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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00406211 and IN00406266. Complaint IN00406211-No deficiencies related to the allegations are cited. Complaint IN00406266- State deficiency related to the allegations is cited at R0240. Survey dates: April 17, 18. 19, and 20, 2023 Facility number: 014279 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 26, 2023	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview, and record review, the facility failed to ensure the results of the most recent Complaint Surveys and corresponding plan of correction was made available to residents for examination for 114 of 114 residents in the facility. Findings include:	R 0042	R042 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will**	05/31/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alberta Taybior	Executive Director	05/09/2023

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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	An observation of the IDOH (Indiana Department of Health) survey binder was made upon entrance to the facility on 4/17/23 at 10:15 a.m. and 4/19/23 at 10:25 a.m. It was on top of a side table next to a chair in the front lobby near the receptionist's desk. The survey binder was reviewed on 4/19/23 at 10:25 a.m. The most recent survey included in the binder was a Complaint Survey dated 7/18/22. All other surveys included in the binder were dated prior to 7/18/22. The Complaint Survey conducted at the facility on 2/10/23 that included a total of 10 individual complaints was not included in the binder, nor was its' plan of correction. The Complaint Survey conducted at the facility on 3/17/23 with no deficiencies was not included in the binder either. An interview was conducted with the ED (Executive Director) on 4/19/23 at 10:29 a.m. She indicated she updated the survey binder when she received the survey. She forgot and started to make another binder that was in her office. She pulled the most recent survey this morning and hadn't put it back out yet. After being informed there was only one survey binder present in the lobby since the beginning of the current survey, the ED indicated perhaps she pulled the most recent survey prior to 4/17/23. An interview was conducted with Receptionist 23 on 4/19/23 at 10:30 a.m. at the receptionist's desk. She indicated she'd worked at the facility since 2020 and there was always just one survey binder on the side table in the front lobby. An interview was conducted with the ED during exit conference on 4/20/23 at 1:25 p.m. She indicated even though the 2/10/23 Complaint		**identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. ED posted the survey results while the survey was in progress. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. The Executive Director or designee will post survey results and plan of correction timely. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Executive Director or designee will audit the survey binder for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all survey results and plan of correction are posted timely with the most recent ones available. Survey results and plan of correction to be reviewed at monthly QI meetings and make further recommendations based off	

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	Survey and plan of correction was not included in the survey binder in the front lobby, it was present in the facility in her office, and she had conducted town halls at the facility informing residents of the plans they had in place to address the deficiencies cited at the 2/10/23 Complaint Survey.		audit results. **5. By what date will the systematic changes be completed?** The binder was updated April 19, 2023	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation, interview, and record review, the facility failed to implement the Medication Management, Administration, & Storage policy by not assuring each controlled substance was reconciled with the Pharmacy Count Sheet and Stored in a controlled-medication binder, not assuring all controlled substances were physically counted by the outgoing and oncoming licensed nurse and/ or QMA (Qualified Medication Aide), and not ensuring that upon the completion of the controlled substance count, each party, both oncoming and outgoing, provided their signature, date and time on a Controlled Medication Shift to Shift Change Log for 3 of 3 medication carts and 1 medication storage room observed.	R 0091	091 1. What Corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice a. No residents experienced adverse effects from the alleged deficient practice 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken	05/31/2023

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	Findings include: On 4/18/23 at 9:30 a.m., Resident H was observed receiving his scheduled morning medications from QMA (Qualified Medication Aide) 8. Resident H approached the medication cart and asked for his medications. QMA 8 opened the drawer of the medication cart and removed Resident H's pill packet from the drawer, opened the pill pack and poured the medication into a plastic cup. QMA 8 did not remove Resident H's medication from a locked compartment in the medication cart. QMA 8 then handed the medications to Resident H. Resident H inquired if his pain pill was in the cup and QMA 8 indicated it was. Resident H took his medications and handed the cup back to QMA 8, who took it and threw it away. During an interview on 4/18/23 at 10:04 a.m., QMA 8 indicated that Resident H had received Oxycodone with his scheduled medications. When a resident receives a scheduled narcotic, it comes in the timed pill pack. The narcotic medications in the pill packs were not signed out on a narcotic count sheet and the counts of the narcotic medications were not reconciled with another nurse or QMA at shift change. There were no controlled- medication binders for any of the medication carts in the building, only in the medication room where the PRN (As Needed) controlled medications were stored. On 4/18/23 at 10:18 a.m., the narcotic storage box in the medication room was observed with LPN 11. LPN 11 located the controlled- medication binder inside of the double locked narcotic storage box. LPN 11 indicated she had not counted the controlled medications but understood that the night shift counted the controlled medications each night. She was unsure if they were counted		a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on shift-to-shift reconciliation of narcotics. b. DON or designee will provide an in-service to all QMAs and Nurses on properly recording medication administration in the narcotic log binder. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: a. DON or designee will do an audit of all narcotic logs ensuring accurate and timely completion. Any clinical staff member out of compliance with facility's policies and protocols relating to proper documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to recording proper documentation during employee job-specific orientation moving forward. 4. How the corrective action(s) will be monitored to ensure the deficient practice will no recur, i.e what quality assurance program will be put into place:	

