident's health care plan intervention, added on 7/7/22, was for occupational therapy to evaluate for positioning and to provide the resident with a reacher to assist with picking items up from the floor. The electronic health record (EHR) lacked indication of the interdisciplinary team (IDT) investigation of incident. On 7/26/22, the resident had a witnessed fall. She was sitting on her walker moving around without it being locked. She fell over onto the floor. She was assessed to have no injuries. No immediate intervention was indicated on the fall report. The			

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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
	EHR indicated the IDT reviewed the resident's fall on 7/27/22 and indicated the health care plan for falls had been updated. Review of the resident's fall health care plan lacked an updated intervention for the fall occurring 7/26/22. On 8/18/22, the resident was trying to assist another resident and fell backwards onto the floor. The resident was assessed to have no injuries. The IDT met to review the fall on 8/22/22 and indicated the health care plan for falls had been updated. Review of the resident's fall health care plan lacked an updated intervention for the fall occurring 8/18/22. During an interview on 9/23/22 at 3:37 p.m., the ADON indicated the IDT should meet after each resident fall to investigate cause and update the care plan accordingly. She does not know why the care plans had not been updated or why IDT did not investigate some recent falls. A current facility policy, dated 6/2/19, titled, "Fall Policy and Procedure," provided by the Administrator on 9/22/22 at 1:55 p.m., included, but was not limited to, the following: "PROCEDURE:...5. The resident care plan should be updated to reflect any new or change in interventions." 3.1-45(a)(2)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days			

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	15E064	A. BUILDING 00 B. WING	09/23/2022

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	a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on observation and interview, the facility failed to employ a full time Director of Nursing for clinical oversight of the facility. This had the potential to affect all 36 residents residing in the facility. Finding includes: During an interview on 9/19/22 at 9:32 a.m., the Social Services Director (SSD) indicated the facility did not have a Director of Nursing (DON) but the Assistant Director of Nursing (ADON) and Administrator were on their way to the facility for entrance conference. During an interview at entrance conference on 9/19/22 at 9:52 a.m., the ADON indicated she was not the interim DON. The facility did not have an interim DON and they contacted the Corporate Nurse Consultant for any questions or concerns. The facility did not have any nursing waivers in place. A DON was not present during the entrance conference. During an interview on 9/19/22 at 9:59 a.m., the ADON indicated they had not employed a DON since approximately March of 2022. A request	F 0727	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** Plan of correction for Failure to employ a DON for oversight: *RN coverage was present on a daily basis according to the state regulations since last DON date of 1/17/2022.(EXHIBIT C) *Nurse Consultant was also hired to be on call 24 hours instead of part time for consolation of issues and concerns in nursing. *Administrator updated the absent of a Director of Nursing Policy (EXHIBIT D) *In-service completed and education provided on absent of a DON policy with the management and IDT team. (EXHIBIT A) *DON was hired and start date is	11/07/2022

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	was made for the date the facility last had a full time DON at the facility. During an interview on 9/21/22 at 3:09 p.m., the Administrator indicated the facility lacked a full time DON. She indicated the facility consulted with the Corporate Nurse Consultant, but she only worked part time. During an interview on 9/21/22 at 4:09 p.m., Licensed Practical Nurse (LPN) 6 indicated they were required to report accidents to the Administrator, DON, and ADON. Since the facility did not have a DON, the Administrator and ADON were notified of any accidents. During an interview on 9/22/22 at 10:33 a.m. , the Administrator indicated the last day worked for the facility's last employed full time DON was 1/17/22. During an interview on 9/23/22 at 2:05 p.m., Registered Nurse (RN) 3 indicated Resident 34's fall on 5/26/22 lacked an Interdisciplinary Team review note because no one was assigned to review falls at that time. During exit conference on 9/23/22 at 4:23 p.m., a DON was not present. A current undated policy, titled "Departmental Supervision," provided by the Administrator on 9/22/20 at 2:48 p.m., indicated the following: "The Nursing Services department shall be under the direct supervision of a Registered or Licensed Practical/Vocational Nurse at all times. Policy Interpretation and Implementation...2. A Registered Nurse (RN) is employed as the Director of Nursing Services (DNS). The DNS is on duty during the day shift Monday through Friday...."		11/07/22. (EXHIBIT E) The outcome of this tool will be reviewed during the facility's Quality Assurance Performance Improvements meetings monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The results of the review and any corrective actions will be discussed at the quarterly QA meetings and current plan revised as warranted Nurse consultant is an RN see Exhibit 9 The nurse consultant will fill the role of the DON by reviewing the 24-hour report and addressing issues that need attention, updating care plans, and providing the nursing staff with leadership for providing quality care to the residents. When the nurse consultant is not present at the facility, staff RN's can assume the duties of the DON. Like for example the IP nurse can review the 24-hour report and address issues, or the MDS nurse doing follow ups with falls and making IDT notes maintain the continuum of care. The Administrator and ADON will monitor the various nurses as they perform the duties of the DON, on a daily bases till a DON is hired to fill the role.	

