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	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT GRANGER	6330 N FIR RD GRANGER, IN 46530

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00423080. Complaint IN00423080 - State deficiency related to the allegations is cited at R0064. Survey dates: 1/3/2024 to 1/4/2024 Facility number: 012229 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/12/24.	R 0000	1/28/24 – To Whom It May Concern: On January 3rd and 4th, 2024, a health survey was conducted at StoryPoint Granger. Attached is the plan of correction for tags R064, R092, R121, R216, R217, R246, R302, R306, R349, R356, R409, R410, and R414 the creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey revisit. Thank you for your time and consideration, Martin Lebbin Executive Director StoryPoint Granger	
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on record review and interview, the facility failed to ensure a resident was free of misappropriation of property for 1 of 1 residents	R 0064	**R064 – Residents' Rights - Noncompliance** It is the practice of this provider to	01/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Martin Lebbin	Executive Director	01/27/2024

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	reviewed for misappropriation of property. (Resident B) Finding includes: A State Reportable Form indicated on 11/18/2023, Resident B's family had reported a check had been cashed for $3,500.00 from Resident B's account that the resident did not write. The check was made out to CNA 13. CNA 13 was immediately suspended pending investigation. The Wellness Director and Executive Director were notified. Follow up was added on 11/30/2023, which indicated on 11/18/2023, the Executive Director asked if a copy or picture of the check was available. Resident B's son indicated a picture would be sent. On 11/27/2023, a picture of the front of the canceled check was received. On 11/28/2023, a picture of the back of the check was received. On 11/18/2023 CNA 13 provided a written statement that she did not have any knowledge of the check. On 11/30/2023, CNA 13 was contacted, after prior attempts, regarding there alleged allegation. CNA 13 was provided a copy of the check per her request to follow up. CNA 13 was terminated on 11/30/2023 as a result of the allegation. Resident B's bank identified the check as fraud an reimbursed the resident the $3,500.00. The Police department was notified. During an interview on 1/4/2023 at 1:35 P.M., the Wellness Director indicated the employee had been terminated for misappropriation of resident property. On 1/4/2023 at 1:40 P.M., the Wellness Director provided the policy titled, " Abuse, Neglect or Exploitation", with a revision date of 6/7/2023, and indicated the policy was the one currently used		exercise reasonable care for the protection of residents' property from loss and theft. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B's missing property was reported per policy. State, police, and family were all notified. The residents did not experience any negative outcomes related to the deficient concern. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. Resident B's missing property was reported per policy. State, police, and family were all notified. The residents did not experience any negative outcomes related to the deficient concern. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** New employees will continue to be screened prior to hiring, including background checks for any concerns or issues. Staff will be re-educated on resident abuse and neglect policy. **How the corrective action(s) will be monitored to ensure the**	

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	by the facility. The policy indicated"... 3. Definitions: Exploitation - Misuse of an adults funds...by another person...." This citation pertains to Complaint IN00423080.		**deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the ED/DNS/designee will be responsible for completion of and reviewing the new employee orientation packet to make sure employees have been oriented to resident's rights and abuse and neglect. The completed paperwork will be reviewed by the business office prior to creating the employee file. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic chances will be completed:** Compliance date: 1/31/24	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on a record review and interview, the facility failed to ensure quarterly fire drills were completed for the months of January of 2023 through May of 2023. This had the potential to affect all residents residing in the facility. Finding includes: A review of the fire drill binder on 1/3/2024 at 2:15 P.M., indicated that no fire drills were completed from January of 2023 through May of 2023, and no documentation was located for these months. During an interview on 1/4/2024 at 10:05 A.M., the Maintenance Director indicated that no documentation of any fire drills from January 2023 through May of 2023 could be provided. On 1/3/2023 at 2:28 P.M., the Wellness Director provided the policy titled "Fire Drill Standard Operating Procedure", dated 9/22/2017 and revised 1/22/2021, and indicated the policy was the one currently used by the facility. The policy indicated " ...4. Drills are required quarterly on each shift to familiarize employees with signals and actions required. Because the communities operate 24 hours, a total of 12 drills a year with four on each shift are required. The drills will need to be conducted monthly throughout the year to	R 0092	**R092 – Administration and Management - Noncompliance** It is the practice of this provider to conduct quarterly fire drills on each shift. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** The Maintenance Director was re-educated regarding the requirement to conduct fire drills quarterly on each shift to familiarize all facility staff with signals and emergency action required under varied conditions. The residents did not experience any negative outcomes related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. The Maintenance Director was re-educated regarding the	01/31/2024

