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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF EVANSVILLE	475 S GOVERNOR STREET EVANSVILLE, IN 47713

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: July 21 & July 22, 2021. Facility number: 014238 Residential Census: 93 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 30, 2021.	R 0000		
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview, and record review, the facility failed to treat the residents with consideration and respect of individuality for 1 of 1 observations of meal service in the main dining room. Not all of the 93 residents were allowed to dine in the dining room for meals.(Resident 63) Finding includes: On 7/21/21 at 11:50 a.m., the Dietary Manager was observed standing at the doorway of the main dining room with a clipboard with a list of residents, checking off residents as they entered the dining room. The dietary manager indicated the residents have to call down to the front desk by 10:00 a.m. to be added to the list to come to	R 0029	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC.	09/15/2021

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

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	the dining room, and 20 residents were allowed in the dining room at a time. This was decided by the Director of Nursing and the Executive Director. On 7/21/21 at 11:52 a.m., the Director of Nursing indicated the residents have to be vaccinated for the dining room meals. This was decided by the Dietary Manager and the Executive Director, and she provided the information as to which residents were vaccinated. She indicated there were 73 vaccinated residents in the facility, and 18 unvaccinated residents currently, current census was 93. They have been eating in the dining room with lunch only for a week, and then lunch and dinner for about 2 weeks. We just want everyone to be safe. On 7/21/21 at 11:56 a.m., the Dietary Manager indicated this was the 2nd week of two meals being served in the dining room, with previous 2 weeks serving lunch only in the dining room. The facility planned on having all meals served in the dining room by August. On 7/21/21 at 12:14 p.m., the Regional Executive Director indicated the dining room was only open to the vaccinated residents. They were feeding the unvaccinated residents in their apartments. They had tried to put dividers on the tables but they kept falling. On 7/22/21 at 10:53 a.m., Resident 63 indicated she was unvaccinated for COVID-19 and doesn't go to the dining room due to she was not vaccinated. She would normally would eat in there if she could. On 7/22/21 at 2:10 p.m., the Regional Executive		**R 029 Residents' Rights** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident's of the Community have the potential to be The Dining Room is open to Resident's of the Community regardless of Vaccination Status.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **The Dining Room is currently open to Resident's of the Community regardless of Vaccination Status, ongoing.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **The Dining Room is currently open to Resident's regardless of Vaccination Status. Any changes in Dining Room status will be approved by the Executive Director or designee. The Dining Room is currently seating all residents in socially distancing capacity and asking masks be worn**	

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	Director indicated she had told the facility staff in morning meeting that the dining "wasn't going to work". On 7/22/21 at 2:30 p.m., the COVID-19 LTC (Long Term Care) Facility Infection Control Guidance Standard of Operating Procedure, last updated 7/1/21, was reviewed and indicated, but was not limited to, "...fully vaccinated residents can participate in communal dining without facemask or maintaining physical distance of > 6 feet. If any one person congregates in a group activity or communal dining area is not fully vaccinated, all residents should wear facemask while not eating and the unvaccinated persons must physically distance > 6 feet." On 7/22/21 at 3:01 p.m., the Director of Nursing provided the current facility policy, Maintaining Resident's Dignity, Individuality, and Privacy, dated 6/15/18. The Policy indicated, but was not limited to, "All members of the nursing staff will treat residents with consideration and respect in order to preserve residents dignity, individuality and privacy. ...allow for maximum flexibility for residents to choose what they will do and when they will do it. Elicit and respect resident's preference regarding such things as food choices, clothing, religious activities, friendships, activity programs and entertainment..."		**when not eating.** **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;** **Executive Director or designee is responsible to monitor the Dining Room for appropriate seating on a daily basis M-F for 3 weeks and a minimum of weekly ongoing, thereafter.** **What date the systemic changes will be completed: 9/15/21**	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and			

