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	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT HOBART	1420 ST MARYS CIRCLE HOBART, IN 46342

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00404588, IN00405063, IN00408004, and IN00409458. Complaint IN00404588 - No deficiencies related to the allegations are cited. Complaint IN00405063 - State deficiencies related to the allegations are cited at R0036, R0144, and R0349. Complaint IN00408004 - State deficiencies related to the allegations are cited at R0349 and R0407. Complaint IN00409458 - No deficiencies related to the allegations are cited. Survey dates: August 15 and 16, 2023 Facility number: 002627 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/21/23.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or			

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

Sandra Williams | Executive Director | 09/18/2023

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	(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the Physician and the resident's responsible party was promptly notified of a change in condition related to not eating and the discontinuation of medication for 2 of 8 residents reviewed. (Residents C and F) Findings include: 1. The record for Resident C was reviewed on 8/15/23 at 10:42 a.m. Diagnoses included, but were not limited to, vascular dementia without behaviors, syncope, chronic kidney disease, cardiac pacemaker, heart disease, and stroke. The resident was admitted on 2/10/23. A Physician's Order, dated 2/10/23, indicated the resident was to receive a mechanical soft diet with fortified foods or shakes with meals. Nurses' Notes, dated 4/12/23 at 3:56 p.m., indicated the resident did not eat breakfast or lunch and drank very little that day. Nurses' Notes, dated 4/12/23 at 6:42 p.m., indicated the resident did not eat supper and drank very little that evening. Nurses' Notes, dated 4/14/23 at 3:48 p.m., indicated the resident had a poor appetite and did not eat breakfast or lunch. The resident drank only the water that was offered with medications. The resident indicated she does not want to eat. The Physician and Power of Attorney were notified.	R 0036	=”” b=””> /b> All nursing staff issued a nursing non-negotiable per PLC policy signed to acknowledge their responsibilities. All nursing staff issued a specific detailed job description and scope of practice, signed to acknowledge what they are responsible for and what they are limited to. Staff educated on notification to MD and family on change of condition, lab results, new orders and medication changes. Most importantly weight loss and decline and health. Director of nursing to audit shift to shift reporting and review nursing/pertinent charting daily. Assistant director of nursing put in place for memory care unit to monitor all clinical issues and will audit shift to shift reporting and nursing/pertinent charting daily.	09/28/2023

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	Nurses' Notes, dated 4/14/23 at 8:54 p.m., indicated the resident had a poor appetite this shift. She only ate 4 spoons of yogurt with medication and refused fluids. Nurses' Notes, dated 4/15/23 at 4:26 p.m., indicated the resident still had a poor appetite. Nurses' Notes, dated 4/15/23 at 8:55 p.m., indicated the resident only ate 1 bite for dinner. Nurses' Notes, dated 4/16/23 at 4:29 p.m., indicated the resident had a poor appetite again today. She did not eat or drink anything for lunch and kept shaking her head no and turning away. Nurses' Notes, dated 4/18, 4/19, and 4/20/23 indicated the resident still had a poor appetite and was not eating. There was no Physician or family notification after 4/14/23 that the resident had stopped eating or had a poor appetite. Interview with the Administrator on 8/16/23 at 2:22 p.m., indicated the Physician nor the resident's family had been notified of the resident's continued refusals to eat.2. Resident F's record was reviewed on 8/15/23 at 10:14 a.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and Alzheimer's disease without behavioral disturbance. The Level of Care Assessment, dated 4/19/23, indicated the resident resided in the memory care unit and required constant reminders and cueing. She required staff assistance with grooming, dressing, medication administration, toileting. She had behaviors requiring staff intervention and/or re-direction once per shift.			

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	During the initial tour of the facility on 8/15/23 at 9:30 a.m., QMA 7 indicated Resident F had a recent change in status and was currently not taking anything by mouth. She was under hospice care and had stopped eating and taking medications orally. A Progress Note, dated 8/10/23 at 4:26 p.m., indicated new orders were received from [hospice name] to discontinue all current oral medications except for morphine (a pain medication) and ativan (an anti-anxiety medication) . New orders were received for morphine 20 milligram/milliliter (mg/ml), give 5 mg (0.25 ml) every six hours sublingually by mouth. There was no documentation to review regarding Physician notification or family notification of the resident's change in status. A Policy titled, "Change in Resident Status," and noted as current, indicated "...3. If there is an actual change in status or ability to function the resident's physician should be immediately notified. Always have the resident's complete chart, list of medications, current vital signs (if available), and concise list of problems. a) The facility must immediately consult the resident's physician and the resident's legal representative when the facility has noticed: i) a significant decline in the resident's physical, mental, or psychosocial status; or ii) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment..." This State Residential tag relates to Complaint IN00405063.			