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	at any other time of the day. The controlled-medication binder was opened by LPN 11, and she was unable to locate the current Change of Shift Controlled Medication Count Sheet. There were Change of Shift Controlled Medication Count Sheets present in the binder for October 2022, November 2022, and December 2022. The December 2022 Change of Shift Controlled Medication Count Sheet contained a signature of the 1st shift QMA on 12/1/22 and 12/2/22. The remaining days and shifts for December 2022 were blank. On 4/18/23 at 2:03 p.m., the RDHS (Regional Director of Health Services) indicated when narcotic medications came in a scheduled pill pack they were not signed out or tracked on a narcotic count sheet. She was unaware of where the current Change of Shift Controlled Medication Count Sheet and would try to locate them. During an interview on 4/18/23 at 3:06 p.m., RPH (Registered Pharmacist) 12 indicated the controlled medications, such as narcotics, were in the individual dose packs when they are scheduled. He believed that the facility had a "waiver" which allowed the controlled substances to be done this way. RPH had not seen the waiver, but the controlled medications had been dispensed to the facility that way for "years". Without a "waiver" the scheduled controlled medications would not come in the dose pack, but instead would come in a punch card and be signed out on a narcotic count sheet when each dose was given. On 4/19/23 at 10:10 a.m., the RDHC provided the Controlled Medication Shift to Shift Change Logs for January, February, March, and April 1st		a. The Director of Nursing or designee will audit incident narcotic logs for six (6 weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all narcotic logs are being properly completed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. 5. By what date will the systematic changes be completed a. Education and in-service will be provided to all clinical staff between now and concluding on May 31, 2023	

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	through April 18th, which were completely filled in with no missing signatures for any shift. On 4/19/23 at 1:43 p.m., the RDHC provided the Daily Schedules as worked for March 21, 2023, through March 31, 2023. The daily schedules as worked were compared to the Controlled Medication Shift to Shift Change Log for March 2023. The follow days had discrepancies between the scheduled staff who worked and the staff who signed the Controlled Medication Shift Change Log: 3/19/23 the Daily Schedule as worked indicated QMA 13 was present for the 3rd shift, which started 3/19/23 at 10:00 p.m. and ended 4/20/23 at 6:00 a.m. The Controlled Medication Shift Change Log had QMA13's signature at the beginning of the shift and QMA 14's signature at the end of the shift. QMA 14 was not listed on the schedule as worked for the 3rd shift starting 3/19/23. The Daily Schedule as worked for 3/22/23 indicated QMA 13 was present for the 3rd shift. The Controlled Medication Shift Change Log was signed by QMA 14 at the beginning and end of the 3rd shift starting 3/22/23. QMA 14 was not listed on the Daily Schedule as worked for the 3rd shift on 3/22/23. The Daily schedule as worked for 3/26/23 indicated QMA 14 was present on the 3rd shift. The Controlled Medication Shift Change Log had the signature of QMA 14 at the beginning of the 3rd shift. The off going 3rd shift signature was QMA 13's. QMA 13 was not listed on the Daily Schedule as worked for the 3rd shift on 3/26/23. On 4/18/23 at 2:03 p.m., the RDHS provided the Medication Management, Administration, & Storage policy, last revised 3/23/22, which read " ...Delivery, Storage, & Handling of Controlled Substances...Each time a controlled substance is delivered, it will be reconciled with the Pharmacy			

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	Count Sheet and Stored in a controlled-medication binder... The number of signature lines on the Controlled substance Inventory Sheet should be equal to the number of doses placed in the controlled substance medication box... Controlled Substances- Hand off Procedure 1. At shift change, the oncoming licensed nurse or QMA responsible for medication administration will verify the resident, medication, dosage and count of all controlled substances by physically counting each medication in the direct presence of an off going licensed nurse or QMA...2. Upon completion of the controlled substance count, each party, both oncoming and outgoing, should provide their signature, date and time on the Controlled Medication Shift to Shift Change Log. a. In the event of a controlled substance discrepancy is discovered during the controlled substance count, the Director of Nursing, or designee, should be notified immediately..."			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly			

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	receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review the facility failed to ensure a staff member, certified in first aide, was scheduled on each shift. This had a potential to affect 114 of 114 residents that reside in the facility. Findings include: The schedule, as worked, for 4/9/23 through 4/15/23 was provided by the Business Office Manager on 4/17/23 at 11:55 a.m. It indicated that on the following days and shifts there were no staff members who were certified in First Aid present in the building: 4/10/23 on the first shift, 4/11/23 on the second shift, 4/12/23 on the second shift, and 4/15/23 on the first shift. During an interview on 4/19/23 at 1:30 p.m., the Business Office Manager indicated the Certifications of CPR (Cardiopulmonary Resuscitation) and First aid which she had available to her for the staff were in the licensing binder. On 4/20//23 at 10:51 a.m., the Regional Director of Health Services provided the CPR & First Aid Certifications policy, dated 9/29/21, which read "...It is the responsibility of the Director of	R 0117	R117 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Executive director or designee will ensure that all staff will be certified in CPR and First aid. b. DON or designee will ensure that each shift will have an associate that is certified in CPR and First aid. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. DON or designee will do an audit of current associates to	05/31/2023

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	Nursing or designee to ensure at least one on-duty employee has current CPR & First Aid Certifications at all times..."		identify associates certified in CPR and First aid. completion. Any staff member out of compliance with facility's policies and protocols relating to CPR and First aid certification will be offered certification classes. b. DON or designee will review weekly schedule to ensure that at least 1 associate certified in CPR and First aid is scheduled each shift. Newly hired staff will be offered CPR and first aid certification classes if needed. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit weekly schedule for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all narcotic shifts have an associate that is certified in CPR and First aid. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. CPR and first aid classes are being offered now and concluding on May 31, 2023	

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R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to assure staff received resident rights and dementia training prior to working independently	R 0119	R119 **1. What Corrective action(s) will be accomplished for those residents found to have been**	05/31/2023

