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	03/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00425925, IN00425552, IN00429132, IN00427955, IN00429127, and IN00428535. Complaint IN00425925 - State deficiencies related to the allegations are cited at R091 Complaint IN00425552- No deficiencies related to the allegations are cited. Complaint IN00429132 - State deficiencies related to the allegations are cited at R036, R240, and R354. Complaint IN00427955 - State deficiencies related to the allegations are cited at R240. Complaint IN00429127 - State deficiencies related to the allegations are cited at R052 and R091. Complaint IN00428535 - State deficiencies related to the allegations are cited at R091 and R240. Survey dates: March 12, 13, 14 and 15, 2024 Facility number: 014279 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 22, 2024	R 0000		
R 0036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lily Price	Executive Director	04/04/2024

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

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Bldg. 00	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify a resident's physician and or psychiatric provider of medication refusals for 1 of 8 resident records reviewed (Resident B); and a resident fall for 1 of 2 closed records reviewed (Resident D). Findings include: 1. The clinical record for Resident B was reviewed on 3/12/24. Resident B's diagnoses included, but not limited to, schizophrenia, schizoaffective disorder, chronic obstructive pulmonary disease (COPD), hypertension, and inadequate sleep hygiene. A SLUMS (Saint Louis University Mental Status) assessment completed on 2/1/24 indicated, Resident B had a mild neurocognitive disorder. Resident B's medication orders were reviewed on 3/12/24 at 11:20 a.m. Resident B's medications included, but not limited to: - melatonin (a sleep aid) 5 mg (milligrams) tablet; take one at bedtime - amlodipine (blood pressure reducing medication) 5 mg tablet; take one once daily - metoprolol (a blood pressure reducing medication) 25 mg; take 1/2 tablet twice daily - quetiapine (antipsychotic) 25 mg; take one tablet	R 0036	**R036** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** a All residents that receive medications administered by the facility had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure the residents physician and/or mental health provider are notified in a timely manner of resident refusal of medication and are notified in a timely manner in the instance of a fall. Employees found to be out of compliance with medication documentation will receive additional education and	06/01/2024

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	at bedtime An interview with Resident B was conducted on 3/12/24 at 10:02 a.m. Resident B indicated, her primary care provider was NP (Nurse Practitioner) 34 at a local health clinic. She also stated, she doesn't need to take any medications other than vitamins because she "doesn't need any". An interview with Resident B's psychiatric service provider (Psych 35) was conducted on 3/13/24 at 1:39 p.m. Psych 35 indicated, Resident B was first referred to them when she was admitted to the facility, but at the time she had refused their services. However, after an incident with another resident, the facility referred Resident B again for their services. Psych 35 indicated, in October of 2023, they started to document their attempts of reaching out to Resident B. It wasn't until January 2024 that Resident B allowed them to gather information needed for their initial evaluation. When asked if they had been made aware of Resident B's refusal of medications, they replied, "if we had been made aware, we would have had an acute visit with her today." An interview with Resident B's Pharmacist (Pharm) 14 was conducted on 3/13/24 at 1:55 p.m.. Pharm 14 indicated, they are the facility's pharmacy which Resident B had used for her medications, but they had not been made aware that Resident B was refusing her medications and would have liked to have known that information. Also, they were unaware of who Resident B's primary care physician was since her last provider had left the facility's providers company some time ago. Pharm 14 indicated, they had continued to send Resident B's maintenance medications to the facility because they didn't want to just cut her off.		corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** a DON and/or designee will ensure the residents physician and/or mental health provider are notified in a timely manner of resident refusal of medication and are notified in a timely manner in the instance of a fall. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part	

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	An interview with LPN (Licensed Practical Nurse) 8 conducted on 3/13/24 at 1:59 p.m. indicated, Resident B had stopped taking her medications (except vitamins) a few months ago. LPN 8 indicated, they have twice faxed Resident B's primary care provider for an order to discontinue her medications related to refusals, but had not received a response. An interview with Pharm 14 conducted on 3/13/24 at 2:52 p.m. indicated, the last time Resident B had seen her primary care provider was on 5/26/23. A nursing note dated 6/28/23 at 8:22 p.m. indicated, "Resident always refuses medications. Says she had no need for them." The nursing note did not indicate if/when Resident B's physicians were notified. A nursing note dated 7/14/23 at 12:29 p.m. indicated, "Resident refused all meds. Said she is fine and has no need for them." The nursing note did not indicate when/if Resident B's physicians were notified. A nursing note dated 12/27/23 at 9:54 p.m. indicated, "Resident refused all her meds." The nursing note did not indicate when/if Resident B's physicians were notified. A nursing note dated 1/7/24 at 1:34 p.m. indicated, "Resident is always refusing all her meds all day." The nursing note did not indicate when/if Resident B's physicians were notified. A nursing note dated 1/10/24 at 9:19 a.m. indicated, "Resident refused all her day medications. Says she has no need for them." The nursing note did not indicate when/if		of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed.** 6/1/24	

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	Resident B's physicians were notified. A nursing note dated 2/9/24 at 11:57 a.m. indicated, "Resident refused all her day meds". The nursing note did not indicate when/if Resident B's physicians were notified. A history and physical report from Resident B's primary care provider was received from NC (Nurse Consultant) on 3/14/24 at 12:02 p.m. It indicated, under Unspecified Psychosis, "Pt [sic, patient] is unfocused, rambles, and goes on tangents. Pt has a hx [sic, history] of unspecified psychosis and had delirium during her stay at the hospital w/[sic, with]covid. Pt mentions multiple conspiracy theories including not wanting the covid-19 vaccine because she is a 'natural woman', nurses from Oasis stealing from her, that the world is changing, etc...". In the physical examination section, it mentioned in the neurologic and psychiatric sections that Resident B was unfocused and rambling during her visit, her insight was questionable and speech was tangential (diverging from a previous course or line, erratic). It further indicated, within the assessments section, under psychosis, Resident B "does not follow w/[sic]psychiatry and has not had a proper psychiatry evaluation. Consider referral at next visit." Resident B's Service Plan dated 5/25/23 was received on 3/12/24 at 2:55 p.m. It indicated, Resident B needed monitoring related to a history of mood disturbance, support related to a diagnosis of schizophrenia and schizoaffective disorder, and refuses medications. Interventions included, but not limited to, monitor for changes in Resident B's usual mood, routine, conversations, and to notify the licensed nurse as needed; and the licensed nurse was to notify			

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	physician and mental health provider of changes in mood and behavior. 2. The clinical record for Resident D was reviewed on 3/12/24 at 10:00 a.m. The diagnoses included, but were not limited to: stroke and type 2 diabetes mellitus. A My Mobile MD [medical doctor] agreement and services form dated 9/19/23 indicated Resident D did want medical provider services by this company. An incident report dated 1/13/24 at 10:31 a.m., indicated Resident D had an unwitnessed fall in his apartment. Nurse Practitioner (NP) 29 was notified by phone on 1/15/24 at 9:00 a.m., about the fall. A nursing progress note dated 1/13/24 indicated, "Writer went to give resident medication and found resident on the floor. Resident stated that while he was trying to transfer himself to the recliner chair to wheelchair resident denials hitting head. No visible injury detected..." An incident report dated 1/16/24 at 12:30 p.m., indicated Resident D had an unwitnessed fall in the bathroom. It did not indicate a medical provider was notified of the resident's fall. A nursing progress note dated 1/16/24 at 2:09 p.m. It indicated "Writer was notified by housekeeping that resident was found on the floor of his bathroom. Writer called for help in lifting him up but resident seemed to be in pain and the nurses called 911 so as to have him sent to hospital for evaluation. Resident however refused to go to the hospital when the EMT [Emergency Medical Technician] arrived. He said he will be fine and just needed help getting off the floor. His vitals checked were stable."			

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	An incident report dated 1/17/24 at 6:30 a.m., indicated Resident D had 2 falls. NP 29 was notified by phone at 9:00 a.m. "...Resident initially refused to go to hospital, upon falling for a 2nd time nurse on duty and EMS [Emergency Medical Services] convinced resident to go be seen for observation at [name of hospital]..." An interview was conducted with License Practical Nurse (LPN) 8 on 3/14/24 at 11:37 a.m. She indicated Resident D's POA (Power of Attorney) wanted NP 29 to be utilized as his medical provider. At that time, she provided the contact number to reach NP 29. The resident had switched medical providers, but was unsure when he had changed. The resident's medical provider at the time of falls could have been NP 26. On 1/17/24, LPN 8 had notified NP 26 of the resident's fall. On 3/14/24 at 11:40 a.m., the contact number provided for NP 29 was contacted. The staff person that answered the phone indicated the phone number was for an Intensive Care Unit; that number was not a contact number to reach NP 29. An interview was conducted with NP 26 on 3/14/24 at 3:00 p.m. He indicated he did not have any record of Resident D on his system as a patient of My MD Mobile. He was unable to pull any information the resident had been seen and/or services had ever been provided to the resident. A Fall Prevention and Management Policy was provided by the Executive Director on 3/13/24 at 3:17 p.m. It indicated...E. The resident's primary care provider shall be notified of any fall event. Any communication with the primary car provider			