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	(6) involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 1 of 1 residents reviewed for abuse. Resident was handled roughly, grabbed roughly by staff and is afraid to sleep to in her bed due to treatment by staff.(Resident 123) Finding includes: On 7/21/21 at 10:24 a.m., Resident 123 was interviewed and indicated she "had a little trauma thing". A couple of staff had put 5 diapers on her, then they couldn't get the pads under her and jerked it out, but the facility took care of it. She still won't sleep in the bed and only sleeps in the chair now due to she was "traumatized". She can get up from the chair by herself, but was afraid she wouldn't be able to get out of the bed. They had taken her call light and she was afraid no one would come and it scared her. On 7/21/21 at 11:14 a.m., the clinical record for Resident 123 was reviewed. Diagnoses included, but were not limited to, history of cerebral vascular accident dated 11/20/18, with left sided hemiparesis and urinary incontinence. On 7/21/21 at 2:05 p.m., the State Reportable incident was reviewed and it indicated on 6/3/21, "Resident reported that 2 CNA's on night shift were rude and told her that is was time to go to bed. They were demanding and roughly assist to bed. Grabs her arm when taking her to bed....". Both staff were suspended pending investigation. The follow up information dated 6/7/21, indicated ..."Determined that staff were rough and inconsiderate with resident. Resident has anxiety at night time due to these 2 employees. Both employees were terminated..."	R 0052	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC. **R 052 Resident's Rights - Offense** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident 123 has remains free of harm. Resident 123 is comfortable reporting concerns to Social Worker or DONW.** **The two Staff members employment was terminated.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **The Social Worker, DONW and Executive Director will conduct**	09/15/2021

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	On 7/22/21 at 10:30 a.m., the Social Worker was interviewed and indicated she had been informed she would need to do resident interviews. She had asked questions including abuse questions, any fear living here, and had saved Resident 123 for last. She had interviewed Resident 123 and had been informed the staff had been abrupt and rough with her. Resident 123 had refused mental health services. She had notified the Executive Director (ED) and the Director of Nursing (DON). The staff involved no longer work here. The resident had not wanted to go to the hospital and she had checked on Resident 123 following the incident interview and had spoke to the family who were aware of the incident. Resident 123 was still anxious and she had recommended some mental health services for her and had referred to [agency name] for services. On 7/22/21 at 3:23 p.m., the Director of Nursing provided the current facility policy, Abuse, Neglect, Exploitation and Misappropriation Policy and Procedure. The Policy contained, but was not limited to, "...Residents-have the right to be free from physical, verbal, ...mental abuse...Abuse includes deprivation of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being...Verbal abuse...examples include threats of harm saying things to frighten a resident...Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Prevention: ...supervision of staff to identify inappropriate behaviors such as using derogatory language, rough handling, ignoring residents while giving care..."		**interviews with Alert and Oriented Residents of the Community to determine Residents feel safe and know who to inform if an incident occurs.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **Resident Rights and Abuse in service completed by the DONW and designated Nurses on 6/14/2021_ thru 6/15/2021_ with Staff of Community. Resident education for reporting fear, abuse or concerns was provided by Social Worker, DONW and Executive Director at time of Community interviews. Interviews took place on 6/3/2021_.** **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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			program will be put into place; - **Executive Director or designee will meet with 3 residents weekly x 4 weeks and ask them questions regarding their feelings of safety and well being. Concerns will be addressed immediately upon being voiced by the Executive Director or Designee.** - - - - - - - - - **What date the systemic changes will be completed** **9/15/21**	
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			