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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 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 ensure an attempt was made to hold a fire and disaster drill in conjunction with the local fire department at least every 6 months. This had the potential to affect 101 residents who resided in the facility. Finding includes: The Fire and Disaster Drills were reviewed on 8/15/23 at 9:35 a.m. There was no documentation the local fire	R 0092	At this time I request IDR due to administrator spoke with Hobart Fire Marshal and asked if there was participation of fire drill with our facility and there was. See letter attached. Due to transition of maintenance directors our previous did not have on file. The reason I am asking for the IDR is due to at the time of request of record it was not in house. Going forward maintenance director and the administrator will	09/01/2023

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	department was invited to participate in at least 1 fire drill every 6 months. Interview with the Administrator on 8/15/23 at 10:09 a.m., indicated the fire department has not been included in the fire drills since she started in April 2023.		keep two copies of completed fire drill with local fire department to ensure there is documentation available at all times.	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (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. Based on record review and interview, the facility failed to ensure criminal history checks for new employees went through the appropriate agency for a statewide background search for 5 of 8 employee files reviewed. (QMA 2, QMA 3, QMA 4, QMA 5 & QMA 6) Findings include: The employee files were reviewed on 8/16/23 at 10:45 a.m. a. QMA 2 was hired on 6/1/23 and did not have a criminal history check through the Indiana State Police (ISP) Repository. b. QMA 3 was hired on 7/26/23 and did not have a criminal history check through the ISP. c. QMA 4 was hired on 7/17/23 and did not have a criminal history check through the ISP.	R 0116	Administrator would like this reviewed due to our new hired staff did have background checks through our Global HR Research which runs County and National Multi Jurisdictional search-multi jurisdiction. Facility will run background checks through ISP along with company's Global HR Research.	08/31/2023

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	d. QMA 5 was hired on 7/3/23 and did not have a criminal history check through the ISP. e. QMA 6 was hired on 6/2/23 and did not have a criminal history check through the ISP. Interview with the Office Manager on 8/16/23 at 1:50 p.m., indicated the criminal history check program used for new employees did not check the ISP. A Long Term Care Newsletter, dated 6/1/23, indicated "A facility is required to have completed a limited criminal history background check for all unlicensed staff. Visit the Indiana State Police (ISP) website for the requirements on how to complete the limited criminal history background check. Surveyors will request evidence that a limited criminal history background check, per ISP requirement, has been completed. The ultimate source of information for the limited criminal history background check must be ISP. A search of the applicable professional registry should be completed for any staff member with a professional certification or licensure to determine if there are any findings or disciplinary action against the individual."			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the Kitchen was clean and in good repair related to dirt, crumbs, dust and debris, dirty PVC pipes, lime build up, and discolored plastic light covers for 1 of 1 kitchens (Main Kitchen) and the residents' environment	R 0144	=”” b=””> /b> Dietary Manger issued per PLC policy weekly and daily clean logs for kitchen staff.	08/29/2023

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	was clean and in good repair related to splitting wood floors on 1 of 4 units. (The Memory Care Unit) Findings include: 1. During the kitchen sanitation tour on 8/15/23 at 8:49 a.m. with the Dietary Food Manager (DFM), the following was observed: a. An accumulation of dried spillage and debris was observed in the left hand corner behind the ice machine. The pipes leading to the ice machine had an accumulation of dust. b. The PVC pipes underneath the hand washing sink and juice machine had an accumulation of dust and dried food spillage. c. A plastic light cover located above the reach in cooler was discolored with an orange substance. Interview with the DFM at that time, indicated the stain was from an old ceiling leak and the light cover needed to be changed. d. An accumulation of a dried black substance was located on the floor tile underneath the oven. e. An accumulation of dried spillage and dark colored debris was observed on the floor behind the convection oven and steamer. f. There was an accumulation of lime build up on top of the dishwasher. Interview with the DFM at the time, indicated all of the above were in need of cleaning. 2. During the Environmental tour on 8/15/23 with the Maintenance Supervisor, there were splitting wood planks in the hallways throughout the		All kitchen staff issued job descriptions and duties signed and acknowledge what they are responsible for. Kitchen will be deep cleaned in all areas by staff and during regular hours of operation to achieve this goal. Once the cleaning has been completed, staff will sign off on daily and weekly clean logs and held accountable for any duties not completed. Maintenance director also will assess light fixture to see if it can be cleaned or replaced. Maintenance director has contacted flooring companies for bids to have memory care unit flooring replaced. ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b="">	

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	Memory Care Unit. Interview with the Administrator on 8/16/23 at 2:25 p.m., indicated she was aware of the splitting wood planks when she first arrived in April 2023. This State Residential tag relates to complaint number IN00405063.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure a Semi-Annual Evaluation was completed every 6 months for 3 of 8 residents reviewed for Semi-Annual Evaluations. (Residents 4, 6, and H) Findings include: 1. The record for Resident 4 was reviewed on 8/15/23 at 2:46 p.m. Diagnoses included, but were not limited to, high blood pressure, rheumatoid arthritis, COPD, kidney disease, and osteoporosis. The resident was admitted on 7/22/22. A Semi-Annual Evaluation was completed on 7/22/22. There were no other Semi-Annual Evaluations available for review. Interview with the Administrator on 8/15/23 at 2:22	R 0214	/b> All current residents will have annual evaluations to begin 9/1/2023 and 6mo semi annually and when there is a change of condition. New admissions to have pre admission evaluation and 6mo semi annual thereafter and per change of condition. DON and ADON to audit weekly for 6months to ensure all residents have evaluations/assessments completed in the timely manner. DON and ADON to print out progress notes, assessments and pertinent charting on the last day of the month for a year. Plan will be in effect on 9/30/2023	10/01/2023

