STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification, State Licensure Survey, and Investigation of Complaints IN00440998 and IN00441019. This visit included a State Residential Licensure Survey with Investigation of Residential Complaint IN00445357. Complaint IN00440998- Federal/State deficiencies related to the allegations are cited at F0622 and F0690. Complaint IN00441019- No deficiencies related to the allegations are cited. Survey dates: October 15, 16, 17, 18, and 21, 2024. Facility number: 013005 Provider number: 155816 AIM number: 201256400 Census Bed Type: SNF/NF: 29 SNF: 13 Residential: 15 Total: 57 Census Payor Type: Medicare: 11 Medicaid: 23 Other: 8 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 28, 2024.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey and Investigation of Complaint (IN00441019, IN00440998, IN00445357) conducted October 15, 2024 through October 21, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 7, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janet Worley	DHS, RN	11/06/2024

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

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F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on interview and record review, the facility failed to timely inform a resident and the State Ombudsman Agency of a facility-initiated discharge due to payment coverage, that was initiated following a resident being discharged to an acute care hospital for a medical change of condition, for 1 of 4 residents reviewed for transfer and discharge rights (Resident C). Findings include: The clinical record for Resident C was reviewed on 10/16/24 at 3:05 p.m. The diagnoses included, but were not limited to, pressure ulcer of left and right buttocks. He was discharged to an acute care hospital due to a change of condition on 2/8/24. A Social Services Comprehensive Note, dated 12/22/23, indicated Resident C anticipated remaining in the facility long-term. A nursing progress note, dated 2/8/24 at 4:30 p.m., indicated Resident C remained hypotensive (low blood pressure) and his temperature had decreased. He was showing signs and symptoms of sepsis. Emergency Medical Services were called. A nursing progress note, dated 2/8/24 at 5:18 p.m., indicated Emergency Medical Services had arrived and Resident C was transported to an acute care hospital. The clinical record contained a Notice of Transfer or Discharge, dated 2/8/24, which indicated	F 0622	**F 0622 -** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** -Resident C has discharged from the facility **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents with facility-initiated discharges related to payment coverage have the potential to be affected by the alleged deficient practice. ED/Social Service Support will educate SSD/BOM/DHS/ADHS on resident/family and Ombudsman notification guidelines for a facility-initiated discharge. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - As a measure of ongoing compliance, the SSD/designee will review the resident record of 5 facility-initiated discharges due to payment coverage to verify timely notification of the resident/family and Ombudsman 5 weekly x8 weeks, then every other week x8 weeks and then monthly x2	11/08/2024

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	Resident C was being transferred to another health facility. The reason for transfer or discharge was that the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility. A copy of the facility bed hold policy was sent with Resident C upon transfer. The clinical record did not contain any further Notice of Transfer or Discharge dated after 2/8/24. A Discharge Return Anticipated Minimum Data Set (MDS) assessment, completed 2/8/24, indicated Resident C was discharged to an acute care hospital. His short-term memory was intact and there was no active discharge plan in place to return to the community. An acute care hospital in-patient palliative care note, dated 2/14/24, indicated Resident C was admitted to the acute care hospital on 2/8/24. The social determinants of health were Resident C had to find a new extended care facility as the one he had been residing at was no longer covered in network with his insurance. The facility electronic health record did not contain information or documentation that Resident C had been informed that he would not be residing at the facility due to insurance coverage or issued a new Notice of Transfer or Discharge due to non-payment. During an interview on 10/15/24 at 1:22 p.m., State Ombudsman (SO) 10 indicated Resident C had been sent to the hospital due to health issues and while in the hospital the facility had taken Resident C's belongings to him and informed him, he was discharged. During an interview on 10/17/24 at 11:17 a.m., the		months to ensure proper notification has been made. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? -For quality assurance, the ED and/or Designee will review any findings and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.** **5: Date of Completion: 11/08/2024**	