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	along with any orders received shall be documented in the resident's medical record..." This tag relates to Complaint IN00429132.			
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on interview and record review, the facility failed to ensure a resident's grievance was addressed that included follow up with the resident for 1 of 14 resident reviewed for grievances. (Resident S) Findings include: During Confidential Interviews, they indicated residents do not fill out grievance forms to address concerns, because the facility does not address them. Confidential Interview 51 indicated, they do not fill out the grievance forms; "It is a waste of time. No one addresses them." The clinical record for Resident S was reviewed on 3/13/24 at 3:00 p.m. The diagnosis included, but was not limited to: cancer. A Level of Service Evaluation for Resident S dated 1/24/24 indicated Resident S was alert and oriented to person place and time. The resident understands information provided to her and her	R 0041	**R041** **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a All residents have the potential to be affected by the alleged deficient practice. No other residents were affected. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a Administrative staff will be educated on the Policy titled Resident Grievance Policy and Procedure. b Executive Director/Designee	06/01/2024

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	judgement was assessed as "Decisions are made in an organized manner, daily routine and decisions are consistent, reasonable, and organized reflecting lifestyle, culture and values." An interview was conducted with Resident S on 3/13/24 at 2:15 p.m. She indicated approximately a week ago, she had turned in a grievances form that included concerns with food that was served in the kitchen regarding a speciality diet needed. She was unable to eat dairy, beef or pork due to her diagnosis. She placed the grievance form in the grievance box on the wall by the Executive Director's office. She indicated she had not receive any follow up on her grievance. An interview was conducted with the Executive Director on 3/13/24 at 2:28 p.m. She indicated she did not have a grievance form for Resident S nor does the dietary manager. The dietary manger has been working with Resident S regarding food preferences, but does not have documentation to provide. She does keep a grievance log when grievances are reported to her, but she does not have individualized grievance forms that included resolutions to the residents' concerns. Some residents voice grievances verbally that are addressed at that time, but she does not always fill out the grievance forms. A January 2024 and February 2024 Grievance Log reports were provided by the Executive Director on 3/13/24 at 3:17 p.m. They indicated the following: The January 2024 grievance log indicated " Date: 1/25/24, Department: Multiple, Concern: bathroom/food choices/elevators, Resolution: addressed w/ [with] resident/family.."		will educate residents on their right to file grievances/how to file grievances at resident council. **3 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** a Administrative staff will be in-serviced on the Resident Grievance Policy and Procedure. b All new administrative staff will be in-serviced on Resident Grievance Policy and Procedure. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date will the systematic changes be completed:** 6/1/24	

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	The February 2024 grievance log indicated "Date: 2/20/24, Department: Dietary, Concern: food/meal service/customer service, Resolution: training on 2/23/24 with dietary staff." The grievance logs did not include residents names, detail of concerns, and resolutions to the concerns were discussed with the resident(s) who had the concerns. An interview was conducted with the Activities Director on 3/14/24 at 3:32 p.m. He indicated he does not routinely fill out grievance forms when residents voice concerns. He notifies the Executive Director verbally when a concern has been brought to his attention. A grievance policy and procedure was provided by Executive Director on 3/13/24 at 3:17 p.m. It indicated "...All residents shall have the right to voice concerns and/or complaints which affect their lives at the facility without fear of discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will initiate the Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint. If such action is not satisfactory to the affected Resident, the Regional Director of Guardant Management Solutions., the management company of the facility, shall further investigate the issue and shall provide the Resident with a written report of his/her analysis and any			

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	corrective action taken. Such a report shall be provided within 10 days of the date of the Administrator's report...The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these records for review by the HFS staff when requested..."			
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 (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident's right to be free from physical abuse for 1 of 8 resident records reviewed. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/12/24. Resident B's diagnoses included, but not limited to, schizophrenia, schizoaffective disorder, chronic obstructive pulmonary disease (COPD), hypertension, and inadequate sleep hygiene. A SLUMS (Saint Louis University Mental Status) assessment completed on 2/1/24 indicated, Resident B had a mild neurocognitive disorder. A nursing note dated 9/25/23 at 9:20 p.m. indicated, Resident B had allegedly been slapped by another resident while outside in front of the facility.	R 0052	**R052** **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a All residents have the potential to be affected by the alleged deficient practice. No other residents were affected. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a Administrative staff will be educated on the Policy titled Abuse, Neglect, and Financial Exploitation Prevention.	06/01/2024

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	An incident report reported to Indiana State Department of Health (IDOH) on 9/26/23 indicated, incident occurred on 9/25/23 at 5:15 p.m. The brief description indicated, Resident P allegedly hit Resident B in the face while sitting outside in from of the facility. Staff intervened and separated the two residents. Resident B had left with a friend in a car following the slap. Resident B was asked if she would like to contact the police, to which she responded, "No, i[sic] don't want to get [sic, Resident P's name] in trouble." The investigation was ongoing. No injuries were noted. The follow up dated 10/2/23 indicated, the police were later contacted by Resident B, the residents were kept separated and no further incidents/contact occurred between residents involved. Resident P was seen by Psychiatric NP (Nurse Practitioner) on 9/28/23 and noted Resident P does not want to harm other residents and denied any thought/ideas to hit/slap anyone else or to further pursue the issue. Resident B voiced potentially getting a protective order against Resident P. Resident B's case manager was to assist Resident B with that process if she chose to move forward. The investigation file for the 9/25/23 incident between Resident P and B was received on 3/13/24 at 11:54 a.m. from ED (Executive Director). It included: a copy of the report sent to IDOH; an emergency printout sheet for Resident B; an emergency printout for Resident P; a copy of Resident B's communication log from 9/25/23 at 9:20 p.m. to 9/26/23 at 7:39 p.m.; a copy of Resident P's communication log from 9/25/23 at 9:16 p.m. to 9/29/23 at 10:53 a.m.; and a statement from ED dated 9/27/23. The investigation file did not contain written statements from one of the staff members involved in separating the residents		**3 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** a All staff will be in-serviced on the Abuse, Neglect, and Financial Exploitation Prevention policy. b All new staff will be in-serviced on the Abuse, Neglect, and Financial Exploitation Prevention policy. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date will the systematic changes be completed: 6/1/24**	

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		A. BUILDING 00 B. WING	03/15/2024

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	nor the resident's who witnessed Resident P slap Resident B. Resident B's communication log from 9/25/23 at 9:20 p.m. to 9/26/23 at 7:39 p.m. included: - A nursing note dated 9/25/23 at 9:20 p.m. indicated, "Writer was notified that res[sic, resident] had allegedly been slapped by another res [sic] while outside, investigation still pending, res case manager had been notified, in house np[sic] for mental health has been notified and md[sic, medical doctor] will be contacted during normal business hours, it is to be said that res[sic] did leave the facility with a family friend after the incident, staff will look out for res[sic]return." - A nursing note dated 9/25/23 at 9:24 p.m. indicated, "F/u [sic, follow-up] res[sic] did return back to facility and res[sic]has no visible injury or complaints of pain from earlier in the evenings incident, re[sic] states that she does feel safe." - A CNA (certified nursing assistant) note dated 9/26/23 at 5:48 p.m. concerning laundry. - A nursing note dated 9/26/23 at 7:39 p.m. indicated, "F/u[sic] incident 9/25. Writer met with res[sic] face to face res[sic] stated: She stated that as she was waiting for her ride, other res[sic] came out of nowhere and slapped her. She stated that she had spoke with to [sic] other resident before about how she should carry herself as a woman and not be asking for sex if in fact that is true what she is doing. [sic, Resident B's first name] states that she will continue to pray and stay away from other resident and states she does feel safe. Resident P's communication log from 9/25/23 at 9:16 p.m. to 9/29/23 at 10:53 a.m. included: - A nursing note dated 9/25/23 at 9:16 p.m. indicated, "Writer was notified that res[sic] allegedly slapped another resident while outside earlier this evening, resident had had no further			

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	contact with res[sic] at [sic] since incident...md[sic], mental health and case management has been made aware, son will be called during appropriate hours." - A nursing note dated 9/26/23 at 7:36 p.m. indicated, "F/u[sic] incident 9/25...Writer did a face to face interview with res[sic] and res[sic] had this to say: She stated that it had been told to her by another resident that other res[sic] had been going around telling people she had been asking men for their private area. She said that while she was outside she went up to the resident and asked her why was she going around saying that, and she said she didn't even let her finish she slapped her and made her head shake. - A Psychiatric note dated 9/29/23 at 10:53 a.m. An interview with ED conducted on 3/13/24 at 4:19 p.m. indicated, on the date of the occurrence she was not present to witness the altercation, but staff called her stating that they were in the parking lot and said that Resident P had hit Resident B in the face. When asked who were the staff members that had separated the two residents, she indicated BOM (Business Office Manager) and DOM (Director of Marketing) saw what happened. An interview with DOM conducted on 3/13/24 at 4:27 p.m. indicated, she had not witnessed Resident P slap Resident B in the face instead she had heard loud voices outside and went out to see what was the commotion. It was then she saw Resident P and B yelling at each other outside in front of the facility. She indicated they were yelling about someone had called the other promiscuous. She stated, they (she and BOM) separated them and Resident P was taken to a different area by BOM and Resident B left in a family member's car.			