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	in the facility for 2 of 5 employee's records reviewed (LPN 6 and QMA 7). Finding include: The employee file for LPN (Licensed Practical Nurse) 6 was reviewed on 4/18/23 at 2:10 p.m. The employee file indicated that LPN 6 has started employment with the facility on 9/23/22. The employee file did not contain information that she had received dementia training during the orientation process. The employee file for QMA (Qualified Medication Aide) 7 was reviewed on 4/18/23 at 2:20 p.m. The employee file indicated that QMA 7 had started employment with the facility on 9/20/22. The employee file did not contain information that she had received dementia training during the orientation process. During an interview on 4/18/23 at 9:45 a.m., the Business office manager indicated all available training information had been added to the employee files. On 4/20/23 at 10:51 a.m., the Regional Director of Health Services provided the Staff Training Policy and Procedure, last reviewed on 6/6/22, which read "...Within 30 days of employment, all staff members will complete orientation and training to the community and their assigned department and area of responsibility...training topics will include, but not be limited to...techniques for working with persons with disabilities and the elderly populations..."		**affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Executive director or designee will ensure that all current staff complete dementia training. b. The Executive Director or designee will ensure that each newly hired associate will complete dementia training in orientation. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. The ED or designee will do an audit of current associates to identify associates who have completed dementia training. Any staff member out of compliance with facility's policies and protocols relating to dementia training will be required to complete it before their next scheduled shift. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	

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			will not recur, i.e what quality assurance program will be put into place: a. The Executive Director or designee will audit employee education record for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all associates have completed dementia training. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** Dementia training is being offered now and concluding on May 31, 2	
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			

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OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	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 interview and record review, the facility failed to discuss services plans with residents and ensure service plans are signed and dated by the resident for 2 of 6 residents reviewed for service plans (Resident K and L). Findings include: 1. The clinical record for Resident K was reviewed on 4/19/23 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, hypertension and chronic obstructive pulmonary disease. She was admitted to the facility on 11/8/19. A Level of Services Assessment, dated 2/23/23, indicated she was alert and oriented to person, place, and time. During an interview on 4/19/23 at 1:30 p.m., Resident K indicated that she had never attended a service plan meeting. She was unaware of what a service plan was. On 4/20/23 at 12:30 p.m., the RDHS (Regional Director of Health Services) provided Resident K's	R 0217	R217 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Director of nursing or designee will ensure that all current residents will have their service plans reviewed with them of their designee. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	05/31/2023

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	current service plan, last updated 12/9/22. The service plan was not signed and dated by Resident K. 2. The clinical record for Resident L was reviewed on 4/19/23 at 9:32 p.m. The Resident's diagnosis included, but was not limited to, diabetes and hypertension. She was admitted to the facility on 1/1/21. A Level of Services Assessment, dated 4/11/23, indicated she was alert and oriented to person, place, and time. She was independent with decision making. During an interview on 4/20/23 at 11:15 a.m., Resident L indicated that she had never been invited to a service plan meeting. She was not familiar with a service plan and had never signed one. On 4/20/23 at 12:30 p.m., the RDHS provided Resident L's current service plan, last updated 12/22/22. The service plan was not signed and dated by Resident L. During an interview on 4/20/23 at 12:30 p.m., the RDHS indicated there was no documentation in the clinical records that the service plan had been reviewed with Resident K or Resident L. On 4/19/23 at 10:10 a.m., the RDHS provided the Service Plans policy, dated 1/12/22, which read "...The nursing staff along with the resident and/ or family members will identify resident problems, needs and strengths... All service plans are to be reviewed every quarter, upon significant change in condition and as dictated by changes in resident needs or preferences..."		**practice does not recur:** a. The Director of nursing or designee will do an audit of current residents' service plans to identify associates who signed their service plans. Any resident who did not sign their service plan will have an opportunity to have it reviewed and signed by them. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of nursing or designee will audit residents' service plans for signatures for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all associates have completed dementia training. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Resident service plans updated with signatures has been initiated and will be completed on May 31, 2023	

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R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to timely obtain laboratory services for 1 of 5 residents reviewed for laboratory service provision. (Resident B) Findings include: The clinical record for Resident B was reviewed on 4/17/23 at 10:52 a.m. Her diagnoses included, but were not limited to, CHF (congestive heart failure,) coronary artery disease, hypertension, and anxiety. On 4/17/23 at 12:57 p.m., the BOM (Business Office Manager) provided a list of residents who administered their own medications in the facility. Resident B was on the list. Resident B's service plan, updated 12/12/22, indicated Nursing staff and the assigned department director and family were to assist Resident B with making appointments and transportation arrangements as needed. Resident B would request help with scheduling an appointment as needed. On 4/18/23 at 9:23 a.m., the RDHS (Regional Director of Health Services) provided the 3/23/23 BMP (basic metabolic panel) lab order for Resident B from Physician 4. It indicated for the lab to be drawn once, expected 4/6/23. On 4/18/23 at 9:23 a.m., the RDHS provided the 4/14/23 BMP lab results with verification of physician notification on 4/14/23. The results	R 0240	Survey Event ID: POBG11 R240 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Director of nursing or designee will work with residents and providers regarding lab orders. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. The Director of nursing or designee will do an audit of current residents' lab orders to assist with scheduling lab service. b. The Director of nursing or designee will work with resident care providers to assist with scheduling labs.	05/31/2023

