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	08/31/2021

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BLOOM AT GERMAN CHURCH	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 30, and 31, 2021 Facility number: 003916 Residential Census: 56 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 8, 2021	R 0000	Submission of this response and plan of correction is not a legal admission that the deficiency exists or that the statement of deficiencies was correctly cited and is not to be construed as an admission against any interest by the residents or any employees, agents or other individuals who drafted or who may be discussed in the response or plan of correction. In addition, preparation, and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
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 (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 interview and record review, the facility failed to provide the residents and resident representatives weekly updates of the facilities Covid-19 status, affecting 55 of 55 residents	R 0036	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:	10/08/2021

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

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	residing at the facility. Findings include: On 8/31/21 at 9:10 a.m., the ADM (Administrator) provided the communication tool for updating residents and their representatives of the Covid-19 status in the building. During an interview on 8/31/21 at 10:50 a.m., she indicated it had last been sent out on 8/7/21. During an interview on 8/31/21 at 11:50 a.m., the AD (Area Director) indicated that weekly updates on the Covid-19 status of the facility had not been sent to residents or their representatives weekly. On 8/31/21 at 1:45 p.m., the Long-term Care Facility Communication Guidelines Informing Family Members during COVID-19, updated 3/15/21, was retrieved from the IDOH website. It read "... the Indiana State Department of Health...is requiring... assisted-living facilities... to provide to residents and their designated representatives the following: 1. How the facility is handling issues with care and staff shortages 2. General information about COVID-19 3. The number of residents and staff who have tested positive and the number of "new" positive cases (those in the last 14 days) 4. The number of residents who have died due to the virus 5. Facility mitigation actions implemented to reduce the risk of COVID-19 transmission, including if normal operations of the facility must be altered...Communication Requirements...2. The guidelines for cumulative updates to residents, designated representatives, and families is changing from daily to weekly..."		*The weekly communication from Bloom Senior Living has been reinstituted and is being distributed weekly via email to resident representatives and families and one on one to residents.* How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: *The Administrator, or her designee, will audit the emails of all resident representatives who want to receive the weekly COVID-19 communication and will update the distribution list with corporate offices. (All resident's representatives, family members and residents will have the option to opt out of notices.) The administrator, or her designee, will distribute a copy of the corporate communication on a weekly basis to all residents in the facility.* What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur: *The Administrator, or her designee, will ensure that the email of new resident representatives, as the resident moves into the facility, will be added to the communication's distribution list, as will the new*	

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			resident moving into the facility. The corporate offices will continue to distribute the weekly communication as long as it is required by the Indiana State Department of Health. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: *The Administrator, or her designee, will maintain a copy of all communications distributed and a record of who received the communication. The Administrator will audit this record each week for two months and each month for four months.*	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview and record review, the facility failed to ensure self medication	R 0216	What corrective actions will be accomplished for those residents	10/08/2021

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	evaluations were conducted on residents that have medications left at bedside for 1 of 7 medication administrations observed and 1 of 1 randomly observed resident with medication in her room. (Resident 8 and 49) Findings include: 1. The clinical record for Resident 49 was reviewed on 8/31/21 at 8:40 a.m. The diagnosis included, but was not limited to, diabetes. A service plan dated 7/6/21 indicated "...judgment Action: Experiences difficulty in decision making...Notes: [Resident 49] is alert and oriented, but will forget things from time to time. Will continue to monitor and adjust plans of care as needed...Medication Procedures. Action: Insulin injections administered at least one time per day. Notes. Staff to order, administer, and store all medications..." An observation was made of a medication administration with Qualified Medication Aide (QMA) 1 on 8/31/21 at 8:40 a.m. QMA 1 was observed pulling Resident 49's morning medications and placing them in a medication cup. She then entered Resident 49's room and placed the cup of pills on the table next to the resident. QMA 1 was observed administering the eye drops and insulin to the resident. After, she then requested the resident to take her pill medications. The resident at that time, indicated she would take them in a minute. QMA 1 stated she would be back to check on her later and left the room. Resident 49 had not taken her pill medications prior to QMA 1 leaving the room. An interview was conducted with QMA 1 on 8/31/21 at 8:55 a.m. She indicated Resident 49 was		found to have been affected by the deficient practice: *Resident #49 and Resident #8 were monitored for a twenty-four (24) hour period for any adverse effects from noted medication administration. No adverse effects were noted. The assessments for self-administration for Resident #49 and Resident #8 were reviewed and found to be correct: neither resident has the ability to self-administer their medications. Resident #49 and Resident #8 now receive and take their medications while the QMA/LPN is observing them.* How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: *All residents who have medication administered by nursing staff have the potential to be affected. Nursing staff administering medications will remain with each resident while they take their medication(s) and no medication(s) will be left for them to take at another time. Wellness Director or her designee will observe medication administration for 20% of residents each week for 2 months, then 20% of residents each month for 4 months.*	