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	p.m., indicated a new management company took over on 5/1/23 and she does not have access to the old computer system for clinical records. 2. The record for Resident 6 was reviewed on 8/15/23 at 11:49 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, and high blood pressure. The resident was admitted on 5/3/22 A Semi-Annual Evaluation was completed on 4/29/22 and then again on 3/20/23. There were no other Semi Annual-Evaluations available for review. Interview with the Administrator on 8/15/23 at 2:22 p.m., indicated a new management company took over on 5/1/23 and she does not have access to the old computer system for clinical records.3. Record review for Resident H was completed on 8/15/23 at 10:32 a.m.. Diagnosis included, but not limited to, Alzheimer disease, ileostomy status, major depressive disorder, other acute kidney failure, restless leg syndrome, over active bladder, and hypothyroidism. The Semi-Annual Evaluation had not been completed. Interview with Administrator on 8/16/23 at 4:20 p.m., indicated the Semi-Annual Evaluations were not completed, or they could be in the previous system that she had no access to.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the			

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	services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure the Service Plan was signed by the resident and they were revised and updated according to the resident's change in condition for 5 of 8 residents reviewed for Service Plans. (Residents C, 4, 6, F, and H) Findings include: 1. The record for Resident C was reviewed on 8/15/23 at 10:42 a.m. Diagnoses included, but were not limited to, vascular dementia without behaviors, syncope, chronic kidney disease,	R 0217	=" b=""> =" b=""> =" b=""> /b> All service plans will be updated accordingly and will coincide with outside services when in place such as Hospice and home health services. Director of Nursing to audit service plans weekly for 3months and monthly indefinitely.	10/01/2023

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	cardiac pacemaker, heart disease, and stroke. The resident was admitted on 2/10/23. The Service Plan, dated 2/9/23, was not signed by the resident and/or responsible party, only by facility staff. Interview with the Administrator on 8/16/23 at 2:22 p.m., indicated the Service Plan was not signed by the resident. 2. The record for Resident 4 was reviewed on 8/15/23 at 2:46 p.m. Diagnoses included, but were not limited to, high blood pressure, rheumatoid arthritis, COPD, kidney disease, and osteoporosis. There was no Service Plan available for review. Interview with the Administrator on 8/15/23 at 2:22 p.m., indicated a new management company took over on 5/1/23 and she does not have access to the old computer system for clinical records. 3. The record for Resident 6 was reviewed on 8/15/23 at 11:49 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, and high blood pressure. The resident was receiving hospice care. The Service Plan, dated 3/20/23, was not signed by the resident and/or responsible party, only by facility staff. The Service Plan did not address hospice care. Interview with the Administrator on 8/15/23 at 2:22 p.m., indicated the Service Plan was not signed by the resident and did not address hospice care. 4. Resident F's record was reviewed on 8/15/23 at 10:14 a.m. Diagnoses included, but were not			

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	limited to, diabetes mellitus, high blood pressure, and Alzheimer's disease without behavioral disturbance. The Service Plan, dated 4/19/23, indicated the resident resided in the memory care unit and required constant reminders and cueing. She required staff assistance with grooming, dressing, medication administration, toileting. She had behaviors requiring staff intervention and/or re-direction once per shift. The Service Plan was not signed by the resident and/or responsible party. A Progress Note, dated 6/13/23 at 5:23 p.m., indicated the resident started hospice care that afternoon. There was no updated Service Plan to review that indicated the resident had a change in status and was receiving hospice services. Interview with the Administrator on 8/16/23 at 2:20 p.m., indicated she had no further information to provide. A Policy titled, "Home Health and Other Outside Agencies," and noted as current indicated, "...9. The care plan of the home health/outside agency should be completely consistent with the Community's Service Plan."5. Record review for Resident H was completed on 8/15/23 at 10:32 a.m.. Diagnosis included, but not limited to, Alzheimer disease, ileostomy status, major depressive disorder, other acute kidney failure, restless leg syndrome, over active bladder, hypothyroidism. The Service Plan was completed, but not signed			

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	by the resident. Interview with Administrator on 8/16/23 at 4:27 p.m., indicated the Service Plan was not signed by the resident.			
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 and interview, the facility failed to store, serve, and prepare food under sanitary conditions related to dirty food equipment, food crumbs on clean surfaces, undated food in the refrigerator, food crumbs in the reach in cooler, a food storage bin with dried food spillage and stains, an accumulation of dust on a fan grate and on top of the juice machine, and serving food uncovered from the kitchen for 2 of 2 kitchen areas observed. (The Main Kitchen and the Second Floor Servery) This had the potential to affect the 101 out of 101 total residents who received food from the kitchen. Findings include: 1. During the kitchen sanitation tour on 8/15/23 at 8:49 a.m. with the Dietary Food Manager (DFM), the following was observed: a. An accumulation of dust was observed on top of the juice machine. b. There was an accumulation of food spillage on the bottom shelf of the reach in cooler. c. A plastic bin containing potato chips was	R 0273	Dietary Manger issued per PLC policy weekly and daily clean logs for kitchen staff. All kitchen staff issued job descriptions and duties signed and acknowledge what they are responsible for. Kitchen will be deep cleaned in all areas by staff and during regular hours of operation to achieve this goal. Once the cleaning has been completed, staff will sign off on daily and weekly clean logs and held accountable for any duties not completed. ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""	09/28/2023