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	Social Service Director (SSD) indicated Resident C had been discharged from the facility due to financial reasons. During an interview on 10/17/24 at 1:23 p.m., Resident C indicated he was sent to the hospital, on 2/8/24, due to a urinary tract infection. He was hospitalized several times during his stay at the facility and was allowed to return to the facility after each of the hospitalizations. Resident C was unaware he would not be returning to the facility until the Administrator and the Director of Nursing brought his belongings to the hospital, on 2/19/24, and informed Resident C he was discharged. During an interview on 10/17/24 at 1:55 p.m., the Administrator (ADM) indicated, on 2/19/24, he and the Director of Nursing (DON) had taken Resident C's belongings to the hospital and informed Resident C he was discharged from the facility. Resident C had become upset and told us to leave his room. At the time of Resident C's discharge, on 2/8/24, Resident C had been private pay. Resident C had been discharged because he had not paid to hold the bed privately. During an interview on 10/17/24 at 3:03 p.m., SO 10 indicated she had been involved with Resident C due to a previous facility- initiated 30-day discharge notice. She had been present at an Appeal Hearing about the involuntary discharge, on 2/7/24, and the case had been dismissed by the Administrative Law Judge. Resident C had been discharged to an acute care hospital the next day, 2/8/24. On 2/9/24, SO 10 went to the facility to visit Resident C and was told he had been sent to the hospital for health reasons. SO 10 went to the facility to visit Resident C, on 2/13/24, when she went to his room it was empty and she was told			

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	Resident C was still in the hospital. SO 10 was not informed, at that time, Resident C would not be returning to the facility. On 2/20/24, SO 10 received a call from Resident C informing her the facility had brought his belongings to the hospital and told him he had been discharged. During an interview on 10/18/24, Nurse Consultant (NC) 1 indicated Resident C belongings had been taken to him on the eleventh day of his hospital stay. On 10/17/24 at 2:54 p.m., the Administrator provided the Guidelines for Transfer and Discharge Policy, last reviewed 12/31/23, which read, "...The resident has the right to refuse involuntary transfer out of, or discharge from, the facility under certain circumstances.... Purpose According to federal regulations, the facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: 1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. 2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the service provided by the facility. 3. The safety of individuals in the facility is endangered. 4. The health of the individuals in the facility is endangered. 5. The resident had failed, after reasonable and appropriate notice, to pay for [or to have paid under Medicare or Medicaid] a stay at the facility. 6. The facility ceases to operate...Procedures 1. Non-Emergency Transfer or Discharges...This portion of the policy applies to transfers or discharges that are initiated by the facility, not by the resident or the resident's representative. The Social Service Designee or other designated staff member should manage all			

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	non-emergency transfers or discharges. Procedure should include: a. Notify the resident in writing, and in know, a family member or legal representative, 30 days in advance, of the transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged, and the reason for the transfer or discharge, according to the criteria for transfer or discharge. Exceptions to the 30-day requirement are if/ when a resident is endangering the health or safety of themselves or others, when a resident's health has improved to allow an immediate transfer, or when a resident's urgent medical needs require immediate transfer, and when a resident has not resided in the facility for 30 days...b. Record the reason for, the effective date of transfer or discharge, and the location to which the resident is being transferred or discharged in the medical record and on a discharge form or a letter. Give a copy of the discharge notice to the resident and his/her family legal representative.... D. Provide the resident with a statement of the right to appeal the action to the state agency designated for such appeals, along with the name, address, and phone number of the State long-term care ombudsman...". On 10/18/24 at 11:07 a.m., NC 1 provided the Bed Hold Policy, last reviewed on 11/1/16, which read, "...The campus will properly inform residents in advance of their option to make bed-hold payments as well as the amount of the facility's charge to hold a bed. For this optional payment, the campus must make clear that the resident/ responsible party must affirmatively elect to make them prior to being billed... Procedures 1. Private Pay Residents if the resident leaves the campus for hospitalization...if the resident is not eligible for or receiving Medicaid benefits, and upon notification agrees to resident's bed will be			