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	always left unattended with her medications. The resident will get upset if you ask her too many times to take the medications while in the room. An interview was conducted with the Director of Nursing on 8/31/21 at 10:45 a.m. She indicated Resident 49 did not have a self medication assessment to be left unattended with her medications. 2. A random observation was made of Resident 8's room on 8/31/21 at 10:33 a.m. with AD (Area Director). Resident 8 had a bottle of Nystop (a fungal medication) powder at her bedside. A physician's order was placed on 2/10/21 for Nystop 100,000 units/gram. The directions read, " Apply to underbelly daily for yeast." An interview with AD was conducted on 8/31/21 at 10:34 a.m. AD indicated, unless the resident has an order from the physician stating a medication can remain at bedside, then a resident's medications should not be left in their room. Resident 8's clinical record did not contain a Self-Administration of Medication Assessment, a physician's order to allow for medication at bedside nor monthly documentation of the resident's continued ability to self-administer medications. A Medication- Self-Administration policy was received on 8/31/21 at 10:38 a.m. from AD. It indicated, "All residents have the right to self-administer medications upon the order of their physician within certain parameters: 1. They have not been declared incompetent or otherwise incapacitated under the laws of the State. 2. They are able to demonstrate to the Wellness Director		What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur: *An in-service on medication administration and application of same for this facility will be done with nursing staff on September 28, 2021.* How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: *Wellness Director or her designee will observe medication administration for 20% of residents weekly for 2 months, then 20% of residents monthly for 4 months.*	

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	that they are capable of following the directions for the medications and have been assessed using a recognized self-administration assessment tool. 3. They are able to demonstrate to the Wellness director, who will report to the physician, that they are responsible for self-administering the medication correctly...The physician will make the final determination of the resident's ability to self-administer medications...6. The resident continues to demonstrate the ability to self-administer medications with monthly documentation of this continued ability in the Nurse's Progress Notes. Procedure: Written documentation in the form of a Physician's Order must be maintained in the Resident's Record and updated quarterly."			
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 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.			

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	(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 interview and record review, the facility failed to ensure service plans were updated that included interventions for fall prevention for a resident at risk for falling and for hospice services for 1 of 2 residents reviewed for falls. (Resident 8) Findings include: The clinical record for Resident 8 was reviewed on 8/31/21 at 9:41 a.m. Resident 8's diagnoses included, but not limited to, breast and colon cancer. Resident 8 was admitted to the facility with hospice services. A Fall Risk Assessment form was received on 8/31/21 at 1:57 p.m. from DON (Director of Nursing). The form indicated a Fall Risk Assessment was completed for Resident 8 on the following dates: 10/14/20, 2/19/21, and 5/18/21. All of the fall risk assessments scored above a 10, which indicated, Resident 8 was considered a high fall risk. A Nursing progress note dated 2/17/21 at 9:45 p.m. indicated, Resident 8 was found in her room with her head resting on her wheelchair and her knees on the floor. Two nurses had assisted back to her bed and she had no apparent injuries. A Nursing progress note dated 2/28/21 at 5:55 p.m. indicated, the CNA (Certified Nursing	R 0217	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: *The Wellness Director has reviewed Resident 8's records and has updated Resident 8's service plan to include assistance offered by staff for resident while dressing, toileting, showering, and transferring. In addition, Wellness Director will create a care plan to address resident's history of falls.* How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: *All residents who have experienced a fall have the potential to be affected. For each resident fall, nursing staff will complete a resident Fall Assessment. Wellness Director will review all Fall Assessments and determine if further measures need to be put into place. For those residents who require additional support Wellness*	10/08/2021