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	accommodate a rotation of a different shift every month ...5 ...It shall be the responsibility of the Maintenance Lead at each community to conduct fire drill that are required ... All drills must be documented and records maintained for three years. It shall be the responsibility of the community Executive Director to make sure this process is current and records are maintained ...."		requirement to conduct fire drills quarterly on each shift to familiarize all facility staff with signals and emergency action required under varied conditions. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** The Maintenance Director will conduct and monitor quarterly fire drills on each shift to familiarize all facility staff with signals and emergency action required under varied conditions. A record of completed fire drills will be maintained in the maintenance office and in the TEAMS computer system. If concerns are noted, the ED/DON/Designee will be notified immediately for corrective action. ***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:*** To ensure ongoing compliance with this corrective action, the Maintenance Director/ED will be responsible for completion of the audit tool titled, “Safety Drill Grid” monthly. A record of completed fire drills will be maintained in the maintenance office and in the TEAMS computer program. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the	

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			Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 1/31/24	
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 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			

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	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 record review and interview, the facility failed to ensure new employees had a health screen prior to resident contact for 4 of 5 employee files reviewed for health screens (LPN 10, Housekeeper (HK) 11, Dietary Aide (DA) 12, & CNA 14). Findings include: 1. A record review of LPN 10's employee file was completed on 1/4/2024 at 1:30 P.M. LPN 10 had a hire date of 3/21/2021. LPN 10's employee file lacked the documentation to indicate she had a health screen prior to resident contact. 2. A record review of HK 11's employee file was completed on 1/4/2024 at 1:35 P.M. HK 11 had a hire date of 5/9/2023. HK 11's employee file lacked the documentation to indicate she had a health screen prior to resident contact. 3. A record review of DA 12's employee file was completed on 1/4/2024 at 1:40 P.M. DA 12 had a hire date of 6/16/2023. DA 12's employee file lacked the documentation to indicate he had a health screen prior to resident contact. 4. A record review of CNA 14's employee file was completed on 1/4/2024 at 1:45 P.M. CNA 14 had a hire date of 8/28/2023. CNA 14's employee file lacked the documentation to indicate she had a health screen prior to resident contact.	R 0121	**R121 – Personnel - Noncompliance** It is the practice of this provider to assure all staff have a health screen prior to resident contact. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** The orientation process was immediately updated, to make sure all employees have a health screening. The residents did not experience any negative outcomes related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. The orientation process was immediately updated, to make sure all employees have a health screening. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not***	03/01/2024

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	During an interview on 1/4/2023 at 3:30 P.M., the Wellness Director indicated the facility doesn't require employees to have a health screening upon hire or before resident contact. A policy for pre-employment health screening and a policy for maintaining employee records was requested, but neither were provided prior to the survey exit.		***recur:*** The Wellness Team Supervisor/designee will monitor the completion of new employee health screenings. The Wellness Team Supervisor/designee will work with the ADON to ensure health screenings are completed upon hire. If concerns are noted, the ED/DNS will be notified immediately for corrective action. ***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:*** The Wellness Team Supervisor/designee will monitor the completion of new employee health screenings. The form titled "Communicable Disease Reporting Agreement" will be utilized for the health screening. The Wellness Team Supervisor/designee will work with the ADNS to ensure annual health screenings are completed. All employee records will be reviewed for a health screening and updated as needed. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 3/1/24	