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	reserved through payment of the basic rate...If the resident elects to not reserve his/ her bed, then the resident will be discharged from the campus and readmission to the facility shall be subject to bed availability. 2. Medicaid Assistance Residents If the Resident is eligible for or is receiving Medicaid assistance, and the Resident leaves the Facility for hospitalization or therapeutic leave, the Resident's bed will be reserved for the applicable number of days paid for a reserved bed under the State Medicaid program...If the period of hospitalization or therapeutic leave exceeds the maximum time for reservation of the Resident's bed under the Medicaid program or the Medicaid program does not cover hospital or therapeutic leaves, the Resident will be entitled to the first available accommodation suitable for the Resident's level of care if the Resident requires the Facility's services..." This citation relates to Complaint IN00440998. 3.1-12(a)(7) 3.1-12(a)(10)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to accurately monitor urinary output and to monitor for symptoms of urinary tract infections for residents with urinary catheters for 2 of 3 residents reviewed for urinary catheters (Resident C and Resident E). Findings include: 1. The clinical record for Resident C was reviewed	F 0690	**F 0690 -** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** -Resident C has discharged from the facility. - Resident E orders have been updated, resident without symptoms of urinary tract infection	11/08/2024

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	on 10/16/24 at 3:05 p.m. The diagnoses included, but were not limited to, pressure ulcer of left and right buttocks. A care plan, with start date of 6/16/23, indicated Resident C had a urinary catheter due to neurogenic bladder and stage 4 (full thickness) wound. The goal was for him to be free of adverse effects from catheter use. The interventions included, but were not limited to, observe for any signs of complications such as urinary tract infections and record urinary output. A physician's order, dated 11/10/23, indicated to monitor output every shift. A physician's order, dated 11/10/23, indicated Foley catheter care was to be completed each shift. The February 2024 Treatment Administration Record (TAR) indicated Foley catheter care was provided each shift from 2/1/24 through 2/8/24. The February 2024 TAR indicated Resident C's urinary output(s) were as follows: 2/1/24 - day shift- medium, evening shift - large, night shift - medium/400 milliliters (ml), 2/2/24 - day shift- 1200 ml, evening shift- large, night shift- large, 2/3/24 - day shift- large, evening shift - medium/ 600 ml, night shift- large, 2/4/24 - day shift- medium, evening shift- medium /550 ml, night shift- large, 2/5/24 - day shift- large, evening shift- 800 ml, night shift- large, 2/6/24 - day shift- large, evening shift- large, night shift- large, 2/7/24 - day shift- large, evening shift- large, night		at this time. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** -All like Residents with indwelling catheters have the potential to be affected by the alleged deficient practice. ED or designee to educate nursing staff on the "Urinary Catheter Care Policy", including accurate monitoring of urinary output and monitoring for symptoms of urinary tract infections. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** -As a measure of ongoing compliance DHS or designee will audit records of 5 residents with indwelling catheters for accurate urinary output monitoring 3 times a week times X4 weeks, then 2 times a week X2 months, then 1 time a week X1 month, then monthly times 2 months and until continued compliance is maintained. -As a measure of ongoing compliance DHS or designee will audit 5 residents with indwelling catheters for symptoms of urinary tract infections, 3 times a week times X4 weeks, then 2 times a week X2 months, then 1 time a	

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	shift- large, and 2/8/24- day shift- large. A nursing progress note, dated 2/6/24 at 6:10 a.m., indicated Resident C had some blood in his urinary catheter. The physician was notified and would continue to monitor. The clinical record did not contain any further nursing progress notes addressing Resident C's urine from 2/6/24 at 6:10 a.m. until 2/8/24 at 2:58 p.m. A nursing progress note, dated 2/8/24 at 2:58 p.m., indicated the nurse practitioner had seen Resident C related to dark amber urine and blood noted in urine on 2/6/24. An order was received to complete a urinalysis with culture and sensitivity. Resident C was discharged to an acute care hospital on 2/8/24 for treatment of a urinary tract infection. 2. The clinical record for Resident E was reviewed on 10/15/24 at 12:49 p.m. The diagnoses included, but were not limited to, neurogenic bladder. An Annual Minimum Data Set (MDS) assessment, completed 7/15/24, indicated Resident E had moderately impaired cognition and an indwelling urinary catheter. A physician's order, dated 9/5/24, indicated to monitor urinary output every shift. The order was discontinued on 10/9/24. A physician's order, dated 9/5/24, indicated to provided catheter care every shift. The order was discontinued on 10/9/24.		week X1 month, then monthly times 2 months and until continued compliance is maintained. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** **-For quality assurance, the ED and/or Designee will review any findings and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.** **5: Date of Completion:** **-11/08/2024**	