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	Assistant) was transferring Resident 8 to the toilet when her legs gave out on her so she CNA assisted the resident to the floor. There were no apparent injuries. A Nursing progress note dated 3/17/21 at 7:15 a.m. indicated, Resident 8 was found on the floor in her room by her bedside at 5:45 a.m. Resident 8 had denied hitting her head, but could not state how she had fallen. A Nursing progress note dated 3/26/21 at 1:15 a.m. indicated, Resident 8 was found on the floor by her bedside. She denied any pain or discomfort, but could not state how she had fallen. A Nursing progress note dated 5/14/21 at 4 a.m. indicated, Resident 8 was heard calling out "Help, Help". Resident 8 was found on the floor by her bedside. Resident 8 stated she rolled over and fell out of her bed. No injuries were noted at the time. A Nursing progress note dated 6/17/21 at 7 a.m. indicated, Resident 8 was found on the floor next to her bedside at about 4 a.m. Resident 8 denied hitting her head and nursing to "continue to monitor daily". Resident 8's Service Plan dated 10/19/21 was provided by DON on 8/31/21 at 1:57 p.m. The Service Plan indicated, Resident 8's needs included, but not limited to: Dressing/Morning care-Provide daily assistance with dressing in the a.m.; ADL (Activities of Daily Living): Mobility-Provide occasional escort or assistance with mobility; Night Checks-Provide night checks once a night; Night time preparation-Make sure that resident is in pajamas and in bed at night; Toileting/Incontinence-Provide occasional assistance with incontinent care;		*Director will create a Care Plan.* . What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur: *Wellness Director, when notified of a resident fall, will ensure that a fall assessment has been completed and, if needed, a Care Plan is created.* *An in-service on fall assessments for this facility will be done with nursing staff on September 28, 2021.* How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: *As part of procedure, Administrator reviews all Fall Assessments. In addition, Administrator will audit Resident Service Plans and Plans of Care for residents who require additional support within the Fall Assessment weekly for two months and then monthly for four months.*	

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	Transferring-Provide occasional assistance with transfers; Safety-Evacuate self in 13 minutes or less. Resident 8's Service Plan dated 8/19/21 was provided by DON on 8/31/21 at 1:57 p.m. The Service Plan indicated, Resident 8's needs included, but not limited to: Mobility-"Requires a wheelchair and assistance with all mobility tasks due to overall decline in all areas including increased limitation of strength and ROM[sic, range of motion]"; Night Checks-"Staff to continue to inform [sic, Resident 8's name] of all tasks to be complete, set her all with all items for each task, encourage her to complete simple tasks for herself and then assist her as needed to assure all tasks are complete"; Toileting/Incontinence-"Requires assistance with incontinent care, mostly at night. Staff continue to toilet [sic, Resident 8's name] as needed throughout the day; Transferring-"Requires assistance with all transfers due to overall decline in all areas including increased limitation of strength and ROM"; Safety-Evacuate self in 13 minutes or less. An interview with DON was conducted on 8/31/21 at 2:11 p.m. DON indicated, she believed Resident 8's Service Plan included need for Hospice, but she had not placed any interventions regarding the resident's falls. The Service Plan did not include resident centered interventions for falls for a mobility/transfer impaired resident that was identified as a high risk for falls and had many falls. The Service Plan did not include resident centered interventions regarding Hospice services for Resident 8. A Service Plan policy was received on 8/31/21 at			