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	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 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 record review and interview, the facility failed to ensure a staff member certified in First Aid and CPR (Cardiopulmonary Resuscitation) was in the building during each shift, for 4 of 7 night shifts reviewed. Finding includes: On 7/21/21 at 10:45 p.m., the Regional Executive Director provided the staffing schedule for review. On 7/22/21 at 9:30 a.m., the Director of Nursing provided the CPR and First Aid certifications for facility staff. On 7/22/21 at 2:15 the facility schedule was reviewed for CPR and First Aid certified staff for each shift daily. The schedule lacked CPR and First Aid certified staff for night shift on 7/14, 7/15, 7/19, and 7/20/21. On 7/22/21 at 3:20 p.m., the Director of Nursing indicated she was still waiting on return phone calls from some of the night shift staff. The	R 0117	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC. **R 117 Personnel - Deficiency** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Night Shift employees have completed CpR and First Aide certification.**	09/15/2021

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	facility did not have a policy for a staff member having CPR and First Aid certifications in the building at all times.		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **The Resident's of the facility have the potential to be affected by this alleged deficient practice. Audit completed by the DONW and designees to determine outdated CPR/First Aide. Employees who do not have current certification will have certification completed by 9/15/21. DONW or designee will monitor schedule daily to ensure that regulatory requirements are met.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **DONW or designee will monitor schedule daily to ensure that regulatory requirements are met in regards to 410 IAC 16.2-5.4(b) Personnel M-F with Friday including review of the weekend – ongoing until it is determined that Staff Members have current Certification and audit system is in place for re-certifications.** **How the corrective action will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place; **Once Certifications are deemed to be up to date the DONW or designee will utilize a system as follows: CPR/First Aide certification will be tracked on employees – at the beginning of each Month it will be determined who needs to update CPR/First Aide that month. Staff Member will be reminded by DONW or designee and deadline will be set. Employees who fail to update status will be counseled individually and removed from schedule as appropriate.** - **What date the systemic changes will be completed** **9/15/21**	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least			

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	annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview, and record review, the facility failed to ensure an annual tuberculosis screening , or screening upon hire was done for 4 of 5 staff members reviewed. (RN 1, QMA 4, CNA 1, LPN 1) Findings include: On 7/22/21 at 10:25 a.m.,employee records were reviewed and contained the following:	R 0121	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of	09/15/2021

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	RN 1 had a hire date of 4/12/21. The file lacked a tuberculosis test upon employment. QMA 4 had a hire date of 11/6/18. The file lacked an annual tuberculosis test. CNA 1 had a hire date of 1/11/21. The file lacked a tuberculosis test upon hire. LPN 1 had a hire date of 2/8/21. The file lacked a tuberculosis test upon hire. On 7/22/21 at 12:39 p.m., the DON indicated RN 1, QMA 4, CNA 1, and LPN 1 did not have tuberculosis screening in their employee files. The facility failed to provide a policy pertaining to employee tuberculosis screening.		compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC. **R 121 – Deficiency** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **RN1, LPN1, QMA4, CNA1 will have their initial TB skin test completed on 8/20/21 by DONW or designee.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **The Residents of the Community have the potential to be affected by this alleged deficient practice. Audit will be completed by the DONW and/or designees to identify Employees who are not in compliance with annual tb skin test and complete employee TB skin test.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **DONW or designee will identify**	

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			on a monthly basis the employees who are due for their annual tB skin test or annual health statement and ensure that employees are in compliance. **<u>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;</u>** **DONW or designee will monitor monthly the compliance of TB skin Test for employees – employees who do not get their annual tb skin test or provide one to the community will be counseled and potentially removed from the schedule as necessary.** **<u>What date the systemic changes will be completed</u>** **9/15/21**	
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			

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	and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review, and interview, the facility failed to ensure service plans were signed by the resident or resident's representative for 6 of 7 resident's reviewed for service plans. (Resident 54, Resident 50, Resident 143, Resident 123, Resident 66, Resident 53) Findings include: 1. The clinical record for Resident 54 was reviewed on 7/21/21 at 2:10 p.m. The resident had been admitted to the facility on 7/14/21. The resident's record contained a service plan dated 7/14/21 that has not been signed by the resident or resident's representative. 2. The clinical record for Resident 143 was reviewed on 7/21/21 at 2:50 p.m. The resident had been admitted to the facility on 4/15/21. The resident's record contained a service plan dated 5/31/21 that had not been signed by the resident or resident's representative.	R 0217	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC. **R – 217 Evaluation deficiency** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;**	09/15/2021