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	indicated her glucose and carbon dioxide was high, and her potassium and GFR (glomerular filtration rate-measure of how well your kidneys filter blood) was low. An interview was conducted with Family Member 3 on 4/17/23 at 12:13 p.m. She indicated Resident B was sent to the hospital earlier today to have fluid pulled off. She was supposed to have a BMP (basic metabolic panel) lab drawn 2 weeks ago at the facility on 4/7/23. Resident B gave the lab order to the DON (Director of Nursing) to schedule it after one of her doctor appointments. The facility was supposed to schedule it with their lab, who came to the facility on Fridays, but they didn't, so Resident B was a week late getting it, and didn't have it drawn until 4/14/23. The DON informed Resident B it would be scheduled with the facility's lab for 4/7/23. Resident B was currently on a diuretic medication, trying to figure out the most appropriate dose, and now today she was in the emergency room with a 3 pound weight gain overnight. They were currently unsure if she needed dialysis or just to have her diuretic medication adjusted. If the BMP lab was done timely, and the medication adjusted, perhaps she wouldn't' currently be in the hospital. Resident B was on a low salt diet, but the facility did not honor it. The other day, Resident B asked for a grilled cheese sandwich and a salad, but the grilled cheese was cold, and she was refused the salad. An interview was conducted with Resident B on 4/20/23 at 12:37 p.m. She indicated she just returned from the hospital the evening of 4/18/23 after a 4/17/23 admission where she had fluid pulled off and her diuretic medication adjusted. She felt like she couldn't breathe, so she called her cardiologist who instructed her to go to the		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of nursing or designee will audit residents' lab orders for completion of service for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all services were completed, and results addressed. Audit results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Resident lab orders audit has been initiated and will be completed on May 31, 2023	

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	hospital. Her torsemide (diuretic medication) was now scheduled for 80 mg in the morning and 20 mg in the evening. It used to be 20 mg in both the morning and evening. Resident B administered her own medications at the facility. She was supposed to have a BMP (basic metabolic panel) lab drawn in the facility on 4/7/23, but didn't get it done until 4/14/23. The DON (Director of Nursing) informed her it was scheduled for 4/7/23, but the following Monday, 4/10/23, she informed the DON the lab never came. The DON informed her she was 1 of 5 residents who didn't get their labs done on 4/7/23 and she didn't know why. This was not the first time she was late getting an ordered lab. After having the labs drawn on 4/14/23, here cardiologist increased her torsemide. As far as meals in the facility, she was always supposed to be able to select a salad as a substitute, which would coincide with her low salt diet, but it wasn't always available, especially at dinner and on the weekends when the DM (Dietary Manager) wasn't there. It was "ridiculous" that she had to go to the hospital, which she attributed to mostly "because I eat downstairs and my fluid goes up." An interview was conducted with the RDHS on 4/18/23 at 9:58 a.m. She indicated their lab provider was at will call, and was unsure why Resident B's labs were not drawn until 4/14/23. An interview was conducted with the DON (Director of Nursing) by phone on 4/18/23 at 10:31 a.m. She indicated their facility was considered a will call with their lab provider, and she had access to their lab services electronically. She took all the proper steps to schedule the lab to be drawn on 4/7/23, including calling the lab, but the lab didn't come to draw Resident B's BMP lab until 4/14/23. After Resident B missed the lab draw on 4/7/23, Resident B informed her it was okay to wait			

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	until 4/14/23. The DON faxed the 4/14/23 lab results to Resident B's physician that same day. An interview was conducted with Call Center Service Representative 22 from the facility's laboratory services provider on 4/19/23 at 1:35 p.m. She indicated the facility was an at will facility. They can put in an electronic requisition for a lab to be drawn, but they also needed to call and get a confirmation number for them to send a phlebotomist to the facility for a draw. The DON was aware of their at will status with them and the process for obtaining labs. After a brief hold, Call Center Service Representative 22 returned to the line and indicated she reviewed the lab requisitions for Resident B and there was no request for a BMP lab draw for 4/7/23, only for 4/14/23. The facility did not call them for a 4/7/23 lab draw for Resident B for 4/7/23 either. If there was a requisition or phone call for Resident B's BMP lab to be drawn 4/7/23, she would be able to see it in their records, but there was nothing there. The 4/17/23, 9:15 a.m. QMA (Qualified Medication Aide) note read, "Resident called the nurses station to inform staff that she will be going out to the hospital. Resident stated that she was having difficulty breathing and that she had gained 4 lbs. over night. She called her doctor who directed her to go out to the hospital with concern about her CHF. Paper work including med [medication] list was given to resident to take to hospital with her." The Laboratory Services and Results policy was provided by the RDHS on 4/18/23 at 9:23 a.m. It read, "RESPONSIBILITY: A. It is the responsibility of the community Administrator or designee to establish a relationship with a local lab provider to provide routine lab draw services per physician's orders for the residents of the			

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	community." This Residential Tag relates to Complaint IN00406266.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure proper food storage in the kitchen; wear beard covers in the kitchen; and ensure trash was covered when not in use. This affected 114 of 114 residents in the facility. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 4/18/23 at 11:20 a.m. During the tour, an observation of a food preparation counter was made, and an interview was conducted with the DM. The counter had a large pot of potatoes on it. There was a cellular phone charging on the counter, plugged into an outlet above the counter. There was a large, white bin of sugar underneath the counter. The sugar bin was open, exposed to air, and not in use. The DM shut the lid to the sugar bin and removed the charging cellular phone. He indicated the counter was used to prepare meals, and the potatoes were for tonight's dinner meal. He indicated the cellular phone should not have been charging on the counter and belonged to one of the CNAs (Certified Nursing Assistants.)	R 0273	R273 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Executive Director or designee will ensure that food is store properly, trash is covered when not in use and that beard guard is worn per policy. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	05/31/2023

