STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KESSLERWOOD PLACE	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey Dates: April 13, 14, and 15, 2021 Facility Number: 010064 Residential: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 23, 2021	R 0000	Submission of this response and plan of correction in NOT a legal admission that a deficiency exist, or that this statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents or the individuals who drafted or may be discussed in the response of Plan Of Correction. In addition , preparation and submission of this plan Of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to administer a medication as ordered for 1 of 5 resident's medication administrations observed. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 4/14/21 at 9:00 a.m. The diagnosis for Resident 2 included, but was not limited to dementia.	R 0240	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #2 was monitored for signs and symptoms of adverse reaction by (LPNtitle) and suffered no negative effects. MD and Responsible Party notified of findings. LPN 2 was in-serviced on 6 Rights of Medication	05/21/2021

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

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	A physician order dated 7/30/20 indicated Resident 2 was to receive 81 milligrams of aspirin one time a day. The tablet was to be administered whole. It should not be chewed or crushed. The April 2021 Medication Administration Record (MAR) indicated the 81 milligrams aspirin tablet was to be administered whole. The medication directions was not to be chewed or crushed. Those directions were underlined on the MAR. An observation was made with License Practical Nurse (LPN) 2 of Resident 2's medications prepared and administered on 4/14/21 at 9:00 a.m. LPN 2 was observed pulling medication packets and crushing all his medications and placing in a medication cup with strawberry applesauce. The aspirin was included in the medication cup crushed. LPN 2 then administered the medications to Resident 2. An interview was conducted with LPN 2 on 4/14/21 at 9:52 a.m. She indicated she did notice Resident 2's 81 milligrams of aspirin was not to be crushed, but had forgotten when she was preparing the medications. An interview was conducted with Director of Nursing on 4/14/21 at 2:41 p.m. LPN 2 administered the aspirin crushed to Resident 2. She did not follow the order. It was considered a medication error. A Medication Administration policy dated 9/1/16 was provided by the Executive Director on 4/14/21 at 10:44 a.m. It indicated "...Policy: Medications and treatments are administered to residents as determined by review of their medication status, and in accordance with physician order, state laws, and assisted living regulations...The six		Administration by Care Services Manager (CSM) on 04/2014/2021. (Attachment #1) 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; An audit was conducted on (5/10/2021DATE) by CSM of current nursing staff to ensure medications were administered appropriately and were re-educated at time of findings as necessary. A medication I competency assessment was conducted on current nursing staff by CSM on (5/10,2021DA-). (Attachment #2 & #3). What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Current nursing staff were in-serviced on 6 Rights of Medication Administration on 05/07/2021 by CSM. A medication administration competency assessment will be conducted quarterly by CSM of current nursing staff. (Attachment #4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Executive Director is responsible for sustained	

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	"rights" of medication and treatments administration will be observed every time a medication is administered - right resident, right medications, right dose, right form and route, right time, right documentation..."		compliance. The CSM and/or designee will observe medication administration for a current resident 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. By what date the systemic changes will be completed **05/21/2021**	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure a resident's record included a	R 0354	What corrective action(s) will be accomplished for those residents	05/21/2021

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	transfer form for 1 of 2 residents whose closed records were reviewed. (Resident 24) Findings include: The clinical record for Resident 24 was reviewed on 4/14/21 at 11:44 a.m. The diagnoses for Resident 24 included, but were not limited to, depression. The 12/24/20, 12:00 p.m. Resident Services Note read, "Writer looking for res [resident,] res was in the car outside the parking lot, 12 pm meds [medications] were due & writer tried to wake up res but res not responding. Writer called for help. After multiple knocks on the window res was able to wake up & opened the window. Writer noticed that res was inhaling through leaf blower & smoke was seen in his car. ED [Executive Director] & DON [Director of Nursing] called 911 & ambulance to transport res to the hospital due to self harm. MD notified.....Res transported to [name of hospital.] Res is own POA [Power of Attorney.]" There was no transfer form in the clinical record for Resident 24's transfer to the hospital on 12/24/21. An interview was conducted with the DON on 4/14/21 at 12:25 p.m. She indicated she'd never seen or used a transfer form in the facility. They sent Resident D to the hospital with a copy of his medication administration record, face sheet, emergency contact information, advance directive form, and information "like that," but they didn't make a copy of it to keep in the chart. On 4/15/21 at 8:45 a.m., the ED provided a copy of a blank Resident Transfer Form. The blank form		found to have been affected by the deficient practice; Resident 24 no longer resides in the community 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; An audit was conducted by CSM on (May 5,2021 of the last 5 discharges to determine presence of a transfer form. Any resident identified had their record reviewed to ensure documentation was present for transfer disposition. Findings of audits were reviewed with Executive Director. (Attachment #5) What measures will be put into place or what systemic changes the facility will make to that the deficient practice will not recur, i.e. Current nursing staff were in-serviced on 05/05/2021 by CSM on utilization of transfer form for any resident who transfers from the community to another institution. (Attachment #6) 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; and The Executive Director is responsible for sustained compliance. The CSM and/or designee will review the resident record for residents who transfer	