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review, interview, and observation, the facility failed to ensure a Self-Medication Administration Evaluation was completed for a resident who self-administers breathing treatments, and failed to ensure semi-annual weights were completed for 1 of 1 residents reviewed for self-administration of medications and 1 of 7 residents reviewed for weights. (Residents 2 and 6) Findings includes: 1. A record review was or Resident 2 was completed on 1/3/2024 at 11:20 A.M. Current Physician Orders included a nebulizer treatment four times a day of Ipratropium/Albuterol to be administered per clinician. A Wellness Evaluation, dated 7/28/2023, indicated under the Medication Service Plan section that staff managed the medications for Resident 2 and	R 0216	**R216 – Evaluation - Noncompliance** It is the practice of this provider to assess a resident's ability to self-administer medications. It is the practice of this provider to obtain a resident's weight upon admission, per policy, and when returning from an alternative healthcare setting. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 2 had their "Self-Administration Evaluation" updated. Resident 6 had their weight updated. The residents did not experience any negative outcomes related to the deficient concern.	03/01/2024

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	daily supervision of medications was required. A Wellness Hospice Evaluation, completed by the facility and dated 10/31/2023, indicated Resident 2 required hands-on or standby assistance for the duration of the nebulizer treatment and required assistance with medications. During an interview on 1/3/2024 at 11:40 A.M., Resident 2 indicated staff will fill up his nebulizer and leave it for him to administer himself. He indicated that he takes 2-3 nebulizer treatments per day. A Medication Administration Record, dated January 2024, indicated Resident 2 had performed his own breathing treatment at 3:01 P.M. on 1/3/2024. During an interview on 1/4/2024 at 9:40 A.M., Resident 2 indicated he thought he had a couple of nebulizer treatments the day before. During an interview on 1/4/2024 at 9:45 A.M., QMA 7 indicated staff sets up the nebulizer machine and resident will administer the nebulizer treatment when he wants to. During an observation on 1/4/2024 at 9:48 A.M., QMA 7 checked Resident 2's nebulizer machine in his room and nebulizer medication was in the nebulizer cup. During and interview on 1/4/2024 at 9:42 A.M., QMA 7 indicated Resident 2 would administer his nebulizer when he returned to his room. During an interview on 1/4/2024 at 12:12 P.M., the Wellness Director indicated a Self-Administration of Medication Evaluation should be done upon		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. Resident 2 had their "Self-Administration Evaluation" updated. Resident 6 had their weight updated. Residents did not experience any negative outcomes related to the deficient concern. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing has been re-educated on the requirement to have self-medication orders reviewed and updated upon admission and as a resident's need change by the DNS/designee. Nursing has been re-educated on the requirement to take and document a resident's weight upon admission and current resident's weight per standard operating procedure by the DNS/designee. **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:** To ensure ongoing compliance	

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	admission if a resident wanted to administer their own medications. Once that evaluation was completed, an order would be obtained from the Physician indicating that the resident could administer their own medications. The Wellness Director indicated Resident 2 should have had an evaluation completed in order to administer nebulizer treatments himself. The Wellness Director indicated the facility administered Resident 2's medications and that the order indicated a clinician would administer the nebulizer treatment. On 1/4/2024 at 1:45 P.M., the Wellness Director provided a policy titled "Medication-Self Administration", dated 8/1/2017 and revised 6/10/2022, and indicated this was the current policy used by the facility. The policy indicated " ...4. The Wellness Leader or Designee will review the Self-Administration Evaluation with the resident to evaluate their ability to safely administer and store their own medications. Review shall be performed before the resident begins to self-administer medications, following a significant change in conditions and with each evaluation ...In addition to the completion of the Self Administration Evaluation, a current signed order from the healthcare provider indicating the resident may self-administer specific or all medications must be in the medical record ...." 2. A record review was completed on 1/3/2024 at 11:42 A.M. Resident 6 was admitted on 12/29/2022. A weight was documented for admission on 12/30/2022 of 215 lbs. The clinical record lacked any other weights documented since admission. During an interview on 1/3/2024 at 3:10 P.M., the		with this corrective action, the DNS/designee will be responsible for completing the “Medication Self- Audit” and “Weight Entry” reports out of the Point Click Care computer system monthly. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic chances will be completed:** Compliance date: 3/1/24	

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	Wellness Director indicated there were no current weights for Resident 6. On 1/4/2024 at 12:05 P.M., the Wellness Director provided the policy titled," Resident Weights", with a reviewed date of 10/17/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...2. Each resident will be routinely weighted upon move-in, monthly, and when returning from an alternate healthcare setting...."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (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			