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	A care plan, last reviewed 9/25/24, indicated Resident E had a suprapubic (catheter inserted into bladder through the lower abdomen) catheter due to having a neurogenic bladder. The goal was for her to be free from adverse effects from catheter use. The interventions included, but were not limited to, record urinary output and observe for any signs of complications such as urinary tract infections. The October 2024 TAR indicated Resident E had catheter care completed each shift, from 10/1/24 through 10/5/24, when she went to an acute care hospital. The October 2024 TAR indicated the urinary output(s) were as follows: 10/1/24 - day shift- resident unavailable, evening shift- large, night shift- medium, 10/2/24 - day shift- medium, evening shift- large, night shift- medium, 10/3/24 - day shift- small/ 300 ml, evening shift- large, night shift- medium, 10/4/24 - day shift- resident unavailable, evening shift- 800 ml, night shift- medium, and 10/5/24- day shift- resident unavailable. Resident E returned from the acute care hospital on 10/9/24. The October 2024 TAR did not contain any further documentation that catheter care was completed, or urinary output was recorded from 10/9/24 through 10/21/24. During an interview on 10/21/24 at 12:30 p.m., Certified Resident Medication Assistant (CRMA) 5 indicated urinary catheters are emptied each shift, and the amount of urine should be documented in milliliters (ml).			

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	During an interview on 10/21/24 at 12:41 p.m., Certified Resident Care Assistant (CRCA) 6 indicated urine output was measured in milliliters each shift. During an interview on 10/21/24 at 4:17 p.m., the Administrator indicated urinary output from catheters should be emptied and measured in milliliters at the end of each shift. On 10/21/24 at 2:00 p.m., Nurse Consultant 1 provided the Suprapubic Catheter Care Standard Operating Procedure, last reviewed 12/31/23, which read, "... Overview To prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract...General Guidelines... Observe the resident's urine level for noticeable increases or decreases... Check the urine for unusual appearance...maintain an accurate record of the residents daily output, if indicated...Observe the resident for signs and symptoms of urinary tract infection and urinary retention...empty the collection bag each shift and prn [as needed]... 5. The following information as applicable should be recorded in the resident's medical record...Character of urine, such as color [straw-colored, dark, or red], clarity [cloudy, solid particles, or blood], and odor...Any problems or complaints made by resident during the procedure. 6. Notify the physician of any abnormalities in the skin assessment or character of urine..." This citation relates to Complaint IN00440998. 3.1-41(a)(2)			
F 0812 SS=F	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure beard coverings were worn by the dietary staff with facial hair. This has a potential to affect 42 of 42 residents that receive food prepared in the kitchen. Findings include: An observation was made of the Kitchen with the Director of Food Services on 10/15/24 at 11:44 a.m. During the tour, Cook 5 was observed at the food preparation area preparing the lunch meal. Cook 5 had facial hair on his lip and chin with no beard covering. An interview was conducted with the Director of Food Services on 10/15/24 at 11:55 a.m. He indicated Cook 5 should be wearing a beard covering. A Beard and Mustache policy was provided by the Administrator on 10/17/24 at 11:30 a.m. It indicated, "...Policy. Beard and mustache hair must be covered while in kitchen food product areas. Facial hair restraints are required in any production area. Purpose. Beards and mustache must be covered while in kitchen food product areas. Facial hair restraints are required in any food production area. Facial hair is not exempt from the hair restraining standard..." 3.1-21(i)(2) 3.1-21(i)(3)	F 0812	F 0812 - **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** -No negative outcomes identified for 42 of 42 residents. Facial coverings in place as applicable in all food preparation areas. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** -All residents have the potential to be affected by the alleged deficient practice. ED/Dietary Support Staff or designee to educate dietary staff on “Beard and Mustache Policy”. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - As a measure of ongoing compliance, DFS or designee will observe 5 staff members in food preparation areas to ensure beard and mustache covers are in place. This audit will be completed 3 times a week times 4 weeks, and then 2 times a week times 8 weeks, and then every other week	11/08/2024

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	155816	A. BUILDING 00 B. WING	10/21/2024