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	included fields for identification data, transferring institution, date of transfer, diet order, advance directive, code status, date of chest X-ray and tuberculosis test, functional status, treatment, etc.		from the community to ensure transfer form completed. Audits will be completed 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. By what date the systemic changes will be completed **05/21/2021**	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure infection control was maintained during medication administrations with utilizing hand hygiene for 5 of 5 residents' medication administrations observed. (Resident 1, 2, 3, 4, and 22) Findings include: 1. The clinical record for Resident 1 was reviewed on 4/14/21 at 8:47 a.m. The diagnosis for Resident 1 included, but was not limited to dementia. 2. The clinical record for Resident 2 was reviewed on 4/14/21 at 9:00 a.m. The diagnosis for Resident 2 included, but was not limited to dementia.	R 0414	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Residents 1, 2, 3, 4 and 22 suffered no negative effects from these findings. LPN 2 was educated on 5/4/2021 by CSM on appropriate hand hygiene. (Attachment #7) How the facility will identify other residents having the potential to be affected by the same deficient An audit was conducted on 5/4/2021by CSM of staff to ensure	05/21/2021

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	3. The clinical record for Resident 22 was reviewed on 4/14/21 at 9:15 a.m. The diagnosis for Resident 22 included, but was not limited to osteoarthritis. 4. The clinical record for Resident 3 was reviewed on 4/14/21 at 9:27 a.m. The diagnosis for Resident 3 included, but was not limited to osteoarthritis. 5. The clinical record for Resident 4 was reviewed on 4/14/21 at 9:35 a.m. The diagnosis for Resident 4 included, but was not limited to dementia. An observation was made of medication administrations with License Practical Nurse (LPN) 2 on 4/14/21 at 8:47 a.m. LPN 2 was observed preparing Resident 1's medications. LPN 2 pulled a medication package labeled 8:00 a.m., out of the medication drawer with Resident 1's medications inside the packaging. During that time, she had dropped a pen and paper onto the floor. After retrieving the pen and paper from the floor, LPN 2 then emptied the pill package that contained individual packaged pills. Using her nails, she punctured inside the pill pack and slid her nail back and forth inside to enlarge the opening of the pill pack. She then emptied the pills in a medication cup. LPN 2 locked the cart and went to the dining room. Resident 1 was assisted by LPN 2 placement of his face mask and returned him to his room. Resident 1 was then transferred by LPN 2 and Certified Nursing Assistant (CNA) 4 to his recliner. LPN 2 was observed administering the medication to the resident. After, LPN 2 then went to the receptionist desk and used hand sanitizer. There was no hand hygiene observed prior to medication preparing, after picking up pen and paper from the floor, assisting with placement of face mask on to the resident, or prior to administration of the medications to the resident.		they are utilizing proper hand hygiene and were re-educated at time of findings as necessary. (Attachment #8) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Current staff were in serviced on 05/045/2021 by CSM on appropriate hand hygiene. (Attachment #9) 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; and The Executive Director is responsible for sustained compliance. The ED/CSM and/or designee will conduct observation of performance of appropriate hand hygiene completed 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. By what date the systemic changes will be completed May 21,2021	

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	At 9:00 a.m., an observation was made of Resident 2's medication administration. LPN 2 had pulled medication packaging from the cart for Resident 2. She then opened the packaging with her nails then crushed the medication. LPN 2 placed the crushed medication in the medication cup and entered Resident 2's room. She then administered the medication to Resident 2. LPN 2 did not utilize hand hygiene prior to medication preparing nor after administration. At 9:15 a.m., LPN 2 was observed preparing Resident 22's medications. She pulled out the medication from the cart and opened the individual pill packages with her nails. After placement of the medications in the medication cup, she then entered the resident's room. She was observed administering the pill medications, and then left the room. LPN 2 retrieved gloves from CNA 4 and then returned back to Resident 22's room. She donned on the gloves and then administered a nasal spray to the resident. There was no observation of hand hygiene prior to preparing mediations, donning on or off the gloves, administration of the medications, or after administration. After returning to the cart, LPN 2 was observed at 9:27 a.m., preparing Resident 3's medications. She was observed pulling pill bottles from the medication cart. She then opened the pill bottles and emptied each pill from the bottles into a medication cup. After, she entered Resident 3's room and administered the medication. There was no observation of hand hygiene used prior or after administration of medications. At 9:35 a.m., LPN 2 had then returned to her cart and prepared Resident 4's medication. Resident 4			