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	An interview with BOM conducted on 3/13/24 at 4:31 p.m. indicated, she had not witnessed Resident B being slapped by Resident P instead she stated she heard loud yelling coming through the glass window in her office that faces the front of the building. She stated, Resident P had admitted to her that she slapped Resident B and would do it again. An Abuse, Neglect, and Financial Exploitation Prevention policy received on 3/13/24 at 3:17 p.m. from ED indicated, "Residents of the community have the right to be free of abuse, neglect and financial exploitation." This tag relates to IN00429127.			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation, interview, and record review, the facility failed to: implement their abuse policy by not providing a thorough investigation of resident to resident abuse for 1 of 8 resident records reviewed (Resident B); and to implement the Bed Bug Policy and Protocol by not assuring items were laundered, per protocol, from apartments with bed bugs; not assuring apartments with bed bug activity were swept	R 0091	**R091** **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a All residents have the potential to be affected by the	06/01/2024

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	using the designated vacuum; not posting signage on apartments with bed bugs activity; not providing, using, and disposing of appropriate PPE (Personal Protective Equipment), per protocol; and not providing mattress encasements upon admission, per protocol, for 11 of 11 residents reviewed for bed bugs and the potential to affect 108 of 108 residents residing at the facility. (Resident B, G, K, L, M, N, P, Q, T, W and X). Findings include: 1. The clinical record for Resident B was reviewed on 3/12/24. Resident B's diagnoses included, but not limited to, schizophrenia, schizoaffective disorder, chronic obstructive pulmonary disease (COPD), hypertension, and inadequate sleep hygiene. A SLUMS (Saint Louis University Mental Status) assessment completed on 2/1/24 indicated, Resident B had a mild neurocognitive disorder. A nursing note dated 9/25/23 at 9:20 p.m. indicated, Resident B had allegedly been slapped by another resident while outside in front of the facility. An incident report reported to Indiana State Department of Health (IDOH) on 9/26/23 indicated, incident occurred on 9/25/23 at 5:15 p.m. The brief description indicated, Resident P allegedly hit Resident B in the face while sitting outside in from of the facility. Staff intervened and separated the two residents. Resident B had left with a friend in a car following the slap. Resident B was asked if she would like to contact the police, to which she responded, "No, i[sic] don't want to get [sic, Resident P's name] in		alleged deficient practice. No other residents were affected. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a Administrative staff will be educated on the policy titled Abuse, Neglect, and Financial Exploitation Prevention. b All staff will be educated on the policy titled Bed Bug Policy and Protocol. **3 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** a Administrative staff will be in-serviced on the Abuse, Neglect, and Financial Exploitation Prevention policy. b All new administrative staff will be in-serviced on the Abuse, Neglect, and Financial Exploitation Prevention policy. c All staff will be in-serviced on Bed Bug Policy and Protocol. **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:**	

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	trouble." The investigation was ongoing. No injuries were noted. The follow up dated 10/2/23 indicated, the police were later contacted by Resident B, the residents were kept separated and no further incidents/contact occurred between residents involved. Resident P was seen by Psychiatric NP (Nurse Practitioner) on 9/28/23 and noted Resident P does not want to harm other residents and denied any thought/ideas to hit/slap anyone else or to further pursue the issue. Resident B voiced potentially getting a protective order against Resident P. Resident B's case manager was to assist Resident B with that process if she chose to move forward. The investigation file for the 9/25/23 incident between Resident P and B was received on 3/13/24 at 11:54 a.m. from ED (Executive Director). It included: a copy of the report sent to IDOH; an emergency printout sheet for Resident B; an emergency printout for Resident P; a copy of Resident B's communication log from 9/25/23 at 9:20 p.m. to 9/26/23 at 7:39 p.m.; a copy of Resident P's communication log from 9/25/23 at 9:16 p.m. to 9/29/23 at 10:53 a.m.; and a statement from ED dated 9/27/23. The investigation file did not contain written statements from one of the staff members involved in separating the residents nor the resident's who witnessed Resident P slap Resident B. Resident B's communication log from 9/25/23 at 9:20 p.m. to 9/26/23 at 7:39 p.m. included: - A nursing note dated 9/25/23 at 9:20 p.m. indicated, "Writer was notified that res[sic, resident] had allegedly been slapped by another res [sic] while outside, investigation still pending, res case manager had been notified, in house np[sic] for mental health has been notified and md[sic, medical doctor] will be contacted during		a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date will the systematic changes be completed: 6/1/24**	

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	normal business hours, it is to be said that res[sic] did leave the facility with a family friend after the incident, staff will look out for res[sic]return." - A nursing note dated 9/25/23 at 9:24 p.m. indicated, "F/u [sic, follow-up] res[sic] did return back to facility and res[sic]has no visible injury or complaints of pain from earlier in the evenings incident, re[sic] states that she does feel safe." - A CNA (certified nursing assistant) note dated 9/26/23 at 5:48 p.m. concerning laundry. - A nursing note dated 9/26/23 at 7:39 p.m. indicated, "F/u[sic] incident 9/25. Writer met with res[sic] face to face res[sic] stated: She stated that as she was waiting for her ride, other res[sic] came out of nowhere and slapped her. She stated that she had spoke with to [sic] other resident before about how she should carry herself as a woman and not be asking for sex if in fact that is true what she is doing. [sic, Resident B's first name] states that she will continue to pray and stay away from other resident and states she does feel safe. She mentioned that last night the police did come to the facility and suggested her to file a protection order which she plans on doing(not sure when). I did advise her to give copies to facility when she does. I asked if she would tell me who these men were that had come to her and told her about other resident and she stated that she did not want to get no one else involved. Writer informed resident that she will be followed and seen by mental health np[sic] on Thursday [sic] she agreed but stated she did not want to sign anything but understands and appreciated me stopping by." Resident P's communication log from 9/25/23 at 9:16 p.m. to 9/29/23 at 10:53 a.m. included: - A nursing note dated 9/25/23 at 9:16 p.m. indicated, "Writer was notified that res[sic] allegedly slapped another resident while outside			

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	earlier this evening, resident had had no further contact with res[sic] at [sic] since incident...md[sic], mental health and case management has been made aware, son will be called during appropriate hours." - A nursing note dated 9/26/23 at 7:36 p.m. indicated, "F/u[sic] incident 9/25...Writer did a face to face interview with res[sic] and res[sic] had this to say: She stated that it had been told to her by another resident that other res[sic] had been going around telling people she had been asking men for their private area. She said that while she was outside she went up to there resident and asked her why was she going around saying that, and she said she didn't even let her finish she slapped her and made her head shake. She also admitted to asking another resident for a knife, I asked resident did she feel safe and she stated yes that she was not worried about other res[sic] anymore and will stay away from her...res[sic] does not have any harmful objects to harm self or anyone else, no knife was retrieve[sic] nor give to resident..." - A Psychiatric note dated 9/29/23 at 10:53 a.m. The statement from the ED dated 9/27/23 indicated, ED sampled a random selection of 7 residents and inquired if they felt safe and their current needs were being met. ED met with Resident P to follow up on the situation and the concerns of the knife. Resident P "only had small cooking knife and insisted she would not give it to resident [sic, Resident P's initials]. ED asked resident if she could take the knife for safekeeping and resident refused." An interview with ED conducted on 3/13/24 at 4:19 p.m. indicated, the investigation file for the occurrence on 9/25/23 between Resident B and P received on 3/13/24 from herself was the complete			

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	investigation file. ED indicated, on the date of the occurrence she was not present to witness the altercation, but staff called her stating that they were in the parking lot and said that Resident P had hit Resident B in the face. When asked who were the staff members that had separated the two residents, she indicated BOM (Business Office Manager) and DOM (Director of Marketing) saw what happened. When asked why she didn't include their witness statements, ED replied, she thought they were in with the investigation file and will have to look for them. ED indicated, she did not have any of other residents' witness statements. An interview with DOM conducted on 3/13/24 at 4:27 p.m. indicated, she had not witnessed Resident P slap Resident B in the face instead she had heard loud voices outside and went out to see what was the commotion. It was then she saw Resident P and B yelling at each other outside in front of the facility. She indicated they were yelling about someone had called the other promiscuous. She stated they (she and BOM) separated them and Resident P was taken to a different area by BOM and Resident B left in a family member's car. When asked if she had written a witness statement regarding the incident, she replied, "I don't believe I have a written statement at the time of incident". When asked how she knew that Resident P had slapped Resident B, she indicated, Resident P admitted to it. When asked if other residents were around when the incident occurred, she stated yes but could not remember exactly who was there. An interview with BOM conducted on 3/13/24 at 4:31 p.m. indicated, she had not witnessed Resident B being slapped by Resident P instead she stated she heard loud yelling coming through			

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	the glass window in her office that faces the front of the building. She stated, Resident P had admitted to her that she slapped Resident B and would do it again. BOM indicated, there were so many residents outside when the incident occurred because it was a nice day. She gave two resident's last names that she indicated may have been outside when the incident occurred. An Abuse, Neglect, and Financial Exploitation Prevention policy received on 3/13/24 at 3:17 p.m. from ED indicated, "Residents of the community have the right to be free of abuse, neglect and financial exploitation...Investigation The Department Manager along with the Administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator."2. On 3/12/24 at 10:02 a.m., Resident B was observed sitting on a bench in the hallway. Resident B had small, apple seed shaped, reddish- brown bugs which were crawling on her clothing and hair. Resident B indicated that the "whole place" had bed bugs. During a tour of the facility on 3/12/24 at 10:48 a.m., Resident K's room had a white plastic laundry hamper with clothing in it sitting outside the door in the hallway. LPN (Licensed Practical Nurse) 5 indicated that Resident K's room had an active bed bug issue and that the laundry basket with dirty clothing should not be sitting in the hallway. LPN 5 removed the basket from the hall and placed it inside of Resident K's apartment door. On 3/12/24 at 3:20 p.m., the ED (Executive			