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	11:55 a.m. from AD (Area Director). It indicated, " 2. The Resident Service Plan should be reviewed and revised as necessary by the community care team under the direction of the Executive Director, Wellness Director, or designee: A. Following a change in the condition of the resident that results in altered care needs over a period of greater than two weeks. B. Minimally every quarter. 3. The Resident Service plan should include: A. Specific and individualized needs of the resident. B. Specific and individualized approaches for the care of the resident based on their needs..."			
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 ensure food under sanitary conditions related to placing butter and sour cream packets on top of lunch plates with bare hands and butter and sour cream packets touching food on plates for 1 of 1 kitchens. (The Main Kitchen) Findings include: During the lunch service on 8/30/21 at 12:05 p.m. the following was observed: 1. CNA (Certified Nursing Assistant) 12 picked up a sour cream packet and a butter packet out of the iced tray containing multiple packets of butter and sour cream. She placed the butter packet on top of the green beans. The sour cream packet was placed in the middle of the plate, touching the food around it and then served Resident 2 the	R 0273	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: *All residents residing at the facility and utilizing the dining services have the potential to be affected. All condiments are now being provided to residents as needed by being placed at their tables, being served separately from their plated food.* How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: *All residents residing at the facility*	10/08/2021

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	plate of food. 2. KS (Kitchen Staff) 13 picked up a butter packet out of the iced tray containing multiple packets of butter and sour cream. She then placed the butter packet on top of the plate. The butter packet was touching the other food on the plate and then served the plate of food to a resident. An interview with DM (Dietary Manager) was conducted on 8/30/21 at 2:14 p.m. She indicated, the condiment packets should not be placed onto the plates, but rather should be carried in servers hands as to not possibly contaminate the food. The Indiana Retail Food Manual indicated, "Handling of kitchenware and tableware Sec. 250. (a) Single-service articles, single-use articles, and utensils that have been sanitized shall be handled, displayed, and dispensed so that contamination of food-contact and lip-contact surfaces is prevented."		*and utilizing the dining services have the potential to be affected. All condiments are now being provided to residents as needed by being placed at their tables, being served separately from their plated food.* What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur: *An in-service on sanitation and safe food handling standards will be provided for all staff on September 28, 2021.* How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: *The Dietary Director or her designee will observe meal service weekly for 2 months and then monthly for 4 months to ensure dietary staff are following food handling safety procedures correctly.*	
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use.			

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	(F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.			
	Based on observation, interview, and record review, the facility failed to ensure medications stored on the medication cart was labeled and not expired for 1 of 2 medication carts observed. (Resident 9 and 49) Findings include: 1. The clinical record for Resident 49 was reviewed on 8/31/21 at 8:30 a.m. The diagnosis included, but was not limited to, diabetes. A physician order dated 6/9/21 indicated Resident 49 was to receive 33 units of humalog insulin at 8:00 a.m., and 27 units at 4:00 p.m. 2. The clinical record for Resident 9 was reviewed on 8/31/21 at 8:35 a.m. The diagnosis included, but was not limited to, diabetes mellitus. A physician order dated 8/24/21 indicated Resident 9 was to receive 35 units of lantus insulin daily. An observation was made of a medication cart with Qualified Medication Aide (QMA) 1 on 8/31/21 at 8:30 a.m. There was a basket full of residents' insulin flexpens on top of the medication cart. A lantus insulin flexpen that was in the basket was labeled with Resident 9's name with an open date of 8/1/21. QMA 1 indicated lantus insulin expires in 28 days after opening.	R 0301	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: *Resident 49 has a diagnosis of diabetes and has a physician's order for a Humalog Flex Pen. Resident 49's Flex Pen is properly labeled with resident's name, physician's name, prescription number and expiration date. Resident #9 has a diagnosis of diabetes and has a physician's order for a Lantus Flex Pen. Resident 9's Flex Pen is properly labeled with resident's name, physician's name, prescription number and expiration date.* How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: *All residents who have medication administered by nursing staff have the potential to be affected. Upon receipt of all resident medication the licensed nurse will review for proper labeling of medication to include resident's name, physician name, prescription number and*	10/08/2021

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BLOOM AT GERMAN CHURCH	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

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	Resident 9's lantus had expired. She would discard and get a new one. An observation was made of another flexpen in the basket. It was humalog insulin with an open date of 8/24/21, but did not have a resident's name on it. QMA 1 indicated at that time, the humalog insulin belonged to Resident 9. The flexpen should have been labeled with the resident's name on it. An interview was conducted with the Director of Nursing on 8/31/21 at 10:45 a.m. She indicated all insulin flexpens should be labeled and dated on the medication cart.		*expiration date.* What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur: *On September 28, 2021, all licensed nurses and QMAs will be in-serviced on the proper labeling and storage of medications to include insulin pens.* How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: *The Wellness Director or her designee will review all insulin pens weekly for two months and then monthly for 4 months to insure they are properly labeled and stored correctly.*	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition.			