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			x3 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** **-For quality assurance, the ED and/or Designee will review any findings and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.** **5: Date of Completion:** **-11/08/2024**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control was maintained with hand hygiene during medication administration for 3 of 4 residents observed and failed to ensure staff donned a gown prior to providing activities of daily living (ADL) care for a resident with enhanced barrier	F 0880	**F 0880 -** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** -Resident 9 and 91 have	11/08/2024

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	precautions (EBP) for 1 of 3 residents reviewed for transmission-based precautions. (Residents 2, 9, 31, and 91) Findings include: 1. An observation was conducted of a medication administration with Licensed Practical Nurse (LPN) 6 for Resident 31 on 10/17/24 at 8:47 a.m. LPN 6 was observed at the medication cart preparing the resident's medication. During that time, she had pulled all the medications from the cart, touched the computer mouse, cups, and water pitcher. She then grabbed a straw and unwrapped the paper wrapper touching the end piece of the straw the resident would place in his mouth with her bare hands. After, LPN 6 was observed entering the resident's room and administering the medications to the resident. The resident did utilize the straw in the cup of water to drink from it. LPN 6 then washed her hands. There was no observation of hand hygiene prior to the administration of the medications to the resident. 2. An observation was made of a medication administration for Resident 9 with LPN 6 on 10/17/24 at 9:05 a.m. LPN 6 was observed at the medication cart preparing the resident's medication. During that time, LPN 6 had dropped a pill medication on the floor. She then picked up the pill medication with her bare hands and placed it on the medication cart. After, she donned on gloves and discarded the pill medication in the sharps container. She then doffed off the gloves and continued preparing the medications. There were no observations of LPN 6 utilizing hand hygiene after she picked up the pill medication off the floor nor prior or after donning and doffing gloves. She then went to the resident's room and obtained the resident's vitals utilizing a dynamap		discharged from facility. -Residents 2 and 31 without negative outcomes from observed care and medication administration, no signs or symptoms of infection identified. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents receiving medication administration and with enhanced barrier precautions have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on the “Handwashing/Hand Hygiene Policy” and the “Enhanced Barrier Precautions Policy”. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS or the designee will observe hand hygiene during medication pass to ensure infection control is maintained for 5 residents. This audit will be completed 3 times a week times 4 weeks, and then 2 times a week times 8 weeks, and then every other week x3 months. - DHS or designee will observe staff providing high-contact care activities for 5 residents with	

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	machine (electronic machine to obtain blood pressure, pulse, oxygen saturations and temperature). After, she donned on gloves and obtained the resident's blood sugar utilizing a glucometer. She then doffed her gloves and washed her hands. There was no hand hygiene prior to touching the resident nor donning of gloves. 3. An observation was made of a medication administration for Resident 91 with LPN 6 on 10/17/24 at 11:54 a.m. LPN 6 was observed pulling Resident 91's insulin from the medication cart and entered the resident's room. LPN 6 donned on gloves and administered insulin to the resident. After, LPN 6 doffed her gloves and washed her hands. There was no observation of LPN 6 utilizing hand hygiene prior to donning on her gloves. An interview was conducted with the Nurse Consultant (NC) 1 on 10/17/24 at 3:52 p.m. She indicated LPN 6 should have utilized hand hygiene after picking the pill off the floor. Hand hygiene should be utilized before and after donning and doffing gloves. A medication administration policy was provided by the Nurse Consultant (NC) 1 on 10/17/24 at 3:52 p.m. It indicated the following, "...A. Preparation...2) Handwashing and Hand Sanitization: The person administering medication adheres to good hand hygiene: before beginning a medication pass, prior to handing any medication, after coming into direct contract with a resident, before and after administration...B. Administration...8) Hand hygiene is performed before putting on examination gloves..." 4. The clinical record for Resident 2 was reviewed on 10/15/24 at 1:02 p.m. The diagnoses included,		enhanced barrier precaution orders to ensure proper PPE is donned prior to initiating care. This audit will be completed 3 times a week times 4 weeks, and then 2 times a week times 8 weeks, and then every other week x3 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** -For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. **5. Date of completion:** 11/08/2024	