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	Director) provided the pest control treatment log for 2024. The log indicated, but was not limited to, the following: 1/2/24- Resident K had light bed bug activity on mattress, which was treated by extermination company 50, 1/9/24- Resident K had second bed bug treatment to bed, 1/24/24- Resident L received a follow up bed bug treatment, 2/6/24- Resident K had light bed bug activity on bed, which was treated by extermination company 50, 2/13/24- Resident K had bed bug activity on sheets. suggested replacing mattress and foundation, treatment provided by extermination company 50. 2/13/24- Resident Q has significant bed bug activity on bed. Suggested heat treatment. The apartment had a lot of stuff, the admin would reach out to family. 2/15/24- Resident X's apartment inspected. Bed bugs observed at the head of bed. Apartment sprayed, containment and treatment were challenging due to clutter. Would be discussed with ED. 2/20/24- Resident B apartment not treated for bed bugs due to excessive clutter. ED was informed of the situation. 2/20/24- Resident X significant live activity on bed frame. Extermination company 50 treated and family member spoken to about getting a mattress encasement. 2/27/24- Resident K indicated they were still seeing evidence of bed bug infestation. The mattress was treated and suggested replacing bed frame. 2/27/24- Resident P had live bed bug activity on the floor around bed. Extermination company 50			

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	treated. Resident P would do own laundry. 2/27/24- Resident X mattress did not have encasement. Resident X was encouraged to contact her family. 3/5/24- Resident P bed bug follow up done with some activity on bed. The extermination company sprayed mattress and frame. Would talk with ED about replacing the bed. 3/5/24- Resident L met with ED to discuss treatment options. 3/6/24- Resident K and Resident P met with ED to discuss next steps in treatment of bed bugs, including the need to replace the beds in both apartments. 3/7/24- Resident T indicated they were getting bitten by bugs. Inspected the bed and recliner and saw no evidence of bed bugs. Sprayed the bed frame as a precaution. 3/12/24- Resident K had bed bug activity on the chair the room. Resident encouraged to remove cover on the chair so it could be treated. 3/12/24- Resident P had mattress and bed frame treated by extermination company 50. 3/12/24- Resident M had new bed bug activity in both recliners. Extermination company 50 treated. 3/12/24- Resident T's apartment was inspected by extermination company 50 and treated as a precaution. During an interview on 3/13/23 at 9:45 a.m., Resident K indicated she had a problem with bed bugs. The facility had placed a mattress encasement on her mattress on 3/12/24, but she was still getting bitten. Resident K's mattress was observed covered in a white encasement. The bed frame was observed to have dark brown spots of various sized all over the surface of bed frame close to the mattress. On 3/13/24 at 1:50 p.m., the maintenance room was			

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		A. BUILDING 00 B. WING	03/15/2024

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	observed with the DOM (Director of Maintenance). The DOM indicated that his bed bug treatment supplies were kept in a large bucket. The bucket was observed to have black trash bags and 2 cans of bug killing spray. The DOM indicated that the PPE used during treatment was kept by the nurses on the different floors of the facility. When bed bugs were reported, the DOM would go to the room and inspect. If there was activity noted, then the DOM would spray the area of activity with the appropriated bug killing spray and bag the bed linens for the nursing staff to launder in the designated bed bug washer and dryer. The nursing staff would bag the clothing that needed laundering and would vacuum the apartment using the bed bug vacuum. The DOM indicated the facility did have a designated bed bug vacuum. The designated bed bug vacuum was observed to be empty. The DOM indicated it was not always used, it depended on the room. During an interview on 3/13/24 at 1:53 p.m., the (DOM) Director of Maintenance indicated that Resident B's room had not been treated for bed bugs due to the amount of "stuff" in the room. Resident B would not give permission for her belongings to be gone through. The DOM was not aware that she was sitting on furniture in the common area. The DOM did not believe Resident X had been given a mattress encasement by the facility. The DOM had spoken with Resident X's family about the mattress encasement. Resident Q's apartment had not been treated due to the amount of belongings they had. Resident Q and Resident M were related and visited each other often and the DOM felt that the bed bug activity in Resident M's apartment was due to the bed bugs being brought from Resident Q's apartment and Resident M had been made aware. Resident			

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	K had been given a mattress encasement by the facility on 3/12/24. During an interview on 3/13/24 at 3:15 p.m., the ED indicated some of the residents at the facility had very cluttered rooms and the 2 extermination companies the building used to treat bed bugs would not treat the rooms due to the clutter. The facility had reached out to the families and case workers about the clutter so that the rooms could be treated. The ED did feel there was a problem with bed bugs at the facility. The ED had not been made aware that Resident X did not have a mattress encasement and would have liked to have known. The facility had provided mattress encasements for residents in the past. During an interview on 3/14/24 at 9:28 a.m., PCT (Pest Control Technician) 33 indicated he worked with the facility in the treatment of bed bugs. When bed bugs were suspected, the DOM at the facility would inspect the room and contact PCT 33 for treatment. PCT 33 was at the facility at least once weekly and had encouraged the facility to use bed bug encasements on the mattresses to cut down on the number of bed bugs in the direct area of infestation. Lately, PCT 33 had seen an increase in bed bug activity at the facility. PCT 33 recommended vacuuming the dead bugs and also the items which were being treated for bed bugs. The vacuum needed to be emptied outside of the facility after being used for bed bugs. The bed bugs could go under the base boards and into the next apartment, which could be part of the reason for the increased activity. On 3/14/24 at 10:30 a.m., Resident G indicated his apartment had been treated many times for bed bugs, but they just came back. He did not feel he every really got rid of them. He was on his 3rd			

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	mattress due to bed bugs. The only people Resident G let into his room were the housekeeping staff. Resident G did his own laundry, and no one had told him how to launder his clothes after being treated for bed bugs. He felt that other residents with bed bugs were coming out to the common areas and sitting on furniture, and the bed bugs were just being spread from one resident to the other. On 3/14/24 at 11:06 a.m., the Maintenance Assistant indicated that there were full body covering suits in the maintenance department to be worn while dealing with bed bugs. The Maintenance Assistant produced a full body suit still in the package, to be used as PPE for a bed bug room. He also had a full body suit he had worn once to assist in taking a furniture item out of a room with bed bugs. The Maintenance Assistant indicated he had kept the used full body suit because it had only been used once, in case he needed to wear it again. An anonymous interview was conducted during the course of the survey, they indicated the residents who had bed bugs bagged their own clothing and nursing would wash the clothing in the bed bug washer and dryer. Only the staff had access to the bed bug washer and dryer. They had never seen signage place on any room which indicated to see maintenance prior to entry. They were unaware that Resident B or Resident L had bed bug activity in their apartments. The nursing staff would wear plastic gowns and shoe covers when going into known bed bug rooms. There were no full body suits available to use when going into rooms with bed bugs. The nursing staff did not vacuum the apartments or clean for bed bugs.			

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	On 3/15/24 at 10:39 a.m., Resident T's room was observed. There was not a bed bug encasement on her box springs. On 3/15/24 at 10:45 a.m., Resident W's apartment was observed. Resident W's mattress did not have a bed bug encasement on his mattress. Resident W indicated the facility had not given him one when he was admitted. on 3/4/24. On 3/15/24 at 12:15 p.m., a live bed bug was observed crawling on the base board in the hallway outside of Resident K's room. During an interview on 3/15/24 at 12:17 p.m., LPN 7 indicated that live bed bugs could be seen in the hallway at times. On 3/15/24 at 12:25 p.m., a group of 7 small live bed bugs were observed in a corner of the base board outside of Resident Q's room. During an interview on 3/15/24 at 12:25 p.m., Case Manager 36 indicated he had received complaints about bed bugs from many of the residents. CM 36 had received complaints about live bed bug activity on the second, third, and forth floors of the facility. One of the residents he sees had been treated for bed bugs in their apartment by the facility many times and continued to have re-infestations. The resident decided to contact an outside vendor to treat for bed bugs since what the facility had done did not seem to get rid of them. During an interview on 3/15/24 at 12:36 p.m., Housekeeper 28 indicated the housekeeping staff did not use the bed bug vacuum when cleaning rooms with known bed bugs.			