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	(7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to document the disposition of any released, returned or destroyed medications in the resident's clinical record for 1 of 2 residents chosen for closed record review. (Resident 58) Findings include: The clinical record for Resident 58 was reviewed on 8/31/21 at 11:02 a.m. Resident 58's diagnoses included, but not limited to, left breast cancer, Alzheimer's dementia, and cardiac pacemaker. Resident 58 was discharged from the facility on 6/21/21. The Transfer/Discharge sheet was provided on 8/31/21 at 12:11 p.m. by the DON (Director of Nursing). It indicated, Resident 58 was transferred to another facility related to the need for skilled nursing. In the medications/treatment section of the form, it stated, "sent with resident". The June MAR (Medication Administration Record) for Resident 58 indicated, she was taking the following medications daily: aspirin, Centrum Silver, Plavix(anticoagulant), hydrocodone (pain medication), levothyroxine (thyroid medication), magnesium oxide, Nameda (Alzheimer's medication), potassium chloride, and senna (stool softener). She also had an as needed order of prochlorperazine for nausea/vomiting. The Individual Narcotic Record for Resident 58's hydrocodone medication was received on 8/31/21 at 12:11 p.m. from DON. It indicated, the last entry	R 0306	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: *There were no residents affected by this deficient practice as the resident had been transferred to a skilled facility.* How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: *All residents who have medication administered by nursing staff have the potential to be affected. All medicines will be disposed of per facility policy and in compliance with Indiana State Department of Health guidelines. Medicines that are sent with a resident discharged to hospice or a skilled facility will also be documented on the facility's Medication Disposal Form as being sent to identified facility and will also be documented along with other discharge notes in the resident's chart.* What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not	10/08/2021

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	was on 6/15/21 and there were 21 tablets remaining. The section indicating the disposition of the medication was blank. The clinical record for Resident 88 failed to contain documentation of disposition of medications to include all the necessary information such as amount of and names of medications released. An interview was conducted on 8/31/21 at 11:55 a.m. with DON. She indicated, all of Resident 58's medications were sent with her, but she had not documented the disposition of all medications the resident was taking on a daily basis including the disposition of Resident 58's remaining narcotic medication. A Medication Disposition of Controlled, Discontinued and Deceased Residents policy was received on 8/31/21 at 1:59 p.m. by DON. It indicated, "All controlled substance prescriptions that are no longer active orders due to discontinuation, discharge, or death of a resident shall be destroyed in the community according to State regulations...Procedure: 1. All remaining medication on the Controlled Drug Count Sheet shall remain in the drug storage area and counted each shift by two (2) Wellness associates until destroyed...3. Each item shall be listed on the Medication Disposal-Return to Pharmacy or Resident/Legally Responsible Party form. 4. All remaining items shall be destroyed by two (2) licensed Nurses and documented on the Medication Disposal-Return to Pharmacy or Resident/Legally Responsible Party form..."		recur: *All medications will be disposed of per facility policy and in compliance with Indiana State Department of Health guidelines. Medications that are sent with a resident discharged to hospice or a skilled facility will also be documented on the facility's Medication Disposal Form as being sent to identified facility and will also be documented along with other discharge notes in the resident's chart.* *All nursing staff will be in-serviced regarding the proper disposal of medications, and the proper documentation of disposed medications on September 28, 2021.* How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: *Wellness Director will review all discharge notes and Medication Disposal Forms and sign off on each form on an ongoing basis as part of the resident discharge process. Administrator will audit Medication Disposal Forms weekly for 2 months and then monthly for 4 months.*	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection			