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	but were not limited to, dysphagia (inability to swallow) and attention to gastrostomy (feeding tube placed in stomach). An Annual Minimum Data Set (MDS) assessment, completed 7/25/24, indicated he received nutrition through a feeding tube and was dependent on staff for bathing, toileting, and dressing. A physician's order, dated 8/3/24, indicated staff were to use enhanced barrier precautions, wear a gown and gloves at minimum, during high-contact care activities. A care plan, last reviewed on 8/6/24, indicated Resident 2 required enhanced barrier precautions (EBP) during high-contact care related to the presence of a feeding tube. The goal was the risk of transmission of infection would be minimized with the use of EBP. The interventions included, but were not limited to, utilize gown and gloves per EBP policy during high contact ADL care such as dressing, toileting, and bathing. On 10/15/24 at 1:02 p.m., Resident 2's room was observed. There was a sign posted at the entrance of the room which indicated Resident 2 required EBP during care and a storage bin with disposable isolation gowns was present inside of the room. On 10/21/24 at 10:25 a.m., Certified Resident Care Assistant (CRCA) 4 was observed providing care to Resident 2. CRCA 4 was turning Resident 2 in bed and changing his bed linens and brief. CRCA 4 was not wearing a gown while providing care to Resident 2. During an interview on 10/21/24 at 10:35 a.m., CRCA 4 indicated she should have donned a gown prior to providing care to Resident 2.			

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	On 10/21/24 at 4:00 p.m., the Director of Nursing provided the Enhanced Barrier Precautions Standard Operating Procedure, effective 4/1/24, which read, "...Enhanced Barrier Precautions will be in place during high-contact care activities residents with the following conditions...All Residents with indwelling medical devices...Personal Protective Equipment [PPE] should be used even if blood and body fluid exposure is not anticipated. a. At minimum, staff shall wear gloves and gowns during high-contact care activities... High- contact care activities include but are not limited to morning and evening ADL care, toileting, and showers...." 3.1-18(b)(2) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey with Residential Complaint IN00445357. This visit included a Recertification, State Licensure Survey, and Investigation of Complaints IN00440998 and IN00441019. Complaint IN00445357 - State deficiencies related to the allegations are cited at R0216. Survey dates: October 15, 16, 17, 18, and 21, 2024. Facility number: 013005 Residential Census: 15 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey and Investigation of Complaint (IN00441019, IN00440998, IN00445357) conducted October 15, 2024 through October 21,	

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	Quality review completed on October 28, 2024.		2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 7, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to ensure a resident was assessed to determine the ability to self-medicate prior to leaving medications at the bedside without a nurse present for 1 of 8 residents reviewed. (Resident F) Findings include: The clinical record for Resident F was reviewed on 10/17/24 at 1:00 p.m. The diagnoses included, but were not limited to, hypertension. During a confidential interview, Licensed Practical Nurse (LPN) 3 gave Environmental Services Assistant (ESA) 8 a cup of medicine to give to Resident F. The incident was witnessed by ESA 7. An interview was conducted with Resident F on 10/17/24 at 1:43 p.m. She indicated the staff that administer her medications wear blue clothes. She was unable to distinguish the difference in staff members. An interview was conducted with ESA 7 on	R 0216	**R 0216-** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** -Resident F has discharged. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** -All assisted living residents have the potential to be affected by the alleged deficient practice. DHS or designee to educate nurses on the "Self-Administration of medications Guidelines Policy". **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	11/08/2024

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	10/17/24 at 2:21 p.m. She indicated she had not witnessed ESA 8 give a cup of medications to Resident F. ESA 8 had reported to her, she was asked by LPN 3 to give Resident F her medications while in the resident's room. She was unsure if ESA 8 had done it. An interview was conducted with the Director of Nursing (DON) on 10/18/24 at 8:35 a.m. She indicated there had been an incident regarding LPN 3 asked ESA 8 to give a cup of medications to Resident F. The resident was in isolation, and ESA 8 was going into the isolation room to clean. During that time, LPN 3 had other residents' call lights going off. She had asked ESA 8 to take the cup of medications in the resident's room and place on the resident's bedside for the resident to take. Later, LPN 3 had went into the resident's room to ensure she had taken the medications. Resident F had previously been assessed to self-medicate, but recently had a short stay on the long-term care side. Resident F was cognitively intact but decided for staff to administer her medications. It had not been determined if Resident F could self-medicate at that time. There had been an internal investigation regarding the incident. An investigation folder for an incident regarding LPN 3 asking ESA 8 to place medications on Resident F's bedside was provided by the Nurse Consultant (NC) 2 on 10/18/24 at 2:48 p.m. It indicated the following: A signed statement by ESA 8, dated 9/25/24, indicated "...incident 9/20/24... [LPN 3] asked if I was going to go in there [Resident F's room] and I told her yes. She then said, can you take these in there for me. She was looking at me directly in my eyes and she's a manager so I felt like I couldn't		- DAL or designee will be responsible for observing 5 assisted living resident rooms for medications left at bedside and their records to ensure proper and timely assessments have been completed. An audit of 5 residents will be conducted 2 times a week times 4 weeks, and then 1 time a week times x 8 weeks, and then once monthly times 3 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** - For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. **5. Date of completion:**	