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	On 3/15/24 at 12:45 p.m., a dead bud bug was observed in the resident's laundry room on the 2nd floor. On 3/15/24 at 1:05 p.m., a live bed bug was observed on the base board in the 400 hallway with QMA (Qualified Medication Aide) 30. QMA 30 indicated the live bug was a bed bug. On 3/12/24 at 3:20 p.m., the ED provided the Bed Bug Policy and Protocol, last revised 8/2023, which read "... The purpose of this policy is to set a standard to aid in the prevention and remedy of bed bug infestations in the community...Scope Measures apply to all residents with known or suspected bed bugs. Protocol and Check list... If a unit is suspected of having bed bugs, complete the following items...B. Request the resident receive shower and freshly laundered, heated clothes. Ensure a person-centered approach to allow the resident to still participate in opportunities for engagement in the community while minimizing the spread of the infestation. C. Place appropriate signage on the door. Signage [Stop Sign: Check in with Maintenance Director Prior to Entry]. D. Call the designated pest control vendor to ask for an immediate inspection and treatment if necessary. E. Gather designated team members to begin process of turning over unit...Infestation Control Process A. Have staff members don appropriate and available PPE [head to toe suits, booties, hair cover, gloves) ...B. When discarding PPE, remove inside the unit near the door and place in a sealed bag that can be disposed of directly in the dumpster. C. Bring pre-treated bed bug cart into unit. D. Bed Bug Cart Supplies [alcohol, large black garbage bags, personal protective equipment, tape to seal, etc.] E. Begin the bagging process. For items that can be discarded, place in a sealed bag and take			

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	directly to the dumpster. For items that need to be laundered, seal in bag and leave in unit until it can go directly into the laundry room. These can be double bagged and sealed. The bags need to stay within the unit until a dryer is available for heat treatment. If the bags are placed in a plastic cart for transport to the laundry room, the cart will need to be treated...G. All discovered bed bugs need to be sealed in a bag and discarded in the dumpster immediately...I. Launder process. Dry on high heat for a minimum of 30 minutes. Wash and then dry on high heat again. Take the used garbage bags directly outside for disposal... Reseal laundered items in bags until second spray treatment process occurs in the unit. There can be one accessible bag left available for the resident to access clothing until the second spray treatment. J. Vacuuming process. Each community is to have a designated vacuum for bed bugs. After vacuuming the unit, it should be emptied outside the building into a sealed bag. This then goes directly into the dumpster...L. Based on the extent of the infestation and the recommendations from the pest control professional, it may be necessary to treat common areas...M. If expected results are not achieved by the current pest control vendor, change vendors...Continued Monitoring and Practices...C. Schedule routine community inspections using an interdisciplinary team of trained staff members...D Residents with a cluttered space will need continued follow up and education on the importance in removing unnecessary items and rubbish...G. Provide mattress encasements to new admissions along with inspecting items prior to entry..." This tag relates to complaint IN00424925, IN00429127, and IN00428535.			

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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 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			

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	loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure each employee of the facility at the time of employment were screened for tuberculosis using the 2-step method Mantoux test for health care workers who had not had a documented negative tuberculin skin test during the preceding twelve months for 2 of 5 employee records reviewed. Findings include: The Residential Care Employee Records were provided on 3/14/24. 1. LPN (Licensed Practical Nurse) 7 was hired on 9/26/23. A copy of LPN 7's Tuberculosis (TB) Skin Test Screening record was provided by BOM on 3/15/24. It indicated, LPN 7 received the first TB skin test on 9/22/23 and was read on 9/26/23 which was past the normal range of 24 to 72 hours to be read. LPN 7's second step TB skin test was performed on 9/27/23 and read on 9/30/23. The second step TB skin test was to be performed one to three weeks after the first step TB skin test. LPN 7's second step TB test was administered too early. 2. Dietary Aide (DA) 37 was hired on 11/6/23. A copy of DA 37's first step TB skin test was received on 3/15/24 from BOM. The form indicated the first step TB skin test was administered on 10/11/23 and was read on 10/14/23 at 5:01 p.m. An interview with BOM (Business Office Manager) conducted on 3/15/23 indicated, they were unable to find proof of DA 37's second step TB skin test results.	R 0121	**R121** **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a All residents have the potential to be affected by the alleged deficient practice. No other residents were affected. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a Nursing staff (RN/LPN) and Business office staff will be educated on the policy titled Tuberculosis Skin Testing and Follow Up. **3 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** a Nursing staff (RN/LPN) and Business office staff will be in-serviced on the Tuberculosis Skin Testing and Follow Up Policy. **4 How the corrective**	06/01/2024

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			action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date will the systematic changes be completed: 6/1/24**	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed ensure a resident signed the service plan for	R 0214	**R214** **1 What corrective**	06/01/2024

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	1 of 5 resident reviewed for service plans (Resident F). Findings include: The clinical record for Resident F was reviewed on 10/12/23 at 9:55 a.m. The Resident's diagnosis included, but were not limited to, hip pain and hypertension. A Resident Service Plan, last updated 1/1/23, did not contain the signature of Resident F or Resident F's guardian. During an interview on 3/13/24 at 9:55 a.m., Resident F indicated she did not know what a service plan was and that she had never signed one. During an interview 3/15/24 at 2:35 p.m., the Regional Nurse Consultant indicated that the Resident Service Plans should be reviewed and signed by the resident and/ or the guardian. On 3/14/24 at 11:28 a.m., the Executive Director provided the Service Plans policy, last revised 6/22/22, which read "... 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..."		**action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** a All residents had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure the resident service plans are reviewed and signed by the resident, in a timely manner. Employees found to be out of compliance with medication documentation will receive additional education and corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** a DON and/or designee will ensure the resident service plans are reviewed and signed by the resident, in a timely manner. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee	

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			will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed.** 6/1/24	
R 0240	410 IAC 16.2-5-4(d) Health Services - Deficiency			

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Bldg. 00	(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to: address a resident's change of condition timely for 1 of 1 residents reviewed for falls; ensure residents that utilize the facility's pharmacy services are provided all medications that are ordered for 1 of 5 residents reviewed (Resident D and C); and to implement the Resident Service Plan for licensed nurses to follow up with medication management for 1 of 5 resident reviewed for service plans (Resident F). Findings include: 1. The clinical record for Resident D was reviewed on 3/12/24 at 10:00 a.m. The diagnoses included, but were not limited to: stroke and type 2 diabetes mellitus. A Slums (The Saint Louis University Mental Status) Examination dated 8/8/23 indicated the assessment had determined Resident D had dementia. A Level of Service Evaluation for Resident D dated 11/8/23 indicated Resident D was disoriented 3 or more days of a week and was not able to independently function. The resident's judgement was "Organized daily routine and makes safe decisions in familiar situations. Experiences difficulty in decision-making when faced with new tasks or situations." A My Mobile MD [medical doctor] agreement and services form dated 9/19/23 indicated Resident D did want medical provider services by this company.	R 0240	**R240** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** a All residents had the potential to be affected by the alleged deficient practice. DON and/or designee will in-service clinical staff on procedures of addressing changes in a resident condition, in a timely manner, ensuring timely medication delivery and properly implementing the Resident Service Plan. DON and/or designee will audit nursing notes for correct notifications following a residents change in condition. DON and/or designee will check cycle fill delivery to ensure proper delivery to the proper resident. DON and/or designee will ensure the Resident Service Plan is equivalent to the current administration level in the EMAR. Employees found to be out of compliance with medication documentation will receive	06/01/2024

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	An incident report entered by License Practical Nurse (LPN) 8 dated 1/13/24 at 10:31 a.m., indicated Resident D had an unwitnessed fall in his apartment. Nurse Practitioner (NP) 29 was notified by phone on 1/15/24 at 9:00 a.m., about the fall. Resident's pain level was zero, but was confused and disoriented. A nursing progress note Qualified Medication Aide (QMA) 23 dated 1/13/24 indicated, "Writer went to give resident medication and found resident on the floor. Resident stated that while he was trying to transfer himself to the recliner chair to wheelchair resident denials (sic) hitting head. No visible injury detected..." An incident report written by QMA 30 dated 1/16/24 at 12:30 p.m., indicated Resident D had an unwitnessed fall in the bathroom. Resident's pain was assessed as zero, and he was alert and oriented. The incident report did not indicate a medical provider and/or facility staff nurse was notified of the resident's fall. A nursing progress note by QMA 30 dated 1/16/24 at 2:09 p.m., indicated "Writer was notified by housekeeping that resident was found on the floor of his bathroom. Writer called for help in lifting him up but resident seemed to be in pain and the nurses called 911 so as to have him sent to hospital for evaluation. Resident however refused to go to the hospital when the EMT [Emergency Medical Technician] arrived. He said he will be fine and just needed help getting off the floor. His vitals checked were stable." An incident report dated written by LPN 8 1/17/24 at 6:30 a.m., and revised at 5:00 p.m., indicated Resident D had 2 falls. NP 29 was notified by phone at 9:00 a.m., of a fall. "...Resident initially		additional education and corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** a All clinical staff will be re-educated and in-serviced on procedures of addressing changes in a residents' condition, in a timely manner, ensuring timely medication delivery and properly implementing the Resident Service Plan no later than 06/01/24. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part	