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STORYPOINT GRANGER	6330 N FIR RD GRANGER, IN 46530

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	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 include the resident's signature, date, and a needed service in the service plan for 1 of 6 residents whose records were reviewed. (Resident 5) Findings include: A record review was conducted on 1/3/2024 at 11:30 A.M. Resident 5's diagnoses included, but were not limited to, type 2 diabetes mellitus and chronic kidney disease. An unsigned Service Plan, dated 9/11/2023, did not include the resident received kidney dialysis, the scheduled days for dialysis, transportation plan, or where the dialysis done. The record also lacked a physician order for kidney dialysis. During an interview on 1/4/2024 at 1:28 P.M., Resident 5 indicated she had been receiving kidney dialysis at Fresenius Kidney Care since her admission on 5/12/2023. During an interview on 1/4/2024 at 11:46 A.M., the DON indicated the current service plan was not signed by the resident and should be. The current service plan also does not address her dialysis, days scheduled, or transportation and should. A current policy, provided by the Wellness Director on 1/4/2024 at 12:07 P.M., titled "Service Conference" and updated on 3/23/2023, included, but was not limited to, "...The purpose of the Service Conference Policy is to keep all parties	R 0217	**R217 – Evaluation – Deficiency** It is the practice of this provider to assure all residents have identified needed services in the service plan and they are signed and dated. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident 5 had their service plan reviewed, updated, signed, and dated. The residents did not experience any negative outcomes related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. Resident 5 had their service plan reviewed, updated, signed, and dated. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** The DNS/designee will review and update all service plans for current residents. Nursing staff will be re-educated on the procedure for	03/01/2024

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	informed of the needs and condition of residents that we are serving in our communities...."		updating service plans. If concerns are noted, the Executive Director will be notified immediately for corrective action. ***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;*** To ensure ongoing compliance with this corrective action, the DNS/ADNS/designee will be responsible for running the "Service Plan" reports out of the Point Click Care computer system monthly. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 3/1/24	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure a PRN (as needed) medication administered by a QMA was approved by a licensed nurse for 1 of 7 residents reviewed for	R 0246	**R246 – Health Services – Deficiency** It is the practice of this provider to assure all medications are	02/09/2024

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	medications. (Resident 2) Finding includes: A record review was completed, on 1/3/2024 at 11:20 A.M. Resident 2's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, Hypertension, and Basal Cell Skin Cancer. The MAR (Medication Administration Record), dated December 2023, indicated a PRN (as needed) Lorazepam (anti-anxiety medication) had been administered on 12/5/2023 at 12:26 P.M., 12/28/2023 at 9:37 A.M. by QMA without documentation of a licensed nurse approving the administration of the medication. During an interview on 1/4/2023 at 11:11 A.M., the Wellness Director indicated there should have been documentation that the QMA had authorization from a nurse to administer the Lorazepam. On 1/4/2024 at 12:05 P.M., the Wellness Director provided the policy titled "Medication Administration" and indicated that the policy was the one currently used by the facility. The policy indicated that " ...Documentation: 5. When PRN medications are administered the following documentation is provided: D. Signature or initials of person recording administration and signature or initials of person recording effects if different than person administering medication ...."		administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident 2 had their medication administration reviewed by the ADNS for proper medication administration. Nursing staff was immediately re-educated, by the DNS/ADNS regarding the appropriate authorization for each administration of a PRN medication by a QMA. The resident did not experience any negative outcomes related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. Resident 2 had their medication administration reviewed by the ADNS for proper medication administration. Nursing staff was immediately re-educated, by the DNS/ADNS regarding the appropriate authorization for each administration of a PRN medication by a QMA. The residents did not experience	

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			any negative outcomes related to the deficient concern. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** The DNS/ADNS/designee will educate staff on the utilization of the triage nurse line. QMA's are to call the triage prior to administering a PRN medication to receive authorization to administer when a nurse is not available in the community. If concerns are noted, the Executive Director will be notified immediately for corrective action. ***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:*** To ensure ongoing compliance with this corrective action, the DNS/ADNS/designee are responsible for reviewing the audit tool titled, "PRN Medication Audit Report" located in the Point Click Care system. The report will be viewed daily for 2 weeks and weekly thereafter. If a threshold of 100% is not met, an action plan will be developed. Findings to be submitted to the Executive Director to review/follow-up. **By what date the systemic changes will be completed:** Compliance date: 2/9/24	