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		A. BUILDING 00 B. WING	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF EVANSVILLE	475 S GOVERNOR STREET EVANSVILLE, IN 47713

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	3. The clinical record for Resident 50 was reviewed on 7/22/21 at 8:30 a.m. The resident had been admitted to the facility on 8/2/19. The resident's record contained a service plan that was initiated on 12/10/19 with a revision date of 3/12/21. The service plan was not signed by the resident or resident's representative. On 7/22/21 at 7:47 a.m., the DON indicated Resident 54, 143, and 50's service plans had not been signed by the residents. 4. On 7/21/21 at 3:05 p.m., Resident 53 indicated she had been involved in the development of her service plan. The clinical record for Resident 53 was reviewed on 7/21/21 at 3:40 p.m. Diagnoses included, but was not limited to, chronic kidney disease, essential hypertension, obesity, and major depressive disorder. The clinical record lacked documentation of a signed service plan. On 7/22/21 at 9:45 a.m., the Director of Nursing indicated the resident did not have a signed service plan. 5. On 7/21/21 at Resident 66 indicated he had been involved in the development in his care at the facility. The clinical record for Resident 66 was reviewed on 7/21/21 at 4:00 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the colon, diabetes mellitus type 2, and anxiety disorder. The clinical record lacked documentation of a		**Residents 54, 143, 50, 53, 66 and 123 have signed Service Plans in their chart as of 8/18/21.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **The Residents of the Community have the potential to be affected by this alleged deficient practice. Audit will be completed by the DONW and/or designees to identify Residents who need signature on current Service Plan – Service Plans will be reviewed with Resident by DONW and/or designees and signatures obtained by compliance date.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **DONW and/or designee will utilize scheduling tool in Electronic Health Records to update Service Plans as scheduled and will review with Resident and obtain signatures at time that they come due.** **How the corrective action will be monitored to ensure the deficient practice will not recur,**	

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	signed service plan. On 7/22/21 at 9:45 a.m., the Director of Nursing indicated the resident did not have a signed service plan. 6. On 7/21/21 at 11:14 a.m., the clinical record for Resident 123 was reviewed. The last signed service plan for Resident 123 was dated 1/20/2020. The record lacked a signed service plan due for the current year beginning, January 2021. The current facility policy, "Service Plans," revised 1/31/20, provided by the Director of Nursing on 7/22/21 at 3:21 p.m., included, but was not limited to, "The DOHW (Director of Nursing) or designee will review the service plan with the resident, make changed if needed, and both parties will sign and date after review. DOHW or designed (sic) will meet with residents and review their service plans at least annually or if changes are warranted. If both parties agree on the service plan it is to be signed and dated by the resident and DOHW or designee. The signed copy is to be filed in the resident's chart and/or uploaded into PCC (Point Click Care)."		**i.e., what quality assurance program will be put into place; DONW and/or designee will review EHR weekly to determine the schedule for needed Service Plan updates and follow Silver Birch policy.** **What date the systemic changes will be completed** **9/15/21**	
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 safe food handling techniques were in place for 3 of 3 kitchen observations. Food was outdated, ice build up in freezer, and equipment soiled. (	R 0273	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's	09/15/2021