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		A. BUILDING 00 B. WING	08/16/2023

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	located on the bottom shelf of a storage rack. The aluminum foil covering the potato chips was pulled back and the food was exposed. Interview with the DFM at that time, indicated the potato chips were from 3 days ago and the night shift must have been eating them. d. The plate warming station had an accumulation of food crumbs and spillage. Clean plates were located in the warmer. e. An accumulation of a dark black substance was observed on the stove top. f. Food debris and an accumulation of grease was observed on the top and the side of the fryer. g. Dried food spillage was observed on the front of the convection oven. h. The metal shelves located at the bottom of the food prep table were rusty and had an accumulation of food debris. i. The fan in the dish room had an accumulation of dust on the fan grate. The fan was blowing towards the dishwasher. j. The plastic lid to the flour bin was sticky and had an accumulation of dried food spillage. 2. During the kitchen sanitation tour on 8/15/23 at 9:00 a.m. with the Dietary Food Manager (DFM), the following was observed in the Second Floor Servery: a. A bag of food located in the freezer was not labeled or dated. There was also an accumulation of dried food spillage on the freezer shelves.			

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	Interview with the DFM at that time, indicated the bag contained cut up pieces of waffle and the bag should have been labeled and dated. b. Eleven fruit cups located in the refrigerator were not dated. c. An accumulation of dried spillage was observed on the wall next to the ice machine. Interview with the DFM at the time, indicated all of the above were in need of cleaning. 3. On 8/15/23 at 11:20 a.m., a dietary employee was observed serving lunch trays from a three tiered cart in the main dining room. The turkey burgers, potato chips, and soup were on the top two tiers and the dessert was on the bottom tier. None of the food was covered. Interview with the Administrator on 8/15/23 at 3:45 p.m., indicated the food was to be covered when it left the kitchen.			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service			

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	supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on record review and interview, the facility failed to ensure menus were approved by a Registered Dietitian (RD) and followed. The facility also failed to ensure recipes were available for pureed food preparation. This had the potential to affect the 101 residents who received food from the kitchen, including the 5 residents who received a pureed diet. (Main Kitchen) Finding includes: Interview with the Dietary Food Manager (DFM) on 8/15/23 at 9:30 a.m., indicated the pureed food prep had already been completed. When asked to see the recipe and menu, the DFM indicated he had no RD approved menus and no recipes for puree food prep since the new management company had taken over. He was told they would	R 0274	=”” b=””> Dietary director has printed recipes an spread sheets of the five week cycle menu provided by Priority Life Care's contracted dietician company Dining RD. Menus went live on 8/16/2023. The recipes and spread sheets were placed in five separate weekly binders. One for each week of the five week cycle. The binders are clearly marked and readily available for the cooks to use and for any other staff members to review if needed. Dietary director printed all recipe guidelines for mechanical soft and pureed diets from Dining RD.	08/18/2023

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	be getting the menus and recipes. He also indicated the last management company did not provide menus or recipes and they just used their own judgement. The DFM indicated for today's turkey burger, the Cook pureed the burger with milk and used thicket as needed. At 10:40 a.m., the DFM indicated he still had a binder of old menus and recipes but nothing current. On 8/15/23 at 3:30 p.m., the Administrator provided a menu, dated 8/13/23 thru 9/16/23, that had been approved by the RD. The menu indicated honey dijon pork cutlet, orzo florentine, roasted fresh beets, and bread or a roll was to be served for lunch on 8/15/23. The menu provided by the DFM indicated a Philly style turkey burger, potato chips, a side salad, and pie was to be served for the lunch meal on 8/15/23. This was the meal the residents had received. Interview with the Administrator on 8/15/23 at 3:45 p.m., indicated the menu provided by the RD should be the menu that was being followed.		These recipes and guidelines were placed in a separate binder and are located with the five week cycle menu binders for all staff to review when needed. Dietary manager will audit recipes to weekly menus to ensure that recipes are being utilized for the meals per RD.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and	R 0349	=" b="">	09/28/2023

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	interview, the facility failed to ensure Physician's Orders were followed and clinical records were accurately documented and readily accessible related to insulin administration, insulin being signed out as given by QMA's, fall follow-up related to vital signs and neurological checks, monitoring bruises, skin tears, and sutures, obtaining laboratory specimens, fall interventions, and no orders for hospice care and treatments for 7 of 13 residents reviewed. (Residents J, C, L, K, F, D, and H) Findings include: 1. The record for Resident J was reviewed on 8/15/23 at 2:11 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and type 2 diabetes mellitus. A Physician's Order, dated 6/21/23, indicated the resident was to receive Novolog 70/30 insulin, inject 28 units subcutaneously twice a day at 8:00 a.m. and 5:00 p.m. The insulin was to be held if the resident's blood sugar was less than 120. A Service Plan, dated 6/8/23, indicated the resident had diabetes mellitus. Interventions included, but were not limited to, administer medication as ordered by the Physician and observe for side effects. The August 2023 Medication Administration Record (MAR), indicated the resident's blood sugar at 8:00 a.m. on 8/1/23 was 116. The resident's insulin was signed out as being administered. The resident's scheduled 5:00 p.m. insulin was signed out late on the following dates: - 8/1/23 at 8:13 p.m.		/b> All QMA's issued job description and scope of practice, signed acknowledge what their role is and what they are limited to do. All QMA's in serviced on improper documentation of insulin administration. Counseling also given on blood glucose parameters and MD notification. DON has scheduled insulin certification class for non certified QMA's currently on staff. DON and ADON to audit blood glucose parameters, insulin administration daily for 3 months and 3x week for 3 months then once monthly for 3 months to ensure all parameters are followed and administration of insulin is given by licensed staff. All nursing staff counseled on post fall neurological checks for 72hr are being followed. DON and ADON to audit post fall neuro checks weekly for 3months then once monthly for 3 months. DON and ADON to audit nursing charting on skin issues such as bruising, skin tears weekly for 3 months then once monthly for 3 months. DON and ADON to audit treatment orders, lab orders received from outside services hospice, home health to match our PCC. Audit to be completed weekly for 3 months then once monthly for 3 months.	