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	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, 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 interview and record review, the facility failed to properly prevent and/or contain COVID-19 and ensure infection control was maintained by failing to monitor unvaccinated residents for signs and symptoms of Covid-19 daily and failing to screen employees for signs and symptoms of Covid-19 prior to working for 3 of 3 residents and 1 of 3 employees reviewed for infection control (Resident 6, 43, 49 and Qualified Medication Aide 2). Findings include: 1. The clinical record for Resident 6 was reviewed on 8/31/21 at 11:15 a.m. The Resident's diagnosis included, but were not limited to, hypertension and congestive heart failure. 2. The clinical record for Resident 43 was reviewed on 8/31/21 at 11:25 a.m. The Resident's diagnosis included, but were not limited to, chronic kidney disease and Parkinson's disease. 3. The clinical record for Resident 49 was reviewed on 8/30/21 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, diabetes and congestive heart failure.	R 0407	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: *Residents 6, 43 and 49 have the potential to be affected regarding the monitoring of COVID-19 Symptoms. All residents residing at the facility have the potential to be affected regarding the undocumented health screening of any facility staff member. The Wellness Director has implemented daily monitoring for signs and symptoms of Covid-19 for Residents 6, 43 and 49 and documentation of same in their records. The Administrator has implemented an improved screening of all facility staff entering the facility by requiring each staff member to sign and place their screening information next to their name so we can easily audit their compliance. The form includes the screening questions recommended by the Indiana State Department of*	10/08/2021

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	On 8/31/21 at 9:10 a.m., the ADM (Administrator) provided the list of Covid-19 Resident Vaccination Status, which indicated Resident 6, Resident 43, and Resident 49 were unvaccinated. The August 2021 MAR (Medication Administration Record) and TAR (Treatment Administration Record) for Residents 6, 43, and 49 were reviewed. They did not contain documentation of monitoring for signs and symptoms of Covid-19. During an interview on 8/31/21 at 11:10 a.m., the DON (Director of Nursing) indicated that the resident's temperatures and oxygen saturation levels were monitored daily. The facility did not document monitoring for signs and symptoms of Covid-19 for the unvaccinated residents. 4. The nursing department schedule as worked for the week of August 23, 2021, through August 29, 2021, was provided the ADM on 8/30/21 at 2:29 p.m. It indicated that QMA (Qualified Medication Aide) 2 had worked the 11 p.m. to 7 a.m. shift on August 23, 24, 25, 28, and 29, 2021. The ADM provided the Associate Screening Log for Covid-19 for the week of August 23,2021 through August 29, 2021. It did not contain screening documentation for QMA 2. During an interview on 8/31/21 at 11:55 a.m., the AD (Area Director) indicated no screenings were present for QMA 2 on the shifts he had worked and that he should have been screened prior to working in the building. The COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated		*Health and a place for staff members to post their current temperature.* How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: *The Wellness Director has added a section within the daily MARS where the nursing staff will document the screening of each resident for signs and symptoms of Covid-19. Nursing staff will immediately notify Wellness Director if any signs or symptoms have been noted. The Administrator has installed a new check sheet at the entrance of the facility that includes each staff member's name for an easy audit of staff's required participation. The form includes the screening questions recommended by the Indiana State Department of Health and a place for staff members to post their current temperature.* What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur: *Conducting the daily health screening of residents regarding signs and symptoms of COVID-19 will help detect any early symptoms.*	

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	8/11/21, read "...Long-term care centers should take everyday preventive measures to help contain the spread of COVID-19. Actively screen all healthcare personnel (HCP), visitors, vendors entering the facility for symptoms of COVID 19 and any history of being a close contact or exposed to COVID 19 positive or symptomatic person...Daily Covid-19 Assessments... Unvaccinated residents require once-daily assessment for COVID-19...		*All nursing staff will be in-serviced on September 28, 201 on using the section of the MARs as it relates to screening for COVID-19. All staff will be in-serviced on September 28, 2021, regarding the importance of and how to use the health screening tool upon entering the facility each day they work.* How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: *Wellness Director will review MARS report weekly for two months, then monthly for four months. Administrator will audit staff screening sheets daily for 2 weeks, then weekly for two months then monthly thereafter by comparing the screening sheets with the staff schedule for each day.*	