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	Kitchen) Findings include: On 7/21/21 at 8:30 a.m., during the initial tour of the kitchen the following was observed: 1. The walk in freezer was observed to have ice build up on the floor, walls, door, and food. The same was observed on 7/21/21 at 12:30 p.m., and 7/22/21 at 9:10 a.m. 2. The oven/steamer interior was soiled and had debris build up. The same was observed on 7/21/21 at 12:30 p.m., and 7/22/21 at 9:10 a.m. 3. The walk in refrigerator had 2 gallons of milk, one opened, one unopened, with a date of 7/19/21, a head of romaine lettuce with brown spots, with a packed on date of 5/24/21, a plastic container that contained sausage links with a date of 7/9/21, and use by date of 7/20/21, two trays of red liquid in Styrofoam cups with lids with no date, a plastic container of sliced turkey with a date of 7/1, use by 7/14, a carton of egg yolks with an expiration date of 7/20/21. The same was observed at 12:30 p.m., on 7/21/21, the egg yolks were also observed on 7/22/21 at 9:10 a.m. 4. The stand up refrigerator contained two chef salads covered in saran wrap not dated on 7/21/21 at 8:30 a.m. On 7/21/21 at 8:45 a.m., the Dietary Manager indicated the freezer fan had burned out, that was why there was ice build up in the freezer. The Dietary Manager further indicated everything needed to be taken out of the freezer and the ice removed, and staff had not had time to do so.		desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC. **R 273 Food and Nutritional Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **The walk in freezer was de-iced on 7/23/21 and the fan motor was replaced on 7/15/21.** **Food items with missing dates or outdated were disposed of.** **The Oven has been cleaned.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **The Residents of the Community have the potential to be affected by this alleged deficient practice. Dietary Manager re-educated Dietary Employees on 7/23/2021.** **Education completed included cleaning list, dating and disposing of foods and**	

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	On 7/21/21 at 8:57 a.m., the Maintenance Director indicated the staff were leaving the door to the freezer open and the fan burned up, he believed the freezer fan was replaced last Thursday 7/15/21. On 7/22/21 at 10:15 a.m., the Dietary Manager indicated the cooks are responsible to remove outdated food items, and she checks on Wednesdays to ensure the staff removed the items. She further indicated there is a rotation for cleaning. On 7/22/21 at 11:05 p.m., the Dietary Manager provided the master cleaning schedule effective July 15, 2021. The schedule included, but was not limited to, Combi oven all chefs, deep clean on Sunday, daily, all chefs run self cleaning cycle after each shift, wipe down. On 7/22/21 at 11:05 p.m., the Dietary Manager provided the food storage policy with a revision date of 1/20/2020. The policy included, but was not limited to, all products should be dated upon receipt and when they are prepared. Use "use by dates" on all food stored in refrigerators and use by dates according to the timetable in the Dry, Refrigerated and Freezer Storage Chart found in this section. A document titled food dating and storage procedures indicated, but was not limited to, any left over prepared food stored in the walk-in needs to be thrown away one week after the original expiration date, any food that is on or past its expiration date is to be thrown away.		**notification to Dietary Manager of equipment maintenance needs.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **Dietary Manager or designee will be responsible to monitor the kitchen for cleanliness, proper dating and potential equipment maintenance needs ongoing.** **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;** **Dietary Manager will monitor the following:** **Appropriate dating of foods and removal of outdated foods** **Cleaning schedule use and confirmation of cleanliness of equipment** **Equipment Maintenance Needs** **Daily M-F for 3 weeks and weekly ongoing and will address any areas of non compliance immediately with corrective actions.** **What date the systemic changes will be completed** **9/15/21**	

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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, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview, and record review, the facility failed to ensure OTC (over-the-counter) medications were labeled for 1 of 2 observations of the medication carts and 1 of 1 medication refrigerator. Medications were not labeled with the residents or physician's name on them, medications were outdated, and the medication refrigerator had employee drinks and an unidentifiable substance in it and discontinued medications remained in the medication cart. (100 Unit Medication Cart, Rooms 200-213 Medication Cart, Rooms 221-251, 300 Unit Cart, Medication Refrigerator, Resident 52, Resident 106, Resident 78, Resident 126, Resident 124, Resident 89, Resident 119, Resident 123, Resident 74, Resident 80) Findings include: During an observation of the 100 unit medication cart on 7/22/21 at 10:50 a.m., the following was	R 0301	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC. **R 301 Pharmaceutical Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;**	09/15/2021