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	refused to go to hospital, upon falling for a 2nd time nurse on duty and EMS [Emergency Medical Services] convinced resident to go be seen for observation at [name of hospital]..." A nursing progress note by QMA 19 dated 1/17/24 at 6:30 a.m., indicated "Writer was notified by the CNA [Certified Nursing Aide] that resident was on the floor. Paramedic were called for lift assistance. Resident refused to go to the hospital. Resident Family unreachable..." A nursing progress note dated 1/17/24 at 5:00 p.m., indicated "...Resident found on floor during med pass. c/o [complaints of] pain to RLE [right lower extremity] resident alert, but disoriented. Resident sent to [name of hospital] for eval [evaluation] and treat [treatment] of rt [right] side pain..." A 1/16/24 worked scheduled was provided by the Nurse Consultant on 1/13/24 at 2:00 p.m. It indicated the following staff worked that day included, but was not limited to: LPN 7, LPN 8, and QMA 30. During an entrance tour with LPN 8 on 3/12/24 at 10:48 a.m., she indicated the facility does not currently have a Director of Nursing. Resident D had discharged to the hospital in January 2024. He kept falling, but continued to refuse to go to the hospital. She had convinced him to finally go due to having complaints of leg pain after a fall. The hospital staff had reported he did not have a leg fracture, but he did have pneumonia. Resident D a few days later had passed away in the hospital. An interview was conducted with License Practical Nurse (LPN) 8 on 3/14/24 at 11:37 a.m. She indicated Resident D's POA (Power of		of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed.** 6/1/24	

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	Attorney) wanted NP 29 to be utilized as his medical provider. At that time, she provided the contact number to reach NP 29. The resident had switched medical providers, but was unsure when he had changed. The resident's medical provider could have been NP 26. On 1/17/24, LPN 8 had notified NP 26 of the resident's fall. On 3/14/24 at 11:40 a.m., the contact number provided for NP 29 was contacted. The staff person that answered the phone indicated the phone number was for an Intensive Care Unit; that number was not a contact number to reach NP 29. An interview was conducted with Housekeeper 28 on 3/14/24 at 10:54 a.m. She indicated she had heard Resident D yelling from the hallway on 1/16/24. After entering the room, she had observed the resident on the floor in the bathroom. The resident had hit his head. She reported to his QMA about the fall. The resident had refused to go to the hospital at that time. Later that evening, she went back into his room to see if he wanted his apartment to be cleaned. He denied the cleaning at that time. It was not like him to refuse cleaning. The resident was observed to be "zoned out." He was sitting in his chair just staring off. He was not acting like his normal self. She immediately reported the change in the resident to his QMA. The QMA stated she also had notice the resident was not acting right and had reported it to the nurse. The next day, after falling again he finally agreed to go to the hospital. An interview was conducted with QMA 30 on 3/14/24 at 11:35 a.m. She indicated she does not recall Resident D falling or creating a fall incident report that included nursing progress notes for			

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	Resident D on 1/16/24. An interview was conducted with LPN 8 on 3/13/24 at 2:50 p.m. She indicated she had been working on a medication cart on 1/16/24; LPN 7 would have been the nurse that assessed Resident D after his fall that day. QMAs at times, do think they are able to send residents out to the hospital without reporting to the nurse staff. On 1/17/24, LPN 8 had talked to Resident D and convinced him to go to the hospital after falling a second time. She had thought the resident had broken his leg due to complaints of leg pain. She had notified NP 26 of the resident's fall. An interview was conducted with NP 26 on 3/14/24 at 3:00 p.m. He indicated he did not have any record of Resident D on his system as a patient of My MD Mobile. He was unable to pull any information the resident had been seen and/or services had ever been provided to the resident. An interview was conducted with LPN 7 on 3/15/24 at 9:15 a.m. She indicated she can not recall Resident D falling on 1/16/24. If she did not sign the resident's fall incident report on 1/16/24; its possible the incident was not even reported to her. A Fall Prevention and Management Policy was provided by the Executive Director on 3/13/24 at 3:17 p.m. It indicated...C. Upon a resident fall event, an immediate assessment (if by a licensed clinician) and/or evaluation (if by a non-licensed, trained staff member) of the resident will be completed to determine any possible injury. The license nurse at the Community shall be promptly notified and consulted as appropriate. any injuries noted shall be communicated to the Community licensed nurse for consideration of further			

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	direction. Any post fall interventions determined shall be implemented and documented in the medical record, if applicable...E. The resident's primary care provider shall be notified of any fall event. Any communication with the primary car provider along with any orders received shall be documented in the resident's medical record..." A Change in Condition policy was provided by the Executive Director on 3/13/24 at 3:12 p.m. It indicated "...when a resident exhibits a change in condition, action will be taken to coordinate appropriate care. Procedure: A. All Community staff are responsible for promptly communicating any change in condition that is reported by a resident, loved one, and/or noted by any employee to the Director of Nursing, or designee. B. An acute change in condition is a sudden, clinically notable change from a resident's baseline in physical, cognitive, behavioral, and/or functional domains. C. If a change in status progresses to an emergency at any time, call 911. D. Examples of change in condition may include, but is not limited to...15. Falls..." 2. The clinical record for Resident C was reviewed on 3/12/24 at 2:30 p.m. The diagnosis included, but was not limited to: hypertension. A Slums (The Saint Louis University Mental Status) Examination dated 1/30/24 indicated the assessment had determined Resident C had mild cognitive impairment. A Level of Service Evaluation for Resident C dated 3/12/24 indicated Resident C was oriented to person, place and time. The resident's judgement was "Organized daily routine and makes safe decisions in familiar situations. Experiences difficulty in decision-making when			

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	faced with new tasks or situations." The resident's service plan dated 12/7/23 indicated "...Medication. [Resident C] needs assistance with ordering and setting up medication...Community pharmacy will set up medications per physician orders and deliver medications in multi-dose container..." A self medication assessment for Resident C dated 2/12/24 indicated the resident was able to self medicate independently. A physician order dated 1/24/24 indicated Resident C was to receive 5 milligrams of amlodipine daily. A physician order dated 2/16/24 indicated Resident C was to receive 1% of clotrimazole cream twice a day as needed. During an interview with Resident C on 3/12/24 at 2:30 p.m., the resident indicated she had recently changed pharmacies and had started using the pharmacy the facility uses to receive her medications. She does receive her medication supply, but there was a lengthy delay in getting her blood pressure medication (amlodipine) and her clotrimazole cream. Resident C had taken her blood pressure medication on 1/24/24, and then did not receive another supply until the end of February 2024. She normally goes down to the nurse's station to get her medication supply on Fridays. She does not know most of the staff's names. A Qualified Medication Aide (QMA) had delivered the amlodpine to her when she located it in another resident's medication storage box in his or her room. It was given to another resident by error. Then the clotrimazole cream was ordered on 2/16/24 by the physician, and she had just			

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	received the cream on Monday, 3/11/24. There are long delays in getting all her medications at times. A nursing progress note written by License Practical Nurse (LPN) 7 dated 2/28/24, indicated "Writer spoke with pharmacy and they stated that all of resident's medication was delivered 1-26-24 and 2-4-24." An interview was conducted with LPN 7 on 3/13/24 at 2:50 p.m. She indicated Resident C had not expressed to her she was missing any medications. She was unsure why she had spoken to the pharmacy on 2/28/24 regarding Resident C's medications. An interview was conducted with Pharmacy Staff Person 40 on 3/13/24 at 9:48 a.m. She indicated Resident C's entire medication regimen was sent out by carrier to the facility on 2/2/24. An interview was conducted with Pharmacy Staff Person 27 on 3/14/24 at 9:48 a.m. She indicated Resident C's clotrimazole was ordered on 2/16/24. It would have shipped by carrier that next morning or the next day at the latest. The facility does not use mail service to receive the medications unless out of stock. A carrier brings the medications to the facility. There was no reason why Resident C would not have not received the cream earlier than 3/11/24; unless it was sitting at the nurse's station. An interview was conducted with LPN 8 on 3/14/24 at 10:00 a.m. She indicated she was unsure why there was a delay with delivering Resident C's clotrimazole cream and amlodpine medication. The night nursing staff distribute the residents' medications that are independent with medications. She was unable to locate the QMA that found the amlodipine medication, and			

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	delivered it to the resident. The facility currently does not have a Director of Nursing. The staff do not have the residents sign anything they received their medications. "Maybe we should start." A pharmacy services policy was provided by Executive Director on 3/14/24 at 11:28 a.m. It indicated "...Purpose: The following minimum standard guidelines are intended to serve as a basic guide for the provision of pharmacy services in the Community. Policy: A. Residents who self-medicate may keep and use prescription and nonprescription medications in their apartment as long as they keep them secured from other residents. B. Our Community controls, handles, and administers medications for a resident if medication management is needed. Medication management includes, but is not limited to: Ensuring that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana..."3. The clinical record for Resident F was reviewed on 10/12/23 at 9:55 a.m. The Resident's diagnosis included, but were not limited to, hip pain and hypertension. A Resident Service Plan, last updated 1/1/23, indicated Resident F needed assistance of a licensed nurse to follow up with prescribers as needed for medication management. A physician's order, dated 3/20/23, indicated Resident F was to receive Celecoxib (anti-inflammatory medication) 200 mg capsule once daily. The March 2024 MAR (Medication Administration Record) indicated that Resident F had not received on 3/1, 3/2, 3/3, 3/11 and 3/12/24			

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	due to the medication being unavailable. During an interview on 3/13/24 at 9:55 a.m., Resident F indicated she no longer took Celecoxib due to the medication having a bad effect on her liver. During an interview on 3/13/24 at 4:20 p.m., Pharmacist 31 indicated the Celecoxib needed prior authorization and it had not been filled since May 2023. During an interview on 3/14/24 at 11:30 a.m., LPN 8 indicated that Resident F's Celecoxib need prior authorization before it could be filled by the pharmacy. LPN 8 was unaware that Resident F had not received the medication since May 2023, or that Resident F was no longer to receive the medication. The Celecoxib order should have been clarified with Resident F's physician. This tag relates to Complaints IN00429132, IN00428535, and IN00427955.			
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			