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	During the tour, an observation of the trash bin was made. It was uncovered and not in use. The trash inside of the bin was extending beyond the rim of the bin. During the tour, the dry storage area was observed and an interview was conducted with the DM. There were gnats flying around the room. There were 2 open syrup condiments, partially empty, on one of the food racks. There was a gallon jug of syrup next to the 2 open syrup condiments with syrup remnants around the lid area. There was a 25 pound beef baste container on a bottom rack with an unsealed lid. There was beef baste remnants on top of the unsealed lid. The DM removed the beef baste from the bottom rack, placed it onto the floor, and snapped the lid into place. There was a maroon coat and a pink purse hanging from one of the dry storage racks. There was a black work bag hanging from a different dry storage rack. The DM removed the coat, purse, and bag from the racks and indicated the items should not have been stored on the racks. During the tour, the walk in refrigerator was observed. There was a jar of relish with a cracked lid, leaving the contents exposed to air. There was a container of yogurt with the lid not properly sealed. During the tour, the walk in freezer was observed. There was a large container of chocolate ice cream on a bottom shelf with the lid not properly sealed, leaving the ice cream inside visible and exposed to air. During the tour, the spice rack was observed, and an interview was conducted with the DM. There		a. The Executive Director or designee will audit food storage to ensure compliance. b. The Executive Director will monitor the use of beard guard in the kitchen to ensure compliance. c. The Executive director or designee will audit trash storage when the trash can is not in use. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Executive Director or designee will audit beard guard use, food and trash storage when trash can is not in use for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that compliance with policies is met, and results addressed. Audit results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Education of staff on beard guard, food and trash storage is initiated and will be completed on May 31, 2023	

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	were 6 spice containers with open lids, leaving the spices inside exposed to air. The DM closed each of the lids. A gnat flew up from one of the spices when he closed it. The DM indicated they were having issues with gnats. During the tour, the clean plate and dish rack was observed, and an interview was conducted with the DM. None of the dishes or plates were stored inverted. One of the small bowls on top of a stack of bowls was full of white sugar. The DM stated, "I couldn't even tell you what they doin' with that." He indicated he'd spoken with the DON (Director of Nursing) about how the CNAs who worked in the kitchen were to store clean dishes, but he hadn't heard back about it. The DM indicated he understood all of the concerns in the kitchen, but it wasn't his staff who was creating the concerns. The DM retrieved temperatures of hot foods from the steam table on 4/18/23 at 12:08 p.m. An interview was conducted with the DM at this time. The DM had beard hairs on his chin as long as one inch and was not wearing a beard cover. After retrieving the food temperatures, Dietary Aide/Cook 5 took over the steam table and began plating food from the steam table for the lunch meal. He also had beard hairs on his chin as long as 3/4 of an inch and was not wearing a beard cover. The DM indicated they normally wore beard covers. The Appearance and Dress policy was provided by the DM on 4/18/23 at 3:43 p.m. It read, "Hairnets or appropriate head coverings will be worn by all food service employees while in community kitchen and when handling food." The Garbage and Refuse Storage policy and			

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	procedure was provided by the RDHS (Regional Director of Health Services) on 4/19/23 at 9:57 a.m. It read, "Garbage and refuse on the premises shall be stored in a manner inaccessible to insects and rodents...Lids shall be in place and remain closed at all times." The Dry Food Storage policy was provided by the RDHS on 4/19/23 at 9:57 a.m. It read, Containers of food shall be stored a minimum 18 inches from the ceiling and sprinkler heads. Also, six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area..." The Receiving policy was provided by the DM on 4/18/23 at 3:43 p.m. It read, "If any product has a seal that is open or tampered with it must be set aside for a credit and labeled do not use. Then the item must be discarded."			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.	R 0298	R298	05/31/2023

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	Based on interview and record review, the facility failed to timely address a pharmacy recommendation for 1 of 6 residents reviewed for pharmacy recommendations (Resident M). Findings include: The clinical record for Resident M was reviewed on 4/20/23 at 9:30 a.m. The Resident's diagnosis included, but were not limited to, hypertension. A physician's order, dated 1/27/2020, indicated she was to receive metoprolol (heart medication) extended-release tablet 100 mg (milligram) each day at bedtime. A physician's order, dated 1/26/22, indicated that she was to receive carvedilol (heart medication) 12.5 mg twice daily. A service plan indicated Resident M needed her medications administered by a QMA (Qualified Medication Aide) or licensed nurse and she needed a licensed nurse to follow up with prescriber as needed for medication management. The objective was for her to achieve the highest level of medication assistance while maintaining her independence. A Pharmacy Consultation Report, dated 1/13/23, indicated that Resident M was noted to have a potential duplicate beta- blocker (type of heart medication which decreased heart rate and blood pressure) order. She was receiving carvedilol 12.5 mg twice daily and metoprolol extended release one time daily at bedtime. The recommendation was to clarify which beta-blocker Resident M was to receive and discontinue the other order. A Pharmacy Consultation Report, dated 3/13/23,		**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents with physician orders have the potential to be affected by the alleged deficient practice. DON or designee will audit all pharmacy recommendations and resulting orders. DON or designee will work with pharmacy to ensure all recommendations have been addressed timely. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** b. DON or designee will do an audit of all pharmacy recommendations and resulting orders. DON or designee will work with pharmacy to ensure all orders resulting from the recommendations have been entered into the EMR. **4. How the corrective action(s) will be monitored to**	