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	observed: 1. Resident 52 had an open over-the counter (OTC) bottle of Fish Oil 1000 mg (milligrams) no resident or physician's names on it an open bottle of Calcium Carbonate 500 mg with no resident or physician's names on it, and an open OTC bottle of Vitamin C 500 mg with the resident's name and "AM" wrote on the lid. QMA 3 indicated the medication belonged to Resident 52. 2. Resident 106 had an over-the counter (OTC) bottle of Sentry Multivitamin with "147 and AM" wrote on the lid. The bottle did not have the resident's name or physician's name on it. QMA 3 indicated the medication belonged to Resident 106. During an observation of the 300 unit medication cart on 7/22/21 at 11:00 a.m., the following was observed: 3. Resident 78 was observed to have an open bottle of Combigan Ophthalmic solution 0.2/0.5% with no open date in it. The pharmacy sent to the facility date was 6/8/21. QMA 3 indicated eye drops should be discarded 30 days after opening. 4. Resident 126 had an OTC open bottle of Vitamin B12 1000 mcg with "noon" on the lid an open OTC bottle of Aspirin 81 mg with "noon" on the lid and the resident's room number and physician's name on the bottle, and an open bottle of OTC open bottle of Multivitamins with "1200" on the lid. The bottles lacked documentation of the resident's or physician's names. 5. Resident 124 had an OTC open bottle of		**Resident 52 Fish oil, vitamin C and Calcium Carbonate were disposed of. Resident 106 OTC multivitamin were disposed of. Resident 78 eye drops were disposed of and reordered. Resident 126 Vitamin B12 and Aspirin 81 mg were disposed of. Resident 124 Vitamin D3 was disposed of. Resident 89 eye drops were disposed of. The Acetaminophen in Med Cart 3 was disposed of. Resident 119 eye drops were disposed of. PrevioResident 80 Fish oilus medications were disposed of by the DONW. The mountain Dew was disposed of immediately as was the off-white solution in the medication refrigerator by RN. The 200 unit medications cart Resident 123 eye drops were disposed of, Ventalin inhaler were disposed of by DONW.** **<u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u>** **The Residents of the Community have the potential to be affected by this alleged deficient practice. Medication Cart Audits will be completed by the DONW or Designees and medications will be checked for appropriate labeling per the**	

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	Vitamin D3 1000 IU (international units) with no label on it. QMA 3 indicated the medication belonged to Resident 124. During an observation of the 200 unit medication cart for rooms 220-251 at 11:10 a.m.,, the following was observed: 6. Resident 89 had an open bottle of Latanoprost Ophthamic solution 0.005% with an open date of 5/2/21 and open bottle of Dorzol-Timolol Maleate Ophthalmic solution 2-0.5% with an open date of 5/21/21. QMA 1 indicated eye drops expired after 30 days. The manufacturer's recommended the Latanoprost Ophthalmic drops be discarded after 6 weeks and the Dorzol Timolol Ophthalmic drops be discarded after 28 days after opening. 7. The medication cart had an open bottle of Acetaminophen in it. QMA 2 indicated she did not know which resident the medication belonged to and indicated she would discard it. 8. Resident 119 had an open bottle of Brimonidine Ophthalmic solution 0.2% with an open date of 5/12/21, and open bottle of Latanoprost Ophthalmic solution 0.005% with no open date. The Latanoprost had a pharmacy sent date of 4/14/21, and an open bottle of Timilol Maleate Ophthalmic Solution 0.5% with an open date of 5/12/21. The manufacturer's recommended the Brimonidine Ophthalmic solution be discarded after 4 weeks after opening, the Latanoprost Ophthalmic solution be discarded aft 6 weeks and the Timolol Maleate Ophthalmic solution be discarded after 4 weeks. 9. On 7/22/21 at 11:20 a.m., the medication refrigerator was observed to have an open bottle		**regulation 4 10 IAC 16.2.5-6(c) (5).** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **DONW has provided labels to QMA and Nurse's to label OTC medication as appropriate. Re-education provided to QMA and Nurse's regarding proper labeling, dating and disposing of medication in medication carts on 7/23/2021 and 8/17/2021.** **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;** **DONW or designee will monitor medication carts and medication refrigerator weekly x 3 weeks and monthly ongoing for proper labels, dates and usage with non-compliance being addressed immediately by DONW or designee.** **What date the systemic changes will be completed** **9/15/21**	