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R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, interview, and record review, the facility failed to ensure over the counter medications were labeled in 3 of 6 medication carts observed. (AL 1 & 2 and North Memory Care medication carts) Findings include: 1. During an observation of medication cart 1 on 1/4/2024 at 10:00 A.M. with QMA 8, the following was observed: opened bottles of Centrum gummies and preservision with no labels. During an interview on 1/4/2023 at 10:10 A.M., QMA 8 indicated the medications should have been labeled. 2. During an observation of medication cart 2 on 1/4/2024 at 10:25 A.M. with QMA 7, the following was observed: an opened bottle of preservision with no label. During an interview on 1/4/2024 at 10:30 A.M., QMA 7 indicated the preservision medication should have been labeled. 3. During an observation of the medication cart on the North Memory Care,\ on 1/4/2024 at 10:50 A.M. with QMA 15, the following was observed: opened bottles of Omega 3 and Tylenol with no labels.	R 0302	**R302 – Pharmaceutical Services – Deficiency** It is the practice of this provider to ensure all, over the counted, medications are labeled. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Nursing staff were immediately re-educated by the DNS/ADNS regarding the appropriate identification and labeling of over-the-counter medications. The resident did not experience any negative outcomes related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. Nursing staff were immediately re-educated by the DNS/ADNS regarding the appropriate identification and labeling of over-the-counter medications. ***What measures will be put into***	02/09/2024

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	During an interview on 1/4/2024 at 11:00 A.M., QMA 15 indicated the medications Omega 3 and Tylenol should have labels. On 1/4/2023, the Wellness Director provided the policy titled, "Medication Storage", dated 6/10/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... Medication Storage:... 2. Medication labels must include: resident name, medication name, medication strength/dose, frequency, route, and expiration date. 3. Over the counter medications must be labeled with pharmacy printed label and no"stock meds" are allowed for multi resident use...."		***place or what systemic changes will be made to ensure that the deficient practice does not recur:*** The DNS/ADNS/designee will perform a medication cart audit to ensure the appropriate identification and labeling of over-the-counter medications. If concerns are noted, the Executive Director will be notified immediately for corrective action. ***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;*** To ensure ongoing compliance with this corrective action, the DNS/ADNS/designee will be responsible for completion of the audit tool titled, “Cart Audit Form” on a weekly basis. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 2/9/24	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information:			

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	(1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, interview, and record review, the facility failed to ensure expired medications were removed from the medication carts and destroyed in 3 of 3 medication carts observed. (AL 1 & 2 and North Memory Care medication cart 1) Findings include: 1. During an observation of AL medication cart 1 on 1/4/2024 at 10:00 A.M. with QMA 8, the following was observed: an opened tube of Nystatin ointment that had expired on 8/21/2023. During an interview on 1/4/2023 at 10:10 A.M., QMA 8 indicated the expired medication should not be in the medication cart. 2. During an observation of AL medication cart 2 on 1/4/2024 at 10:25 A.M. with QMA 7, the following was observed: an opened bottle of Milk of Magnesium that had expired on 11/10/2023, and a Ventolin inhaler that had expired on 9/3/2023. During an interview on 1/4/2024 at 10:30 A.M., QMA 7 indicated the expired medications should not be in the cart. 3. During an observation of the medication cart on	R 0306	**R306 – Pharmaceutical Services – Noncompliance** It is the practice of this provider to assure all medications are disposed of in compliance with appropriate, federal, state, and local laws. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Nursing staff were immediately re-educated by the DNS/ADNS regarding the appropriate review and disposal of expired or discontinued medications. The resident did not experience any negative outcomes related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. Nursing staff were immediately re-educated by the DNS/ADNS	02/09/2024