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	- 8/2/23 at 7:19 p.m. - 8/3/23 at 6:47 p.m. - 8/4/23 at 6:45 p.m. - 8/7/23 at 9:27 p.m. - 8/8/23 at 6:54 p.m. - 8/10/23 at 7:15 p.m. - 8/12/23 at 7:42 p.m. - 8/13/23 at 7:24 p.m. The resident's 5:00 p.m. insulin was signed out as being administered by a QMA on 8/2, 8/3, 8/4, 8/8, 8/10, 8/11, 8/12, and 8/13/23. The July 2023 MAR, indicated on 7/1, 7/11, and 7/26/23 at 8:00 a.m., the resident's insulin administration was coded as "NI" no insulin required, however, the resident's blood sugar was not documented. The resident's 8:00 a.m. insulin was signed out as being late on the following dates: - 7/3/23 at 10:21 a.m. - 7/16/23 at 10:36 a.m. - 7/22/23 at 9:46 a.m. The resident's 5:00 p.m. insulin was signed out as being late on the following dates: - 7/4/23 at 7:17 p.m. - 7/6/23 at 6:50 p.m. - 7/12/23 at 7:54 p.m. - 7/13/23 at 7:01 p.m. - 7/25/23 at 7:42 p.m. - 7/26/23 at 8:13 p.m. The resident's 5:00 p.m. insulin was signed out as being administered by a QMA on 7/5, 7/11, 7/12, 7/19, 7/20, 7/25, 7/26, and 7/27/23. Interview with QMA 1 on 8/15/23 at 3:50 p.m., indicated she was not certified to administer		Nursing staff counseled on emergency room visit returns post fall and continuation of neurological checks x 72hours. DON ADON and Memory care coordinator counseled DME orders and follow through on receiving DME in a timely manner once they are ordered.	

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	insulin. She indicated she had not given the resident any insulin on the above dates, the nurse administered the insulin, and the QMA indicated she signed it out to "help" the nurse.2. The record for Resident C was reviewed on 8/15/23 at 10:42 a.m. Diagnoses included, but were not limited to, vascular dementia without behaviors, syncope, chronic kidney disease, cardiac pacemaker, heart disease, and stroke. The resident was admitted on 2/10/23. Physician's Orders, dated 4/14/23, indicated a hospital bed with bolster mattress and fall mat. An After Visit Summary from the Emergency Room (ER), dated 3/15/23, indicated the resident arrived to the ER at 6:36 p.m. after falling. The resident had a head injury. Nurses' Notes, dated 3/15-3/18/23, indicated there were no neurological checks completed or vital signs checked. There was no monitoring of the head injury. An After Visit Summary from the ER, dated 4/13/23, indicated the resident had a fall with shoulder pain. Multiple tests were completed and the resident sustained a closed fracture of multiple ribs on the right side, a head injury, a contusion of the right shoulder, a contusion of the right hip, and was diagnosed with dehydration. Nurses' Notes, dated 4/13-4/17/23, indicated there were no neurological checks completed or vital signs checked. There was no monitoring of the head injury, the contusions, or the fractured ribs. Nurses' Notes, dated 4/16/23 at 5:56 a.m., indicated the resident's new mattress and fall pad arrived, they were still awaiting a hospital bed and			

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	bolsters. A Progress Note, dated 4/18/23, indicated low hospital bed, bolster mattress, and mattress pad due to recurrent falls, difficulty walking, and weakness. A hand written note on the side of the paper indicated "did not fill, canceled due to resident being sent to ER and discharged." Interview with the Administrator on 8/16/23 at 2:22 p.m., indicated neurological checks including vital signs were unavailable for review for the falls on 3/15/23 and 4/13/23. They did not receive the hospital bed or the bed bolsters for the resident after they were ordered on 4/14/23. 3. The record for Resident L was reviewed on 8/16/23 at 9:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes. Physician's Orders, dated 8/1/23, indicated Levemir Insulin flexpen 25 units daily and Humalog Insulin 20 units twice a day. Physician's Orders, dated 8/12/23, indicated Levemir insulin flexpen 28 units at bedtime. Humalog Insulin 20 units three times a day. Hold if blood sugar was less than 100. The 8/2023 Medication Administration Record (MAR) indicated the following: - Levemir 28 units was signed out by a QMA on 8/12 and 8/13 at 8 p.m. - Humalog Insulin twice a day was signed out by a QMA for the a.m. shift on 8/6 and for the p.m. shift on 8/2, 8/3, 8/4, 8/8, 8/9, and 8/10/23. - Humalog Insulin three times a day was signed out by a QMA at 4 p.m. on 8/12 and 8/13/23. 4. The record for Resident K was reviewed on			