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	of Mountain Dew dated 7/18 with QMA 2's name on it and a container of an off-white solution which RN 1 indicated was probably creamer. RN 1 indicated the refrigerator was to be used only for resident's medications and the items were removed. On 7/22/21 at 11:27 a.m., the 200 unit medication cart for rooms 200-213 was observed to have the following: 10. Resident 123 was observed to have an opened bottle of Olopatadine Ophthalmic 2% solution with an open date of 6/10/21. QMA 2 indicated the eye drops were good for 30 days and should have been discarded. The manufacturer recommended the eye drops be discarded after 4 weeks. 11. An open Ventolin Inhaler was open and loose in the medication drawer. The inhaler had only Resident 74's first name on it. QMA 1 indicated the medication belonged to Resident 74. 12. Resident 80 had an open OTC bottle of Fish Oil 1200 mg with the resident's last name and room number on it, an open OTC bottle of Iron 65 mg with "AM" wrote on the lide, an open bottle of Brimonidine Ophthalmic 2% with no label or open date on it, and an open bottle of Timolol Maleate Ophthalmic 0.5% solution with no label or open date on it. Both ophthalmic bottles had the resident's last name and room number on them. On 7/22/21 at 11:37 a.m., QMA 3 indicated OTC medications should be labeled with the resident's name, room number, and physician's names on them.			

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	On 7/22/21 at 2:03 p.m., the Director of Nursing discussed the requirements and rules regarding how OTC medications should be labeled. The facility lacked documentation of a policy for medication storage and labeling.			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview, and record review, the facility failed to ensure resident's had an annual health statement for 7 of 8 residents reviewed for annual health statements. (Resident 54, Resident 50, Resident 143, Resident 53, Resident 123, Resident 66, Resident 93) Findings include: 1. The clinical record for Resident 54 was reviewed on 7/21/21 at 2:10 p.m. The resident had been admitted to the facility on 7/14/21. The resident's record did not contain an annual health statement. 2. The clinical record for Resident 143 was reviewed on 7/21/21 at 2:50 p.m. The resident had been admitted to the facility on 4/15/21. The resident's record did not contain an annual health statement. 3. The clinical record for Resident 50 was reviewed on 7/21/21 at 3:30 p.m. The resident had been admitted to the facility on 8/2/19. The	R 0409	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC. **R 409 Infection Control – non compliance** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;**	09/15/2021

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	resident's record did not contain an annual health statement. On 7/22/21 at 7:47 a.m., the DON indicated Resident 54,143, and 50's record did not contain annual health statements. 4. The clinical record for Resident 53 was reviewed on 7/21/21 at 3:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, essential hypertension, obesity, and major depressive disorder. The clinical record lacked documentation of an annual health statement signed by the physician. 5. The clinical record for Resident 66 was reviewed on 7/21/21 at 4:00 p.m. Diagnoses included, but was not limited to, malignant neoplasm of the colon, diabetes mellitus type 2, and anxiety disorder. The clinical record lacked documentation of an annual health statement signed by the physician.6. On 7/21/21 at 11:14 a.m., the clinical record for Resident 123 was reviewed. The record lacked an annual health statement signed per the Medical Doctor. On 7/22/21 at 8:45 a.m., the Director of Nursing indicated Resident 123 did not have an annual health statement available. 7. On 7/21/21 at 2:35 p.m., the clinical record for Resident 93 was reviewed. The record lacked an an annual health statement signed per the Medical Doctor. On 7/22/21 at 8:53 a.m., the Director of Nursing indicated there were no current annual health statement. The current facility policy, "Tuberculosis Screening Policy," revision date 1/23/19,		**Resident 54, 143, 50, 53, 66, 123, 93, will have initial TB skin test completed by 8/20/21 with results going to PCP and annual health statement signed by PCP** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **DONW or designee will place Annual Health Statement including appropriate TB skin test or questionnaire on EMAR for Residents of Community to populate for Nursing staff.** **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;** **DONW will utilize Reports in EHR monthly to determine needed Annual Health Statements and ensure that they are completed and sent to physician for signatures, ongoing.** **What date the systemic changes will be completed** **9/15/21**	