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	the North Memory Care on 1/4/2024 at 10:50 A.M. with QMA 15, the following was observed: lomotil (anti diarrheal) pills that had expired on 9/23/2023. During an interview on 1/4/2024 at 11:00 A.M., QMA 15 indicated the lomotil medication should have been removed from the medication cart. On 1/4/2023 at 12:05 P.M., the Wellness Director provided the policy titled, "Medication Destruction/Disposal", with a revision date of 6/10/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...Expired 1. Expired medications are never administered. 2. The designated staff person will inspect containers for expired dates on a routine basis. When appropriate, replacement medication will be ordered. 3. To properly dispose of expired medications the designated staff person will: a. Return the medication to the dispensing pharmacy for disposal; or b. Destroy the medication following medication disposal policy...."		regarding the appropriate review and disposal of expired or discontinued medications. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** The DNS/ADNS/designee will perform a medication cart audit to ensure the appropriate review and disposal of expired or discontinued medications. If concerns are noted, the Executive Director will be notified immediately for corrective action. ***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:*** To ensure ongoing compliance with this corrective action, the DNS/ADNS/designee will be responsible for completion of the audit tool titled, “Cart Audit Form” on a weekly basis. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 2/9/24	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an			

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	employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to have Physician's Orders signed timely by a Physician for 3 of 8 residents whose Physician's Orders were reviewed. (Residents 7, 8 and 6). Findings include: 1. Resident 7's record review was reviewed on 1/4/2024 at 10:15 A.M. Resident 7's record had the following unsigned physician's orders: a. A Physician's Order, dated 9/22/2023, for senna 8.6 mg (milligram) tablet. b. A Physician's Order, dated 10/2/2023, for Norco 5/325 mg tablet. c. A Physician's Order, dated 12/3/2023, for lorazepam 2 mg/milliliter (mL). d. A Physician's Order, dated 12/3/2023, for morphine concentrate 100 mg/5 mL. 2. Resident 8's record review was completed on 1/4/2024 at 10:30 A.M. Resident 8's record had the following unsigned physician's orders: a. A Physician's Order, dated 9/22/2023, for furosemide 20 mg tablet. b. A Physician's Order, dated 9/22/2023, for allopurinol 100 mg tablet.	R 0349	**R349 – Clinical Records – Noncompliance** It is the practice of this provider to assure all orders are signed timely by a resident's attending physician. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Residents 6, 7, and 8's physician was contacted and had their orders signed. The residents did not experience any negative outcomes related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. Residents 6, 7, and 8's physician was contacted and had their orders signed. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** Nursing staff have been	03/01/2024

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	c. A Physician's Order, dated 9/22/2023, for rosuvastatin 2.5 mg tablet. d. A Physician's Order, dated 9/22/2023, for levothyroxine 125 micrograms (mcg) tablet. e. A Physician's Order, dated 9/22/2023, for carvedilol 25 mg tablet. f. A Physician's Order, dated 9/22/2023, for Eliquis 5 mg tablet. During an interview on 12/4/2024 at 11:50 A.M., the Wellness Director indicated Resident 7's and Resident 8's Physician's Orders were not signed, but the orders should have been signed. 3. A record review was completed on 1/3/2024 at 2:57 P.M. Resident 6's clinical record lacked the Physician's signature for the following orders: - 8/6/2023 STAT x-ray to left tibia and left fibula,. - 9/5/2023 diet order change to Puree diet, Nectar thick , crush medications. - 8/18/2023 dc (discontinue) BP (blood pressure) parameters. - 9/21/2023 Milk of Magnesium changed to daily. - 9/24/2023 Gabapentin twice a day. - 10/3/2023 DC Prolia injections. - 10/6/2023 DC Bicalutamide (hormone), and Mucinex and start Ipratropium/Albuterol nebulization solution. Start Metalozone (diuretic) , Guifenesin (cough syrup) - 10/9/2023 May change diet to mechanical soft. - 12/18/2023 Tamulosin for retention. - 12/18/2023 Tylenol with Codeine and DC Robitussin when Tylenol/codeine is started. - 12/19/2023 DC Flomax due to allergy. -12/20/2023 UA/C&S (urinalysis and culture and sensitivity) due to urinary retention. -12/21/2023 Pyridium (analgesic). -12/21/2023 Finsteride for BPH (Benign prostatic		re-educated on the process of preparing orders for a physician's signature weekly and filing them in a resident's chart after being signed by a physician. ***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:*** To ensure ongoing compliance with this corrective action, the DNS/ADNS/designee are responsible for reviewing a carbon copy of the telephone orders to confirm the original copies are signed and placed in the resident's chart weekly for 4 weeks and monthly for four months. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 3/1/22	