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	8/16/23 at 9:54 a.m. Diagnoses included, but were not limited to, type 2 diabetes. Physician's Orders, dated 7/19/23, indicated Lantus Insulin 15 units at bedtime. Physician's Orders, dated 7/27/23. indicated Novolog Insulin flexpen per sliding scale: if 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units above 400 give 10 units and call the doctor. The 8/2023 Medication Administration Record (MAR) indicated the Lantus was signed out by a QMA on 8/1, 8/3, 8/6, 8/9, 8/10, 8/11, 8/13, and 8/14/23. The Novolog Insulin was signed out by a QMA at 4 p.m., on 8/1/23. Interview with QMA 1 on 8/15/23 at 4:15 p.m., indicated she worked primarily the 2 to 10 shift, on the first and second floors. She was not certified to administer insulin. She has signed the insulin out on the MAR, however, she has never administered insulin to any resident. She thought she was doing the nurse on duty a favor by signing out the insulin for her. interview with QMA 5 on 8/15/23 at 4:20 p.m., indicated she was not insulin certified and therefore had never administered insulin to any resident. She had signed out the insulin on the MAR, but had made a progress note indicating the nurse administered the insulin. Interview with the Director of Nursing (DON) on 8/16/23 at 10:00 a.m., indicated the QMAs who were not certified to administer insulin should not be signing out on the MAR that they administered the insulin, regardless of the progress note which indicated a nurse			

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	administered. 5. Resident F's record was reviewed on 8/15/23 at 10:14 a.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and Alzheimer's disease without behavioral disturbance. The Level of Care Assessment, dated 4/19/23, indicated the resident resided in the Memory Care Unit and required constant reminders and cueing. She required staff assistance with grooming, dressing, medication administration, toileting. She had behaviors requiring staff intervention and/or re-direction once per shift. A Progress Note, dated 5/12/23 at 9:41 p.m., indicated the resident had a fall on 5/10/23 which resulted in a visit to the hospital. The resident returned with sutures to her left eyebrow, skin discolorations to bilateral shins and her right hand. There was no documentation available for review of vital signs checked at the time of fall, neurochecks, notification to the Physician or responsible parties, or monitoring of the suture site or skin discolorations. A Progress Note, dated 6/2/23 at 2:40 p.m., indicated the nurse was called to Resident F's room. The resident was observed laying on the floor on her left side in front of her wheelchair. A pillow had been placed under the resident's head and blood was observed on the pillow and left side of her face. Upon assessment, a laceration to her left eyebrow and contusion to her left cheek was observed. 911 was called and the resident was transported to the emergency department for further assessment. The Power of Attorney, resident's son, Director of Nursing, and Physician were notified.			

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	A Progress Note, dated 6/3/23 at 12:03 a.m., indicated the resident had swelling observed to the site, sutures were dry and intact. A Progress Note, dated 6/3/23 at 1:44 a.m., indicated monitoring was in progress for the fall that occurred on 6/2/23. The resident's left side of her face was swollen and discolored. The laceration above her left eyebrow was well approximated and scabbed with 6 sutures in place. A Progress Note, dated 6/4/23 at 8:44 p.m., indicated monitoring was in progress for the fall that occurred on 6/2/23. The resident's left side of her face was swollen and discolored. The laceration above her left eyebrow was well approximately and scabbed with 6 sutures in place. There was no documentation available for review of vital signs checked at the time of the incident, neurochecks started, or continued monitoring of the sutures. A Progress Note, dated 6/13/23 at 5:23 p.m., indicated the resident was placed under hospice care on this day. There were no Physician Orders on the current Physician Order Summary (POS) for August 2023. A Physician Order, dated 6/28/23, indicated apply skin prep no sting wipe topically to left thigh every shift until healed. A Progress Note, dated 6/27/23 at 10:37 p.m., indicated the resident had a blister noted to her left thigh. New orders were obtained to apply skin prep every shift until resolved.			

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	A Progress Note, dated 6/28/23 at 2:19 a.m., indicated monitoring was in progress for intact blister to the left upper inner thigh. Order was noted to apply skin prep to the site every shift. The blister was prominent so a bandage was applied for extra protection. A Progress Note, dated 6/29/23 at 3:01 a.m., indicated skin prep continues to the left upper inner thigh for blister. Blister remained intact, but was flatter than what it was previously. Fluid inside blister was pink tinged. A bandage was applied to site for protection. A Progress Note, dated 7/3/23 at 3:28 p.m., indicated the hospice nurse was present and inserted a foley catheter. The resident's sacral wound was cleaned and redressed. There were no wound care orders on the July or August 2023 POS for a sacral wound. A Progress Note, dated 7/17/23 at 9:53 p.m., indicated the resident had a skin tear on the lower left extremity noted on the inner knee. There was no further documentation to review for monitoring or treatments of the skin tear to the inner knee. Interview with the Administrator on 8/16/23 at 2:20 p.m., indicated she had no further information to provide. 6. Resident D's record was reviewed on 8/15/23 at 2:05 p.m. Diagnoses included, but were not limited to, diabetes mellitus, dementia with behavioral disturbance, and high blood pressure.			