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	was to receive a patch. LPN 2 had removed the patch from the drawer, and then rode up the elevator to retrieve a pair of scissors from her bag in the nurse's station. She then rode back down on the elevator and returned to the cart. Using the scissors, she cut the packing and dated the patch. There was no hand hygiene observed prior to pulling the patch out of the drawer, riding up and down the elevator or after returning to her cart. She then entered Resident 4's room and assisted with removal of his shirt. She donned on gloves and felt inside Resident 4's t-shirt to remove the old patch from his skin. She then placed the new patch on his right shoulder. LPN 2 then left the resident's room and returned to the cart. There was no hand hygiene observed after using the scissors, prior to donning on or off gloves, touching the resident or after administration of the patch. An interview was conducted with LPN 2 on 4/14/21 at 9:52 a.m. She indicated this was her first day working in the facility. She had not utilized hand hygiene during the medication administrations, because she did not know where any was. LPN 2 indicated she did not want to wash her hands in the residents' apartments. An interview was conducted with the Director of Nursing on 4/15/21 at 9:55 a.m. She indicated the hand sanitizer was in the drawer of the mediation cart. An infection control policy dated 9/1/16 was provided by the Executive Director on 4/14/21 at 10:44 a.m. It indicated "...III. Staff members who provide personal care must carry an antiseptic hand sanitizer with them or utilize the dispensers provided in our communities. A hand sanitizer is not to be used in place of proper hand washing;			

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	however, it should be readily available for staff to use in situations where hand washing facilities or supplies are not immediately available (e.g. [for example] in resident's apartment)..."			
R 9999 Bldg. 00	3.1-14 Personnel (t) A physician examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The tuberculin skin test must be read prior to the employee starting work. 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. 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 employee 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 examination in order to complete a diagnosis. Compliance by licensed Indiana residential care facilities with the specified portions of 410IAC 16.2-5-1.4 ("Personnel") and 410 IAC 16.2-5-12	R 9999	R9999 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Employee #10 was administered 1 st step tuberculin skin test on 5/05/2021 by CSM. (Attachment #10) 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; An audit of employee records was conducted by (CSM) on 5/06/2021 to determine first and second step tuberculin skin test administration. Findings of audits were reviewed with Executive Director. (Attachment #11) 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 Business Office Manager (BOM), ED and CSM were in-serviced on 05/06/2021 by Regional Director of Care Services on two step tuberculin skin test requirements for new employees.	05/21/2021

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	("Infection control") is WAIVED, subject to the specific terms, conditions, and limits set forth below: 1. The Requirement under 410 IAC 16.2-5-1.4 (f)(l) that "[a]t 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" is waived with modifications as follows: Employees and nonpaid personnel shall be screened for tuberculosis within ninety (90) days after the start of employment or nonpaid work with the facility. Subsequent annual screenings are still required. Based on interview and record review the facility failed to provide a first and second step tuberculin test within 90 days of the start of employment for 1 of 5 employee records reviewed (Employee 10) Findings include: The employee record for Employee 10 was reviewed on 4/14/21 at 2:10 p.m. The record indicated that she began employment with the facility on 12/8/2020. The employee record did not contain a record of her receiving a first or second step tuberculin skin test. During an interview on 4/14/21 at 3:25 p.m., the ED (Executive Director) indicated that the facility had no record of Employee 10 receiving a first or second step tuberculin skin test. She had been employed by the facility since 12/8/2020 and worked full time. On 4/14/21 at 3:03 p.m., the ED provided the TB (Tuberculosis) Testing Policy, effective 9/1/2016, which read "Policy: TB testing will be completed		(Attachment #12) 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; and The Executive Director is responsible for sustained compliance. The BOM and/or designee will review two step oppropr;jüt documentation. Audits will be completed weekly for 4 weeks, biweekly for 4 weeks then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. By what date the systemic changes will be completed **05/21/2021**	

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	per state regulations rod residents, staff and volunteers... "			