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	hyperplasia) During an interview on 1/3/2024 at 3:15 P.M., the Wellness Director indicated the orders should have been signed by the physician. During an interview on 1/4/2024 the Wellness Director indicated she did not have a policy on Physician orders.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure accurate and current emergency information was located in the Resident Emergency binder for 4 of 7 residents whose emergency information was reviewed. (Residents 2, 3, 4, and 6). Findings include:	R 0356	**R356 – Clinical Records – Noncompliance** It is the practice of this provider to ensure accurate and current emergency information is located in the resident emergency binder. ***What corrective action(s) will be***	02/02/2024

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	On 1/3/2024 at 2:40 P.M., the Wellness Director provided the Emergency Binder. 1. Resident 2's emergency information sheet lacked a hospital preference and the current attending Physician being used. 2. Resident 3's emergency information sheet lacked a photo of the resident, and allergies. 3. Resident 4's emergency information sheet lacked a photo of the resident, the hospital preference, and the attending physician. 4. The emergency binder lacked Resident 6's emergency information sheet. During an interview on 1/3/2023 at 2:45 P.M., the ADON (Assistant Director of Nursing) indicated the information sheets should have a photo, the hospital preference, allergies and the current attending physician. On 1/4/2023 a policy was requested for Emergency Binder information, but one was not provided prior to the survey exit.		***accomplished for those residents found to have been affected by the deficient practice:*** Resident's 2, 3, 4, and 6 had their emergency information updated and added to the resident emergency binder. The residents did not experience any negative outcomes related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. Resident's 2, 3, 4, and 6 had their emergency information updated and added to the resident emergency binder. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** Nursing has been re-educated on the need to have updated, resident emergency information in the emergency binder. ***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:*** To ensure ongoing compliance with this corrective action, Nursing will provide the business office with any new residents or any	

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			current resident updates on the face sheet to be included in the emergency binder. All new resident admissions or readmissions will be reviewed, by the DNS/ADNS/designee weekly for 4 weeks and monthly for six months. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 2/2/24	
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 record review and interview, the facility failed to ensure an annual health statement from the physician was obtained on admission for 2 of 7 residents whose records were reviewed. (Residents 3 & 6) Findings include: 1. A record review was completed on 1/3/2024 at 2:39 P.M. Resident 3 was admitted to the facility on 7/24/2023. The clinical record lacked the physician's health statement indicating the resident was free from communicable diseases.	R 0409	**R409 – Infection Control – Noncompliance** It is the practice of this provider to ensure an annual health assessment showing any history of significant past or present infectious disease. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Residents 3 and 6 were provided with an annual health assessment identifying any significant past or	02/09/2024

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	2. A record review was completed on 1/3/2024 at 2:57 P.M. Resident 6 was admitted to the facility on 12/22/2022. The clinical record lacked the physician's health statement indicating the resident was free from communicable diseases. During an interview on 1/4/2023 at 11:19 P.M., the Wellness Director and ADON (Assistant Director of Nursing) indicated they have a different computer system now and the ancillary orders were not being pulled over, so they were unable to provide the documentation of the annual health statements for the residents. On 1/4/2024 at 12:05 P.M., the Wellness Director provided the policy a copy of the IDOH Consumer Services and Health Care Regulations Long-term Care Division Program Letter, with an updated date of 8/11/2021. Titled,"Tuberculosis Assessment and Testing of Long term Care Residents." The letter indicated"... 1. Each resident must have a health assessment upon admission...The medical record should include the assessment and a statement that the resident shows no evidence of TB in an infectious stage verified upon admission...."		present infectious disease. No harm was incurred to residents 3 or 6 related to this deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. All residents require an annual health assessment showing a history of significant past or present infectious disease. No other residents were identified related to this deficient practice. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** Audits will be on-going to ensure compliance with infection control policy and procedure. Audits will be conducted by the nurse management team to monitor compliance. ***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:*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the tool titled, “Order Summary Report” located in the Point Click Care system. Audits will be conducted weekly	