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		A. BUILDING 00 B. WING	08/16/2023

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	The Mini-Mental State Examination, dated 10/7/22, indicated the resident was severely cognitively impaired. A Progress Note, dated 9/21/22 at 4:51 p.m., indicated nursing was to obtain an order for a urinalysis (UA) due to a strong odor of urine. A Progress Note, dated 9/23/22 at 12:29 a.m., indicated nursing was to obtain an order for a urinalysis (UA) due to a strong odor of urine. A Progress Note, dated 9/23/22 at 12:56 p.m., indicated new orders were noted for a foley catheter and then obtain UA with culture and sensitivity (C&S), resident to start Doxycycline (an antibiotic) for now for possible urinary tract infection (UTI). A Progress Note, dated 9/23/22 at 2:55 p.m., indicated the visiting nurse was not aware of new orders for a foley catheter and UA when she arrived to care for the resident. She stated it was the weekend and was unable most likely to get catheter inserted before Monday. A Progress Note, dated 9/26/22 at 2:25 p.m., indicated UA was obtained and lab was to pick up the sample today. The UA Laboratory Results, dated 9/26/22 at 4:01 p.m., indicated the resident had an abnormal level of protein, blood, bacteria, and white blood cell count. On 9/28/22, the Nurse Practitioner ordered Augmentin (an antibiotic). The urine culture dated 9/27/22 indicated >100,000 bacteria count. There was no documentation of a sensitivity performed on the urine sample.			

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	Interview with the Administrator on 8/16/23 at 2:20 p.m., indicated the resident should have been sent out to the hospital to get the urinalysis and culture and sensitivity completed timely. 7. Record review for Resident H was completed on 8/15/23 at 10:32 a.m. Diagnoses included, but not limited to, Alzheimer's disease, ileostomy, major depressive disorder, other acute kidney failure, restless leg syndrome, over active bladder, and hypothyroidism. Progress Notes, dated 7/6/23, indicated CNA's were called to the room. The resident indicated she lost her balance and fell backwards onto the floor, hitting her back, and she wanted to go to the emergency room (ER). Progress Notes, dated 7/7/23, indicated the resident was sent to the ER on 7/7/23 at 1:55 a.m. The resident returned to the facility. No vital signs or neuro checks were performed on the resident after the fall. Progress Notes, dated 7/29/23, indicated the resident had a fall late the previous evening. The Director of Nursing, Doctor, and family were notified of the fall. The resident had swelling and bruising to the left elbow area. There was no documentation of vital signs, neurochecks, or monitoring of the resident after the fall incident. Progress Notes, dated 8/7/23, indicated the resident had a left eye/face bruise from hitting herself while mopping her apartment. There was no documentation provided for monitoring the bruise.			

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	Interview with the Administrator on 8/16/23 at 11:59 a.m., indicated she was aware of the falls and bruising, but could not provide documentation on the monitoring of the bruises. A facility policy titled, "Fall Policy Practice", provided by the Administrator on 8/16/23 at 3:00 p.m., indicated ... "Vital signs (Temperature, Pulse, Respirations, and Blood Pressure) will be taken at the time of the fall .... Falls are then to be documented on every shift for 3 days. The note should include any follow up first aide, a full set of vitals signs, any complaints of pain, and any other pertinent information. Each day is to be notes in the nursing note". A facility policy titled, "Skin Integrity Monitoring", provided by the Administrator on 8/16/23 at 4:20 p.m., indicated, "The Current Skin Issues form will be used to maintain quality assurance by ensuring documentation and monitoring of all resident skin issues within the Community. The skin issues are then weekly documented on the following: a.) Resident Service Plan, b.) Resident Weekly Skin Monitoring form c.) Current Skin Issues form ...." This state residential finding relates to Complaints IN00405063 and IN00408004.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control,			

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	including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to lack of documentation for tracking and trending infections during the review of the facility infection control process, which had the potential to affect all 101 residents in the facility, and residents who received antibiotics without true infections for 4 of 8 residents reviewed. (Residents 6, 11, 12, and D) Findings include: 1. The infection control logs were reviewed on 8/16/23 at 10:00 a.m. There were no infection control logs completed for the months of February and March 2023. The logs were documented with the resident name, apartment number, date of onset, site, treatment, and date resolved. The columns for the culture, organism, isolation and retest day were all blank. Interview with the Director of Nursing (DON) on 8/16/23 at 10:00 a.m., indicated there were no infection control logs completed that had tracking and trending of infections for the months of 2/2023 and 3/2023. Interview with the DON on 8/16/23 at 4:15 p.m., indicated the infection control summary for April, May, June, and July 2023 was not completed. The summary was a tracking tool to be completed	R 0407	Nursing staff educated regarding infection control, monitoring wounds and signs and symptoms of urinary infections. MD and family notifications in a timely manner and documentation of notification. Nursing staff in serviced on handwashing, glove use, peri care and incontinence products to prevent future spread of infection. DON and ADON to audit infection control logs to ensure all logs are filled out organism, date of result, treatment and outcome. NP notified of concerns of ordering prophylactic antibiotic orders before final culture results are returned. NP partnered with Vikor Scientific wound culture swabs and PCR kits are now available in-house for accurate results. NP and nursing staff educated on utilizing McGreer's criteria and ensuring resident meets the criteria. DON and ADON to audit 24hr shift reporting and progress notes daily indefinitely. All nursing staff encourage and offer cranberry juice and water with every meal. Nurses educated and counseled on orders received to obtain urine	09/28/2023