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	permitted. Based on observation, interview, and record review, the facility failed to ensure prescription drugs labels were affixed to medications and included: the resident's full name; physicians name; a prescription number; directions for use; date of issue and expiration; and name and address of the pharmacy that filled the prescription for 1 of 1 medication rooms reviewed at the facility. (Facility) Findings include: A Medication Storage observation was conducted with LPN (Licensed Practical Nurse) 8 on 3/14/24 at 9:58 a.m. Inside the medication room, the medication refrigerator's thermometer that was inside the fridge read 60 degrees Fahrenheit and the following was found: - An unopened vial of Zofran (anti-nausea medication) 4 mg (milligrams) per 2 ml (milliliters) without a resident label affixed. - An opened vial of Lispro insulin without an opened date nor a resident label affixed. - Two opened tubersol vials (used for TB skin tests) containing 5 tu (tuberculin units) per 0.1 ml. Neither vial had an opened date. - An opened vial of lidocaine (anesthetic) for Resident X without an opened date. In a cabinet inside the medication room was an unopened box containing a vial of Tubersol. The Tubersol medication box indicated, to keep medication stored between 2 and 8 degrees Celsius or 35 to 46 degrees Fahrenheit. In a cabinet under the sink within the medication room was a plastic lined box approximately	R 0301	**R301** **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken.** a **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** a b a This process will be reviewed by DON/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date will the systematic changes be completed.** 6/1/24	06/01/2024

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	measuring 10 inches wide by 12 inches long and 5 inches deep that contained loose pills that covered the entire bottom of the box and was approximately an inch deep. The box was labeled "meds to be destroyed". A Medication Management, Administration, & Storage policy received on 3/14/24 at 8:59 a.m. indicated, "Deliveries from the Pharmacy...4. Upon delivery, the licensed nurse of QMA [sic, Qualified Medication Aide] will verify that the medication is labeled with the appropriate resident's name and apartment number."			
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: (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 and interview, the facility failed to ensure: expired medications were disposed of timely; the medication room was appropriately locked at all times; expired supplies were disposed of and not available for continued use; and the disposition of medications for	R 0306	**R306** **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/01/2024

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	discharged/expired residents were destroyed timely for one of one medication rooms observed. (Facility) Findings include: 1. An observation of the medication room conducted on 3/13/24 at 3 p.m. found the nursing station door was unlocked and the door to the medication room was propped open and no staff were present at the time. On the medication door, was a sign that indicated, the door to the medication room was to remain locked at all times. 2. During the medication storage room observation with LPN (Licensed Practical Nurse) 8, conducted on 3/14/24 the following was observed: a. Immediately inside the medication room door was a cardboard box containing residents' medications along with a small, plastic, laundry looking, basket that contained more residents' medications. LPN 8 indicated, the medications inside the basket and box were medications residents had brought from home and were to be destroyed or medications the residents had from a different pharmacy and were now using the facility's pharmacy services. LPN 8 stated, they were instructed to destroy any home medications the residents had brought into the facility and only administer medications from the facility's pharmacy. Resident CC had three bottles of hydralazine (a blood pressure reducing medication) 100 mg tablets inside the basket and/or box that had been waiting to be destroyed since he switched to the facility pharmacy on 1/24/24. Resident Z had two bottles of Coreg 6.25 mg tablets and a bottle of clopedigrel (anticoagulant) 7.5 mg tablets both medications had a discard date 8/17/21. Resident Z was		**practice** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a All residents receiving medication had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on proper and timely destruction of expired or discontinued medications. Employees found to be out of compliance with proper disposal of medications will receive additional education and possible corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a Director of Nursing or designee with provide education to all QMAs and Nurses on the timely and proper disposal of expired and discontinued medications no later than 06/01/24. Any clinical staff members out of compliance with facility's policies and protocols relating to appropriate disposal of medications will receive progressive corrective action. The	

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	discharged on 10/28/2020. b. On top of the medication fridge, in a clear tub labeled with Resident AA's name was a Levemir insulin pen with an opened date of 11/10. c. In an upper cabinet, a box of soft-twist lancets had no resident label affixed and an expiration date of 8/21; and a box of glucose strips with an expiration date of 6/15/19. d. Inside a drawer were speciman swabs with an expiration date of 5/4/22, para-pack cups with an expiration date of 11/21, and several specimen virus tubes with an expiration of 10/11/21. e. In an upper cabinet to left of the sink, was an EDK (Emergency Drug Kit) box containing the following medications which all had an expiration date of 2/15/24: Amoxicillin (antibiotic) 250 mg; 12 tablets Amoxicillin 500 mg; 12 tablets Amoxicillin-Clavulanate (antibiotic) 500/125; 4 tablets; label on top of box indicated there was a total of 6 tablets originally Amoxicillin-Clavulanate 875/125 mg; 6 tablets Coumadin (antcoagulant) 1 mg, 2mg, 3 mg, 2.5 mg and 5 mg; each package contained 6 tablets cephlaxin (antibiotic) 250 mg; 10 tablets; label on front of box indicated there was a total of 12 total tablets originally diphenhydramine (antihistamine) 25 mg; 6 tablets cephalaxin 500 mg; 10 tablets (12 were issued) Lasix (diuretic) 40 mg; 6 tablets Levofloxacin (antibiotic) 250 mg and 500 mg; both with 6 tablets each Macrobid (antibiotic)100 mg; 6 tablets Potassium (supplement) 10 meq(miliequivalants); 6 tablets Prednisone (steroid) 10 mg and 20 mg; both with		Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to medication disposal during employee job-specific orientation moving forward. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a This process will be reviewed by DON/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. a Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date will the systematic changes be completed.** 6/1/24	

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		A. BUILDING 00 B. WING	03/15/2024

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	6 tablets each Bactrim (antibiotic) 800/160 mg; 6 tablets The box did not contain signout sheet to indicate which resident had received missing medications from the EDK box. The facility's pharmacy Service Guide received on 3/14/24 at 12:02 p.m. from NC (Nurse Consultant) indicated, under Destruction/returns "Due to regulatory and licensing requirements the pharmacy is not permitted to accept medication returns that have been delivered to the community. ALL destruction is performed at the community according to individual professional licensure, federal, state and local ordinance. Utilizing the 'destruction of medication' log as provided by the community."			
R 0351 Bldg. 00	410 IAC 16.2-5-8.1(c)(d) Clinical Records - Noncompliance (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law. Based on observation, interview, and record review, the facility failed to store the clinical records of residents in a secure location for 1 randomly observed discharged resident record with the potential to affect 108 of 108 resident's residing at the facility (Resident Y). Findings include: During a tour of the facility on 3/15/24 at 12:30 p.m., the second-floor nursing room was observed	R 0351	**R351** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and**	06/01/2024

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	to be open and unlocked. A large cardboard box was visualized under the counter in the second-floor nursing room. The cardboard box was open and piled full of folders which contained resident's medical records. The fourth-floor nursing room was observed to be open and unlocked. There were 2 large cardboard boxes under the counter of the nursing room. The boxes were piled full of folders which contained residents' medical records. A Resident Service Plan from 2019 for Resident Y was visible on the top of the pile of medical records. During an interview on 3/15/24 at 12:52 p.m., QMA (Qualified Medication Aide) 30 indicated she was unaware of who Resident Y was. The boxes under the counter were put there by the former Director of Nursing for storage. QMA 30 believed there were residents' medical records in the cardboard boxes. On 3/15/24 at 1:28 p.m., the Executive Director provided the Community Record Retention Policy last reviewed 2/3/2023, which read "... Archived Records must be maintained in a locked area and should be stored in banker boxes, storage tubs, and/or file cabinets... Records must be stored on shelves or in cabinets that keep them off the floor..."		**what corrective action will be taken.** a All residents had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure that medical records are stored in accordance with the company Medical Records Storage Policy. Employees found to be out of compliance with medication documentation will receive additional education and corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** a DON and/or designee will ensure that medical records are stored in accordance with the company Medical Records Storage Policy. Any staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **4 How the corrective action(s) will be monitored to**	

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			ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. b This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. c Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed.** **6/1/24**	
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.			