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	3.1-17(b)(4)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review and interview, the facility failed to properly store food in accordance with professional standards for food service safety. Findings include: 1. During the initial kitchen observation on 9/19/22 at 9:49 a.m. with the Dietary Manager, the following was observed:	F 0812	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. Plan of correction for proper food labeling and storage:	09/27/2022

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	a. A pitcher of lemonade on top shelf in the refrigerator without date made or use by date. b. Several trays of prepared beverages in glasses without date prepared. c. A box of hot dog buns on floor in dry storage. d. A box of quick oats on floor in dry storage. 2. During a follow-up tour on 9/23/22 at 2:47 p.m. with the Dietary Manager, the box of hot dog buns and box of quick oaks remained on the bare floor in the dry goods area. Several trays of prepared beverages in glasses were in the refrigerator and lacked a date. During an interview on 9/23/22 at 2:50 p.m., the Dietary Manager indicated the boxes of food items in dry storage should not be stored on the floor and began to move them onto shelving. He indicated these should have been moved following the initial tour on 9/19/22. Food and beverages should be labeled with a use by date. A current facility policy, revised October 2017, titled, "Food Receiving and Storage," provided by the Business Office Manager on 9/23/22 at 2:40 p.m., included, but was not limited to the following: "Policy Statement Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation...6. Food in designated dry storage areas shall be kept off the floor (at least 18 inches) ...8. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date). 3.1-21(i)(3)		*Dietary staff In-serviced on Facility Policy of food Safety: procurement, storage, preparing, and distributing emphasis on labeling of expiration dates. (EXHIBIT E) *Closet rearranging completed on 9/29/22 to accommodate more storage of dry goods. *A change in dietary managers was made on 10/01/2022 to provide staff with increased oversight of the rules and regulations of proper food management and storage. (EXHIBIT F). The outcome of this tool will be reviewed during the facility's Quality Assurance Performance Improvements meetings monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The results of the review and any corrective actions will be discussed at the quarterly QA meetings and current plan revised as warranted Staff In-serviced on proper food storage and labeling. (exhibit 2 & 3 & 4) Labeling and storage signage was hung up in kitchen area to help remind staff of the proper way to handle food safely. (exhibit 5) Dietary manager will perform a food safety checklist for the following 6 months twice a week, then reevaluate. (exhibit 6)	

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F 9999 Bldg. 00	3.1-14 PERSONAL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to complete a pre-employment physical examination and a pre-employment criminal history check requiring fingerprinting prior to employment for 2 of 5 new staff members reviewed for employee records. (Certified Nurse Aides [CNA] 10 and 11) Findings include: Employee files were reviewed on 9/20/22 at 9:49 a.m. 1. CNA 10 had a start date on 9/1/22. During review of her Employee Health Exam, the form contained an initial TB (tuberculin) skin test administered on 8/31/22, but lacked any further information or signature regarding a health exam. During an interview on 9/20/22 at 1:45 p.m., the	F 9999	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. Plan of Correction for HR: employee physical evaluations and background screening: 1. A 30 day notice of termination presented on 9/26/22 to the current Medical Director, Dr. Lebow, for failure of duties as a Medical Director as agreed upon in the signed contract between Dr. Lebow and Care Strategies. (EXHIBIT H) *A new medical director hired and contract signed between Rounding Providers and Care Strategies. Rounding Providers will supply a NP twice a week to be at the facility to perform employment physical evaluations and to address resident needs. The Medical Director will be present according to the state regulations of Indiana. (1x a month x 3 months, then 1 x 60 days after the residents 90 days. Also includes all staff physical examines to be performed prior to working.) (EXHIBIT I)	09/27/2022

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	Administrator indicated the facility has had an issue getting new employees evaluated by the physician in a timely manner. CNA 10 was scheduled to be seen 9/26/22 when the physician was scheduled to be in the facility. A current facility policy, dated 6/27/21, titled, "Employee Health Examinations," provided by the Administrator on 9/20/22 at 1:50 p.m., included, but was not limited to, the following: "PROCEDURE: A physical examination is required prior to beginning your employment with the Company." 2. CNA 11 had a start date of 6/29/22. His Criminal History Request was completed on 6/30/22 and indicated inconclusive results-fingerprint recommended. Fingerprint submission documentation was dated 7/5/22. No results were provided. During an interview on 9/23/22 at 10:20 a.m., the Human Resource Manager (HR) indicated she contacted the city building for criminal background results for CNA 11 after becoming aware of the lack of results during this survey. A current facility policy, dated 6/27/21, titled, "Employee Background Checks," provided by the Administrator on 9/20/22 at 1:50 p.m., included, but was not limited to the following: "PROCEDURE: ...All offers of employment and continued employment are contingent upon a satisfactory background check."		2. The Human Resource department's executive team created and implemented a new employment policy for finger printing results. (EXHIBIT J, K) *In-service performed and education on new hire policies completed on 9/27/22 with Executive HR and local HR team. (EXHIBIT A) The outcome of this tool will be reviewed during the facility's Quality Assurance Performance Improvements meetings monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The results of the review and any corrective actions will be discussed at the quarterly QA meetings and current plan revised as warranted The facility will use local resources to perform employee physical during the interim, sending them to Concentra or Urgent care centers for completion of the employee physical. New employee files will be audited with-in 30 days of hire and quarterly using state form 5440 and New employee orientation checklist (exhibit 1) to ensure completeness of files. HR will monitor this for the next 6 months.	