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	monthly for all infections and broke down the infections by unit and specific types. 2. The record for Resident 6 was reviewed on 8/15/23 at 11:49 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, and high blood pressure. The resident received hospice services and care. A hospice note by the hospice RN, dated 7/28/23, indicated wound was care provided and the Medical Doctor was notified of purulent drainage to the right heel ulcer. New orders were obtained for Doxycycline (an antibiotic medication) 100 milligrams (mg) every 12 hours for 15 days and Gentamicin (an antibiotic) topical cream to the wound with each dressing change three times weekly. A Physician's Order, dated 7/31/23, indicated Doxycycline 100 mg every 12 hours for 15 days. There was no wound culture collected prior to the start of the antibiotic. Interview with the Administrator on 8/16/22 at 2:22 p.m., indicated there were not wound cultures collected to determine the need to start the antibiotic treatment for the right heel. 3. The record for Resident 11 was reviewed on 8/16/23 at 10:20 a.m. The 7/2023 infection control log indicated the resident was started on the antibiotic of Keflex 500 milligrams every 6 hours for 5 days for a Urinary Tract Infection (UTI). Physician's Orders, dated 7/5/23, indicated,		specimens in a timely manner and notify MD immediately if urine cannot be obtained.	

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	urinalysis and culture and sensitivity for increased agitation. An urinalysis obtained on 7/6/23, indicated the urine was negative for bacteria and nitrates, and had a high number of white blood cells. A urine culture reflex was indicated based on the outcome of the test. A final urine culture indicated there was 10-50,000 mixed bacterial morphotypes, and 50-100,000 beta strep group B organisms in the urine. An NP Progress Note, dated 7/13/23, indicated the resident was seen for follow up regarding a UTI. The resident had an urinalysis collected due to increased urinary frequency and confusion. The resident's urinalysis revealed an infection and will be started on antibiotics for 5 days. Interview with the Administrator on 8/16/23 at 1:25 p.m., indicated the facility followed McGeer's criteria for all infections. The "IDOH Infection Surveillance Checklist" provided by the Administrator on 8/16/23 at 3:20 p.m., indicated McGeer's criteria for UTI without an indwelling catheter: Both 1 and 2 must be fulfilled; 1. at least 1 of the following signs or symptoms, acute pain, swelling or tenderness, fever or blood in the urine, increased urgency, frequency or incontinence. 2. at least 1 of the following microbiologic criteria: greater than 100,000 of no more than 2 species of organisms in a voided specimen and greater than 100 of any organism in specimen collected with an in and out catheter. 4. The record for Resident 12 was reviewed on 8/16/23 at 10:30 a.m.			

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	The 7/2023 infection control log indicated the resident was started on the antibiotic of Macrobid 100 milligrams (mg) on 7/26/23 for the treatment of a UTI. A Physician's Order, dated 7/19/23, indicated urinalysis with a culture and sensitivity. Nurses' Notes, dated 7/19/23 at 9:43 p.m., and on 7/20/23 at 8:10 p.m., indicated staff were unable to collect a urine sample. There was no urinalysis available for review. A Physician's Order, dated 7/26/23, indicated Macrobid 100 mg, give 1 two times a day times 5 days for an UTI. Interview with the Administrator on 8/16/23 at 1:24 p.m., indicated the NP ordered the antibiotic without collecting a urinalysis or culture. The NP told her it was because the resident was having a lot behaviors. 4. Resident D's record was reviewed on 8/15/23 at 2:05 p.m. Diagnoses included, but were not limited to, diabetes mellitus, dementia with behavioral disturbance, and high blood pressure. The Mini-Mental State Examination, dated 10/7/22, indicated the resident was severely cognitively impaired. A Progress Note, dated 9/21/22 at 4:51 p.m., indicated nursing was to obtain an order for a urinalysis (UA) due to a strong odor of urine. A Progress Note, dated 9/23/22 at 12:56 p.m., indicated new orders were noted for a foley catheter and then obtain UA with culture and			

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	sensitivity (C&S), resident to start Doxycycline (an antibiotic) for now for possible urinary tract infection (UTI). A Progress Note, dated 9/23/22 at 2:55 p.m., indicated the visiting nurse was not aware of new orders for a foley catheter and UA when she arrived to care for the resident. She stated it was the weekend and was unable most likely to get catheter inserted before Monday. A Progress Note, dated 9/26/22 at 2:25 p.m., indicated the UA was obtained and lab was to pick up the sample "today". The UA Laboratory Results, dated 9/26/22 at 4:01 p.m., indicated the resident had an abnormal level of protein, blood, bacteria, and white blood cell count. On 9/28/22, the Nurse Practitioner ordered Augmentin (an antibiotic). The urine culture dated 9/27/22 indicated >100,000 bacteria count. There was no documentation of a sensitivity performed on the urine sample. Interview with the Administrator on 8/16/23 at 2:20 p.m., indicated the antibiotics should not have been ordered until after the urinalysis and culture and sensitivity was completed. This state residential finding relates to Complaint IN00408004.			