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	07/22/2021

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	provided by the Vice President of Clinical on 7/22/21 at 3:01 p.m., included, but was not limited to, "Prior to admission, each resident shall be required to have a health assessment, including disclosure of significant (past or present) infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage. 410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to complete a tuberculin test on 1 of 2 newly admitted residents reviewed for admission tuberculin test and 3 of 5 residents reviewed for annual tuberculin tests. A resident did not have an admission tuberculin test and			
R 0410 Bldg. 00		R 0410	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to	09/15/2021

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	residents did not have annual tuberculin test. (Resident 66, Resident 53, Resident 50, Resident 123) Finding include: 1. The clinical record for Resident 66 was reviewed on 7/21/21 at 4:00 p.m. Resident 66 was admitted to the facility on 3/23/21. Diagnoses included, but was not limited to, malignant neoplasm of the colon, diabetes mellitus type 2, and anxiety disorder. The clinical record lacked documentation the resident had received a tuberculosis screening or a tuberculin skin test prior to or within 90 days after admission. 2. The clinical record for Resident 53 was reviewed on 3:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, essential hypertension, obesity, and major depressive disorder. The clinical record indicated the resident had a tuberculin test on admission in 2019. The clinical lacked documentation and an annual tuberculin test. On 7/21/21 at 8:45 a.m., the Director of Nursing indicated the resident had not received a tuberculin test as the facility did not have a person certified to administer or read the test. She indicated she had completed the tuberculin course approximately 2 weeks ago, but were still waiting to do the "hands-on." 3. The clinical record for Resident 50 was reviewed on 7/22/21 at 8:30 a.m. The resident had been admitted to the facility on 8/2/19. The resident's record lacked documentation of an annual tuberculin test since 2019. On 7/22/21 at 11:49 a.m. the DON indicated		continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 25, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC. **R 410 Infection Control – non compliance** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident 66, 53, 50, 123, will have initial TB skin test completed by 8/20/21** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **DONW or designee will place Annual Health Statement including appropriate TB skin test or questionnaire on EMAR for Residents of Community to populate for Nursing staff.** **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;** **DONW will utilize Reports in EHR monthly to determine needed Annual Health Statements and ensure that**	

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	Resident 50's last tuberculin test was in 2019. 4. On 7/21/21 at 11:14 a.m., the clinical record for Resident 123 was reviewed. The record indicated the tuberculin test for Resident 123 was completed on 12/27/19 and was negative. The record lacked a negative tuberculin test within the past year. On 7/22/21 at 8:45 a.m., the Director of Nursing indicated there was no current tuberculin test available for Resident 123. The current facility "Tuberculosis Screening Policy," revision date 1/23/19, provided by the Vice President of Clinical on 7/22/21 at 2:01 p.m., included, but was limited to, "... all residents are to be screened for active Tuberculosis (TB) at the time of move in and re-evaluated on an annual basis for the presence of active TB."		**they are completed and sent to physician for signatures, ongoing.** **What date the systemic changes will be completed** **9/15/21**	