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		A. BUILDING 00 B. WING	04/20/2023

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	indicated that Resident M was noted to have a potential duplicate beta- blocker (type of heart medication which decreased heart rate and blood pressure) order. She was receiving carvedilol 12.5 mg twice daily and metoprolol extended release one time daily at bedtime. The recommendation was to clarify which beta-blocker Resident M was to receive and discontinue the other order. The April 2023 Medication Administration Record indicated Resident M was continuing to receive both the carvedilol and metoprolol as ordered daily. During an interview on 4/20/23 at 12:20 p.m., the Regional Director of Health Services indicated that pharmacy reviews should be looked at and addressed by the nursing staff at the facility. The clinical record did not contain information that the pharmacy review from 1/13/23 or 3/13/23 had been addressed. The facility did not have a policy for pharmacy reviews.		**ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit all pharmacy recommendations and follow up for six (6) weeks, then every other week for eight (8) weeks, and then as needed to ensure that all pharmacy recommendations have been addressed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on March 31, 2023	
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. (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,			

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	reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview, and record review, the facility failed to assure medications were labeled with the resident's full name, physician's name, prescription number, name and strength of the drug, directions for use, date issued, name and address of the pharmacy that filled the prescription for 2 of 8 resident records reviewed (Resident S and T). Findings include: 1. The clinical record for Resident S was reviewed on 4/19/23 at 1:30 p.m. The Resident's diagnosis included, but was not limited to, hypertension. A physician's order, dated 11/22/22 indicated she was to receive Norco (narcotic pain medication) 7.5-325 mg (milligram) three times daily. 2. The clinical record for Resident T was reviewed on 4/19/23 at 1:45 p.m. The Resident's diagnosis included, but were not limited to, stroke and diabetes. A physician's order, dated 12/16/22, indicated he was to receive Pregabalin (medication for nerve pain) 200 mg twice daily. On 4/19/23 at 10:32 a.m., the double locked narcotic box in the medication room was observed with QMA (Qualified Medication Aide) 9 and QMA 10. The narcotic medication box contained a clear, unlabeled bag of white oblong tablets. There was no label on the bag containing the resident's name, ordering physician, what	R 0301	R301 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents have the potential to be affected by the alleged deficient practice. DON or designee will audit all medication carts to ensure that medications are labeled per policy. DON or designee will request assistance from pharmacy for any medication out of compliance. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** b. DON or designee will do an audit of all medication carts to ensure that medications are labeled appropriately. Any medication not labeled appropriately will be removed from the cart and pharmacy notified. **4. How the corrective**	05/31/2023

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	medication the bag contained or the strength of the medication inside of the bag, what pharmacy had filled the prescription or when the prescription had been filled QMA 9 indicated the tablets were Norco and belonged to Resident S. The tablets were counted by QMA 9 and QMA 10 and the unlabeled bag contained 12 oblong white tablets, which matched the count on the narcotic inventory sheet. QMA 9 removed another clear unlabed bag with the number "50" on it from the narcotic box. The clear bag was stapled shut and also had small holes beside the current staples. It appeared to have been restapled. The bag contained white, oblong tablets. There was no label on the bag containing the resident's name, ordering physician, what medication the bag contained or the strength of the medication inside of the bag, what pharmacy had filled the prescription or when the prescription had been filled. QMA 9 indicated it was another bag of Norco which belonged to Resident S. QMA 9 indicated that Resident S had brought a large amount of Norco with her when she admitted and the facility had been giving them to Resident S as prescribed. The Medication Count Sheet indicated on 10/25/22 there had been 9 bags of Norco 7.5-325mg. The last entry on the Medication Count Sheet was on 4/5/23 at 4:00 p.m. and indicated that 1 bag remained. QMA 10 indicated this was the last bag of Norco present in the narcotic box for Resident S. QMA 9 indicated there were 50 pills in the bag and that the staff did not normally count them since the bag was labeled with the number 50. QMA 9 and QMA 10 counted the white, oblong pills and the bag contained 50 of them. QMA 9 indicated the bag should have a label. Resident S's name had been written on the bags, but had worn off.		**action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit all medication carts to ensure that medications are labeled correctly for six (6) weeks, then every other week for eight (8) weeks, and then as needed to ensure that medications are properly labeled. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Auditing of carts have been initiated and will conclude on March 31, 2023	

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	QMA 9 removed a clear bag from the narcotic box which contained individual dose packets for Resident T. The individual dose packs were labeled with Resident T's name. Each pack was labeled as pregabalin 200 mg and the prescription number. There were 9 individual dose packs which were attached to each other in a roll, at the end of the roll there was a white soufle cup which was stapled together and taped to the roll of individual dose packs. A orange colored pill was in the stapled soufle cup. QMA 10 indicated that the Narcotic Inventory Sheet had a count of 10 pills remaining. On 3/25/23 someone had signed that a pregaballin 200 mg had been removed from the narcotic box and made a note on the narcotic inventory sheet that the pregabalin was now in the cycle pack and readjusted the count from 9 to 10. The pill must have been put into the soufle cup and taped to the pill pack roll at this time. It should not be stored that way and should have been destroyed. On 4/19/23 at 2:03 p.m., the RDHS (Regional Director of Health Services) provided the Medication Management, Administration, & Storage policy, last revised 3/23/22, which read "... The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines..." 410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a			
R 0304 Bldg. 00				