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	(6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to provide a transfer form to the receiving medical facility for 1 of 2 closed records reviewed. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/12/24 at 10:00 a.m. The diagnoses included, but were not limited to: stroke and type 2 diabetes mellitus. An incident report dated 1/17/24 indicated "...Resident initially refused to go to hospital, upon falling for a 2nd time nurse on duty and EMS [Emergency Medical Services] convinced resident to go be seen for observation at [name of hospital]..." A nursing progress note dated 1/17/24 indicated "Reporting Transition Out on January 17, 2024 at 5:00 p.m., to Hospital/ER [Emergency Room Hospital] Reason(s): Pain-Other. Comments: 'Resident found on floor during med pass, c/o [complaints of] pain to RLE [right lower extremity] resident alert, but disoriented. Resident sent to [name of hospital] for eval [evaluation] and treat of rt [right] side pain..." Resident D's medical record did not include a transfer form that was utilized for the resident's transfer to the hospital on 1/17/24. An interview was conducted with the Nurse Consultant on 3/14/24 at 2:38 p.m. She indicated the staff should have completed and sent a transfer form for Resident D's transfer to the	R 0354	**R354** **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** /p> **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. Nursing staff will be educated on appropriate forms and documentation related to transfers. DON or designee will do transfer audit of all residents who go out to ensure all proper documentation is listed on the resident face sheet (emergency printout), and transfer form is complete. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. An audit of all transfers will be	06/01/2024

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	hospital on 1/17/24. This citation relates to Complaint IN00429132.		conducted by the DON/designee. Any clinical staff member out of compliance with facility's policies and protocols relating to proper documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to recording proper documentation during employee job-specific orientation moving forward. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. This process will be reviewed by DON/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b. Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date will the systematic changes be completed.** 6/1/24	

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R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on observation, interview, and record review, the facility failed to ensure a resident's comprehensive care plan was developed in cooperation with the mental health service provider for 1 of 8 residents reviewed for care plans. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/12/24. Resident B's diagnoses included, but not limited to, schizophrenia, schizoaffective disorder, chronic obstructive pulmonary disease (COPD), hypertension, and inadequate sleep hygiene. A SLUMS (Saint Louis University Mental Status) assessment completed on 2/1/24 indicated, Resident B had a mild neurocognitive disorder. Resident B's medication orders were reviewed on 3/12/24 at 11:20 a.m. Resident B's medications	R 0383	**R383** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** /p> **2. 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.** a. All residents with Mental Health diagnosis had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure the Resident	06/01/2024

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	included, but not limited to: - melatonin (a sleep aid) 5 mg (milligrams) tablet; take one at bedtime - amlodipine (blood pressure reducing medication) 5 mg tablet; take one once daily - metoprolol (a blood pressure reducing medication) 25 mg; take 1/2 tablet twice daily - quetiapine (antipsychotic) 25 mg; take one tablet at bedtime An observation of Resident B was conducted on 3/12/24 at 10:02 a.m. Resident B emerged from her apartment and sat on a bench in the hallway near her apartment. She was wearing a black hat, red printed shirt, red pants and a black jacket. Her red pants had spots on them as if something had been spilled on them. The smell of urine overcame the air as she sat down on the bench. Resident B's fingernails were long and had a dark brown/black substance caked underneath them. As she spoke, little bugs were observed crawling over her hat, jacket, and person. An interview with Resident B was conducted on 3/12/24 at 10:02 a.m. Resident B indicated, the facility gave her bed bugs and she was upset that the facility "locked her out" of her other apartment and moved her into the apartment were she now resides. Resident B stated, she still had furniture in the old apartment and the facility allowed someone to steal it. As she continued to speak, she would jump topics mid thought. When asked who her primary care provider was, she indicated, it was NP (Nurse Practitioner) 34 at a local health clinic. When asked if she receives her medications she stated, she doesn't need to take any medications other than vitamins because she "doesn't need any". An interview with Resident B's psychiatric service		Service Plan is developed in cooperation with the mental health service provider. Employees found to be out of compliance with medication documentation will receive additional education and corrective action. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** a. DON and/or designee will ensure the Resident Service Plan is developed in cooperation with the mental health service provider. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** a. This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months	

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	provider (Psych 35) was conducted on 3/13/24 at 1:39 p.m. Psych 35 indicated, Resident B was first referred to them when she was admitted to the facility, but at the time she had refused their services. However, after an incident with another resident, the facility referred Resident B again for their services. Psych 35 indicated, in October of 2023, they started to document their attempts of reaching out to Resident B. It wasn't until January 2024 that Resident B allowed them to gather information needed for their initial evaluation. Psych 35 indicated, Resident B had told them that she used to be in the mental health business and wants no part of 'psych'. When asked if they had been made aware of Resident B's refusal of medications, they replied, "if we had been made aware, we would have had an acute visit with her today." An interview with Resident B's Pharmacist (Pharm) 14 was conducted on 3/13/24 at 1:55 p.m.. Pharm 14 indicated, they are the facility's pharmacy which Resident B had used for her medications, but they had not been made aware that Resident B was refusing her medications and would have liked to have known that information. Also, they were unaware of who Resident B's primary care physician was since her last provider had left the facility's providers company some time ago. An interview with LPN (Licensed Practical Nurse) 8 conducted on 3/13/24 at 1:59 p.m. indicated, Resident B had stopped taking her medications (except vitamins) a few months ago. LPN 8 indicated, they have twice faxed Resident B's primary care provider for an order to discontinue her medications related to refusals, but had not received a response.		and as needed thereafter as part of the QA process. b. Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5. By what date the systemic changes will be completed.** 6/1/24	

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	An interview with LPN (Licensed Practical Nurse) 8 conducted on 3/14/24 at 3:01 p.m. indicated, they had not been made aware that Resident B's room had an active bed bug infestation. She indicated, they have never seen her wash her clothing and will sometimes wear the same clothing for multiple days. When asked if they had been in her apartment recently, she indicated, Resident B did not allow anyone to come inside her apartment. A history and physical report from Resident B's primary care provider dated 5/26/23 was received from NC (Nurse Consultant) on 3/14/24 at 12:02 p.m. It indicated, under Unspecified Psychosis, "Pt [sic, patient] is unfocused, rambles, and goes on tangents. Pt has a hx [sic, history] of unspecified psychosis and had delirium during her stay at the hospital w/[sic, with]covid. Pt mentions multiple conspiracy theories including not wanting the covid-19 vaccine because she is a 'natural woman', nurses from Oasis stealing from her, that the world is changing, etc...". In the physical examination section, it mentioned in the neurologic and psychiatric sections that Resident B was unfocused and rambling during her visit, her insight was questionable and speech was tangential (diverging from a previous course or line, erratic). It further indicated, within the assessments section, under psychosis, Resident B "does not follow w/[sic]psychiatry and has not had a proper psychiatry evaluation. Consider referral at next visit." Resident B has not been back to this provider since that date. Resident B's Service Plan dated 5/25/23 was received on 3/12/24 at 2:55 p.m. It indicated, Resident B needed monitoring related to a history of mood disturbance, support related to a diagnosis of schizophrenia and schizoaffective disorder, and episodically refuses medications.			

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	The service plan indicated, the local health clinic (same clinic where her primary care physician was located) was monitoring her mental health. Interventions included, but not limited to, monitor for changes in Resident B's usual mood, routine, conversations, and to notify the licensed nurse as needed; and the licensed nurse was to notify physician and mental health provider of changes in mood and behavior.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation and record review, the facility failed to implement an infection control program by not scrubbing the hub of an insulin pen prior to attaching a sterile needle and not performing hand hygiene prior to donning gloves when administering insulin for 1 of 6 residents reviewed for medication administration. (Resident BB) Finding include: An observation of Resident BB's medication administration was conducted on 3/13/24 at 4 p.m. with QMA (Qualified Medication Assistant) 10. Resident BB utilized a continuous glucose	R 0407	**R407** **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** /p> **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken.**	06/01/2024

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	monitor for her blood sugar readings. After checking Resident BB's glucose reading, she exited the resident's room but had not performed hand hygiene after exiting the room. She then grabbed Resident BB's plastic tub which contained her Novolog insulin pen, pulled out the pen, removed its cap and then screwed on the sterile needle to the insulin pen. QMA 10 had not scrubbed the hub of the insulin pen with alcohol prior to affixing the needle to the pen. She then primed the needle with insulin, dialed up the correct dose and then donned a pair of gloves. QMA 10 did not perform hand hygiene prior to donning the gloves. After donning the gloves, she knocked on Resident BB's door, opened the door with her gloved hand, and administered the insulin to the resident. The Novolog insulin FlexPen instructions were provided by NC (Nurse Consultant) on 3/15/24 at 9:28 a.m. The instructions indicated, in the section "Preparing your NovoLog FlexPen Wash your hands with soap and water...A. Pull off the pen cap...Wipe the rubber stopper with an alcohol swab." A Hand Hygiene policy received on 3/14/24 at 8:59 a.m. indicated, "Alcohol-Based Hand Rubs: 1. In most situations, the preferred method of hand hygiene is with and alcohol-based hand rub. If hands are not visibly soiled, you may choose to use an alcohol-based hand rub...for all the following situations: a. Before and after direct contact with residents' b. before preparing or handling medications... d. After contact with resident's intact skin... f. After contact with inanimate objects...in the immediate vicinity of the resident; and g. After removing gloves..."		a. All residents requiring staff proper hand hygiene before providing care had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all medical staff on procedures of appropriate hand hygiene. Employees found to be out of compliance with hand hygiene will receive additional education and possible corrective action. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** a. All clinical staff will be re-educated and in-serviced on the hand hygiene policy no later than 6/1/24. Any clinical staff member out of compliance with facility's policies and protocols relating to hand hygiene will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to hand hygiene during employee job-specific orientation moving forward. **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**	

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	03/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Centers for Diseases and Control (CDC) website located at https://www.cdc.gov/handhygiene/providers/, last accessed on 3/18/24, "Hand Hygiene in Healthcare Settings" indicated, "Glove Use...Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves."		**into place.** a. This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b. Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5. By what date will the systematic changes be completed.** 6/1/24	