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	tell her no, but I wasn't sure that I should do it. She said here ya go and I set the cup of medicine on [Resident F's] table in her room and went about my deep clean. ESA 7 was in the room to train me on how to clean it and told me that wasn't part of my job and I shouldn't be doing that and not to do it again. She did say, I know I shouldn't have asked you to do that, please don't say anything, but thank you...I have not had no other issues prior to or after with [LPN 3] ..." A signed statement by LPN 3, dated 9/25/24, indicated "...incident 9/20/24...I had just prepped [Resident F's] meds [medications], there were a few other residents' lights going off at that time. I saw [ESA 8's] cart by that room and asked 'are you going into that room' she said, 'yes.' I said, 'do you mind putting these on her table since you're going in there so I can answer these other lights.' she said, 'yes' and I asked, 'are you sure you don't mind, are you sure.' the girl said, 'no its fine I can put them in there.' I was in the hall at that time. Then when she went in, I answered the other lights. After they cleaned the room and I was done with the other residents whose lights were on and toileting, I went into her room to make sure she had taken the meds, she verbally confirmed, I threw the empty cup away. It was the midday med pass. After the rush, I was at the station by the cart, her [ESA 8] and [ESA] 7 were by the bathroom I told her thank you and that I shouldn't have asked her to do that..." A Self Administration of Medications Guidelines policy was provided by NC 1 on 10/18/24 at 8:50 a.m. It indicated, "...Purpose. To ensure the safe administration of medication for residents who request to self-medicate or when self medication is a part of their plan of care. Procedures. 1. Residents requesting to self-medicate or has a		11/08/2024	

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	self-medication as a part of their plan of care shall be assessed for safety by a licensed nurse. 2. Results of the assessment will be presented to the physician for evaluation and an order for self-medication...7. Periodic verification of administration compliance will be observed by nursing staff. 8. A self-medication plan of care will be initiated or service plan inclusion and updated as indicated. 9. The assessment will be reviewed bi-annually and PRN [as needed] with change of condition..." This citation relates to Complaint IN00445357.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure beard coverings were worn by the dietary staff with facial hair. This has a potential to affect 13 of 13 residents that receive food prepared in the kitchen. Findings include: An observation was made of the Kitchen with the Director of Food Services on 10/15/24 at 11:44 a.m. During the tour, Cook 5 was observed at the food preparation area preparing the lunch meal. Cook 5 had facial hair on his lip and chin with no beard covering. An interview was conducted with the Director of Food Services on 10/15/24 at 11:55 a.m. He indicated Cook 5 should be wearing a beard covering. A Beard and Mustache policy was provided by	R 0273	**R 0273 -** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** -No negative outcomes identified for 13 of 13 residents. Facial coverings in place as applicable in all food preparation areas. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. ED/Dietary Support Staff or designee to educate dietary staff on "Beard and	11/08/2024

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	the Administrator on 10/17/24 at 11:30 a.m. It indicated "...Policy. Beard and mustache hair must be covered while in kitchen food product areas. Facial hair restraints are required in any production area. Purpose. Beards and mustache must be covered while in kitchen food product areas. Facial hair restraints are required in any food production area. Facial hair is not exempt from the hair restraining standard..."		Mustache Policy". **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - As a measure of ongoing compliance, DFS or designee will observe 5 staff members in food preparation areas to ensure beard and mustache covers are in place. This audit will be completed 3 times a week times 4 weeks, and then 2 times a week times 8 weeks, and then every other week x3 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** -For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6	

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