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	substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review, the facility failed to store a schedule II narcotic medication under double lock for 1 of 5 residents randomly observed for medication administration (Resident H). Findings include: The clinical record for Resident H was reviewed on 4/18/23 at 11:07 a.m. The Resident's diagnosis included, but were not limited to, knee pain and schizoaffective disorder. A physician's order, dated 12/14/22, indicated he was to receive oxycodone (schedule II narcotic pain medication) 5 milligrams three times a day at 8 a.m., noon, and 8 p.m. On 4/18/23 at 9:30 a.m., Resident H was observed receiving his scheduled morning medications from QMA (Qualified Medication Aide) 8. Resident H approached the medication cart and asked for his medications. QMA 8 opened the drawer of the medication cart and removed Resident H's pill packet from the drawer, opened the pill pack and poured the medication into a plastic cup. QMA 8 did not remove Resident H's medication from a locked compartment in the medication cart. QMA 8 then handed the medications to Resident H. Resident H inquired if his pain pill was in the cup and QMA 8 indicated it was. Resident H took his medications and handed the cup back to QMA 8, who took it and threw it away. During an interview on 4/18/23 at 10:04 a.m., QMA 8 indicated that when a resident receives a scheduled narcotic, it comes in the timed pill pack.	R 0304	R304 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents have the potential to be affected by the alleged deficient practice. DON or designee will audit all medication carts to ensure that narcotics are stored under double lock. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** b. DON or designee will do an audit of all medication carts to ensure that narcotics medications are stored under double lock. Education will be given to all current clinical staff and newly hired clinical staff. Any clinical found to be non-compliant will receive progressive discipline. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	05/31/2023

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	Resident H's pill packets were stored in the regular medication drawer and not in a locked compartment in the medication cart. The narcotic medications in the pill packs were not signed out on a narcotic count sheet and the counts of the narcotic medications were not reconciled with another nurse or QMA at shift change. On 4/18/23 at 2:03 p.m., the RDHS (Regional Director of Health Services) indicated that Resident H's pill packs should have been located in the locked compartment inside of the medication cart. When narcotic medications came in a scheduled pill pack they were not signed out or tracked. On 4/18/23 at 2:03 p.m., the RDHS provided the Medication Management, Administration, & Storage policy, last revised 3/23/22, which read "...All controlled substances shall be kept in a designated, secure location under double lock..."		**will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit all medication carts to ensure that narcotic medications are stored under double lock for six (6) weeks, then every other week for eight (8) weeks, and then as needed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Auditing of carts and education of associates have been initiated and will conclude on March 31, 2023	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less			

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	restrictive and more independent living arrangements. Based on interview and record review, the facility failed to ensure comprehensive care plans were developed in cooperation with mental health service providers for 3 of 3 residents reviewed for a major mental illness. (Residents D, H, and N). Findings include: 1. The clinical record for Resident H was reviewed on 4/18/23 at 11:07 a.m. The Resident's diagnosis included, but were not limited to, knee pain and schizoaffective disorder. He was admitted to the facility on 9/12/22. A physician's order, dated 9/12/22, indicated he was to receive quetiapine (anti-psychotic medication) 100 mg (milligram) twice daily. The service plan, last updated 10/17/22, did not contain a comprehensive care plan addressing Resident H's diagnosis of schizoaffective disorder or anti-psychotic medication use. A physician's order, dated 3/31/23, indicated he was to receive an additional 50 mg of quetiapine with his bedtime dose (to equal 150 mg of quetiapine at bedtime). A list of residents in the facility with a major mental illness was provided by the RDHS (Regional Director of Health Services) on 4/18/23 at 2:00 p.m. Resident H was on the list as having schizophrenia. 2. The clinical record for Resident D was reviewed on 4/18/23 at 1:50 p.m. Her diagnoses included, but were not limited to, schizophrenia. She was admitted to the facility on 5/13/22.	R 0383	R383 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents diagnosed with mental illness/disorder have the potential to be affected by the alleged deficient practice. DON or designee will audit all residents diagnosed with mental disorder/illness and schedule appointments with mental health practitioner. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** b. DON or designee will do an audit of all residents with mental health/disorder diagnosis to ensure that they have a practitioner. DON or designee will work with primary care physician(s) as needed for referrals to mental health practitioner. **4. How the corrective**	05/31/2023

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	A list of residents in the facility with a major mental illness was provided by the RDHS (Regional Director of Health Services) on 4/18/23 at 2:00 p.m. Resident D was on the list as having schizophrenia. The March, 2023 and April, 2023 MARs (medication administration records) indicated she refused her daily scheduled quetiapine (antipsychotic medication) 27 times in March, 2023 and 13 times thus far in April, 2023. She also refused her other 7 scheduled medications/treatments thus far in April, 2023 as follows: daily amlodipine 17 times; daily Folic Acid 9 times; twice daily Lubrisoft Lotion 23 times; daily melatonin 13 times; twice daily metoprolol 32 times; twice daily Senna Plus 31 times; and daily Vitamin B-1 eight times. Resident D's service plan, updated 12/10/23, did not include a plan to address her schizophrenia diagnosis, nor did the service plan indicate it was developed in coordination with Resident D's mental health care provider. An interview was conducted with the RDHS (Regional Director of Health Services) on 4/19/23 at 1:37 p.m. She indicated she was unsure if Resident B received mental health services while residing in the facility. An interview was conducted with the RDHS on 4/19/23 at 2:04 p.m. She indicated she was informed Resident D did see a mental health provider and contacted them for their most recent note. Her service plan was not developed in coordination with a mental health provider and they did not have a policy specific to care plans for residents with a major mental illness.		**action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit residents diagnosed with mental health/disorder charts to ensure that they have a mental health provider. PCP to assist with referrals for residents who do not have a mental health provider for six (6) weeks, then every other week for eight (8) weeks, and then as needed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Auditing of charts have been initiated and will conclude on March 31, 2023	