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			for 4 weeks then monthly for six months. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic chances will be completed:** Compliance date: 2/9/24	
R 0410 Bldg. 00	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 ensure a resident was tested for TB and or had a risk assessment completed for 2023 and failed to read an admission TB timely for 1 of 6 residents reviewed for TB testing. (Resident 2)	R 0410	**R410 – Infection Control – Noncompliance** It is the practice of this provider to ensure a two-step Mantoux test for newly admitted residents is complete.	02/09/2024

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	Finding includes: During a record review on 1/3/2024 at 11:20 A.M., no TB (tuberculin) skin testing or an annual TB risk assessment for 2023 was located in Resident 2's chart. During an interview, on 1/4/2024 at 2:45 P.M., the Wellness Director, indicated that she could not provide a completed annual TB risk assessment for the year 2023, and this should have been completed.		***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident 2 and any residents identified as not receiving a two-step Mantoux test will be re-tested. No harm was incurred to resident 2 related to this deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. All new residents require a two-step Mantoux test. Resident 2 and any residents identified as not receiving a two-step Mantoux test will be re-tested. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** Audits will be conducted to ensure compliance with infection control policy and procedure. Audits will be conducted by the nurse management team to monitor compliance. ***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:*** To ensure ongoing compliance	

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			with this corrective action, the DNS/ADON/designee are responsible for reviewing the audit tool titled, “TB Screen” located in the Point Click Care system. The report will be viewed monthly. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic chances will be completed:** Compliance date: 2/9/24	
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 and interview, the facility staff failed to follow standards of care while obtaining a blood glucose level and during an insulin injection for 2 of 3 medication administration observations. (QMA 2 & QMA 7) Findings include: 1. On 1/3/2024 at 11:30 A.M., QMA 2 was observed to check Resident 6's blood sugar. QMA 2 applied gloves and wiped the resident's finger with an alcohol pad. QMA 2 then pricked the resident's finger using a lancet. The QMA obtained the blood sample. She removed the gloves and then went to the medication cart and pulled out Resident 6's medication and gave them to him. QMA 2 completed no hand washing after removing the gloves.	R 0414	**R414 – Infection Control – Noncompliance** It is the practice of this provider to ensure staff follow standards of care while providing resident care. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Nursing staff were immediately re-educated by the DNS/ADON regarding infection control and appropriate hand washing while providing resident care. The resident did not experience any negative outcomes related to the deficient concern. ***How other residents having the***	02/09/2024

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	During an interview at 11:30 A.M., QMA 2 indicated she should have washed her hands. 2. During an insulin administration on 1/4/2023 at 8:02 A.M., QMA 7 applied gloves, obtained the resident's blood glucose level through her device. The QMA indicated she had forgotten the parameters for the insulin injection, and left the room to obtain the ipad. QMA 7 indicated the resident required 2 units. She used an alcohol pad and wiped the resident's abdomen. The QMA then administered the injection. QMA 7, with gloves still on, went into the bathroom looking for a sharps container. She then went to the kitchen area, and with the gloved hand, opened up cabinet doors looking for a sharps container. QMA 7 then exited the room with her hands gloved. During an interview on 1/4/2024 at 8:04 A.M., the QMA indicated the injection pen had the cap over the needle and she had looked for the sharps container. She should have removed her gloves and washed her hands prior to exiting the resident's room. Policies for glove use and hand washing and Insulin administration were requested on 1/4/2024. On 1/4/2024 at 12:03 P.M., the Wellness Director indicated she had no policy for obtaining blood glucose levels and indicated they follow the state regulations for hand glove use and hand washing.		***potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. Nursing staff were immediately re-educated by the DNS/ADON regarding infection control and appropriate hand washing while providing resident care. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** Audits will be on-going to ensure compliance with infection control policy and procedure. Audits will be conducted by the nurse management team to monitor compliance. ***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:*** To ensure ongoing compliance with this corrective action, the DNS/ADON/designee are responsible for the completion of the tool titled, “Hand Hygiene Monthly Monitoring” weekly for 4 weeks and then monthly for four months. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic**	

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			chances will be completed: Compliance date: 2/9/24	