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	An interview was conducted with the RDHS on 4/20/23 at 11:30 a.m. She indicated she was unaware a resident with a major mental illness needed to have a care plan developed with their mental health care provider, and supposed moving forward, they could have the mental health care provider sign off on their service plan. 3. The clinical record for Resident N was reviewed on 4/19/23 at 3:00 p.m. His diagnoses included, but were not limited to, schizophrenia. He was admitted to the facility on 8/4/21. A list of residents in the facility with a major mental illness was provided by the RDHS (Regional Director of Health Services) on 4/18/23 at 2:00 p.m. Resident N was on the list as having schizophrenia. The April, 2023 MAR (medication administration record) indicated he received an every 28 day injection of Invega Sustenna (antipsychotic medication) 117 mg on 4/19/23. Resident N's service plan, updated 12/7/23, referenced needing monitoring related to a history of mood disturbance, behavioral disturbance, and needed support related to a diagnosis of schizophrenia. The service plan did not indicate it was developed in coordination with Resident N's mental health care provider. An interview was conducted with the RDHS (Regional Director of Health Services) on 4/20/23 at 10:57 a.m. She indicated she was unsure if his service plan was developed in coordination with his mental health care provider. She was trying to obtain the most recent notes from them, but currently did not have any.			

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	An interview was conducted with the RDHS on 4/20/23 at 11:30 a.m. She indicated she was unaware a resident with a major mental illness needed to have a care plan developed with their mental health care provider, and supposed moving forward, they could have the mental health care provider sign off on their service plan. On 4/19/23 at 10:10 a.m., the RDHS provided the Service Plans policy, dated 1/12/22, which read "...Service plans shall include coordination and inclusion of services being delivered to a resident by an outside entity..."			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to assure a QMA (Qualified Medication Aide) appropriately performed hand hygiene during medication administration for 4 of 5 residents randomly observed for medication administration (Resident H, P, Q, and R). Findings include: On 4/18/23 at 9:04 a.m., QMA 8 was observed during medication administration. QMA 8 was standing at the medication cart outside of Resident R's room. He opened the drawer of the medication cart and removed the pill packet from the drawer. He opened the pill pack and poured the medications into a plastic cup. He then knocked on Resident R's door and opened the	R 0414	R414 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on hand hygiene.	05/31/2023

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	door. QMA 8 then gave the medications to Resident R and left the room, shutting the door. He did not perform hand hygiene after returning to the medication cart. QMA 8 then moved the medication cart down the hallway to Resident P's door. He opened the medication cart with the key and removed Resident P's medications from the drawer. QMA 8 opened the pill packet and poured the medications into a plastic cup. He picked up the water pitcher and poured water into another cup. He knocked on Resident P's door and waited for her to answer. He put his hands into his pockets while waiting for Resident P to answer the door. When Resident P answered the door, QMA 8 picked up the cup of medications and the cup of water and handed them to Resident P. When Resident P was done taking her medications, QMA 8 took the cups from her and threw them away. QMA 8 did not perform hand hygiene prior to preparing Resident P's Medications or after administering them. QMA 8 then pushed the medication cart to the outside of Resident Q's door. QMA 8 knocked on Resident Q's door and opened the door, telling Resident Q that his medications were coming. QMA 8 then shut Resident Q's door and opened the medication cart draw, removing Resident Q's pill pack from the drawer. QMA 8 opened the pill pack and poured the medications into a plastic cup. QMA opened Resident Q's door and entered the room, handing the medications to Resident Q. When Resident Q was finished taking his medications, QMA 8 took the cup from Resident Q and placed it in the trash. QMA 8 shut Resident Q's door. QMA 8 did not perform hand hygiene prior to or after administering Resident Q's medications. Resident H approached the medication cart and asked for his medications. QMA 8 opened the drawer of the medication cart and removed Resident H's pill packet from the drawer, opened the pill pack and		**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. DON or designee will do an audit of clinical staff during medication administration to ensure appropriate hand hygiene. b. DON or designee will educate new hire staff on hand hygiene during orientation. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit hand hygiene and provide education to staff for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure compliance. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on May 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

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	poured the medication into a plastic cup. QMA 8 then removed a wrist blood pressure cuff from the top drawer of the medication cart and placed it on Resident H's wrist to take his blood pressure, removing the cuff from Resident H's wrist after the blood pressure had been obtained. QMA 8 then handed the medications to Resident H. Resident H inquired if his pain pill was in the cup and QMA 8 indicated it was. Resident H took his medications and handed the cup back to QMA 8, who took it and threw it away. QMA 8 did not perform hand hygiene prior to handling Resident H's medication or after administering the medications. During an interview on 4/18/23 at 9:40 a.m., QMA 8 indicated he normally performed hand hygiene with alcohol-based hand gel. He had ran out of alcohol-based hand gel for his medication cart. QMA 8 normally performed hand hygiene after administering medications to each person. On 4/18/23 at 2:03 p.m., the Regional Director of Health Services provided the Hand Hygiene policy, last revised on 9/30/2019, which read "...Alcohol-Based Hand Rubs...In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub containing 60 to 95% ethanol or isopropanol for the following situations... before and after direct contact with residents...before preparing or handling medications...after handling contaminated equipment...after contact with inanimate objects [e.g., medical equipment] in immediate vicinity of the resident...."			