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	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	1215 TRINITY PLACE MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00399172, IN00400252, IN00402863, IN00415278, and IN00415931. Complaint IN00399172 - No deficiencies related to the allegations are cited. Complaint IN00400252 - State deficiencies related to the allegations are cited at R0240. Complaint IN00402863 - No deficiencies related to the allegations are cited. Complaint IN00415278 - No deficiencies related to the allegations are cited. Complaint IN00415931 - No deficiencies related to the allegations are cited. Survey dates: August 29, 30, & 31, 2023 Facility number: 013330 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5 Quality review completed 9/8/2023.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and			

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

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	unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure employees met the requirement of first aid certification.This deficient practice affected 7 of 21 shifts reviewed. Finding includes: During a review of the facility nursing schedule from 8/27/2023 through 9/2/2023, the facility did not have employees with first aid certification on the following dates: - First shift 8/27/2023. - Second shift 8/27/2023, 8/28/2023, 8/29/2023, 8/30/2023, 8/31/2023, and 9/1/2023. During an interview on 8/31/23 at 10:09 A.M., the Executive Director indicated an employee with first aide certification should be in the building in	R 0117	1 All residents have the potential to be affected by deficient practice. 2 All residents interviewed, no residents displaying any S/SX of symbological distress. 3 The Business Office Manager re-educated to ensure accuracy of employee records. Part time scheduler in place to ensure accuracy of schedule. 4 Health Service Director or designee will complete audit in reference to a minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times, to check for necessary First Aid certifications on file/ current, three	09/01/2023

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	at all times. A current policy was provided on 8/31/2023 at 1:20 P.M., titled, "Cardiopulmonary Resuscitation". The policy did not provide guidance on the need for first aid certification.		times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on a audit form. Concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 09/01/2023	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences,			

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	or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure dementia training and resident rights education was completed for 3 of 5 employee records reviewed. (Employee 9, 10, &11) Finding includes: During an Employee record review on 8/30/2023, the following was indicated: -Employee 9 and 11 had no resident rights education. -Employee 10 and 11 did not have specific dementia training for a specialized unit. A policy was requested by the Executive Director on 8/31/2023 at 11:55 A.M. The Executive Director indicated she would provide the policy, "Onboarding Guide for Care Staff" via email when received from the corporate office. The email was not received. A Policy, titled, "Staff Education and Training", provided on 8/31/2023 at 1:20 P.M., by the Executive Director, indicated, " ...Staff will receive training and education in the care concepts of	R 0120	1 No residents were negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. 3 Executive Director to Inservice all current and future staff members regarding compliance and arrange any necessary correctios of compliance. 4 Executive Director or designee will complete an audit of required Dementia training and Resident Rights training of all current and future hires for three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on an audit form. Concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance	09/01/2023

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	dementia care at orientation and periodically throughout the year, as required by respective state licensing agencies. In addition, staff will be oriented to these policies, procedures and practices ...."		09/01/2023	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record			

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	of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	The facility failed to ensure first and second step tuberculosis testing was completed for 3 of 5 employee records reviewed for tuberculosis tests. (Employee 8, 9 &11) Finding includes: During an Employee record review, completed on 8/30/2023, 3 of 5 records indicated the following: - Employees 8, 9 and 11 did not have documentation of the Mantoux testing requirement for a first step and second step Mantoux. During an interview on 8/31/2023 at 10:09 A.M., the Executive Director indicated that every employee should receive a first and second step Mantoux test within 30 days of employment. A policy title, "Staff Hiring", indicated, " ...The following must be done in accordance with state licensing regulations in the respective state, regarding recruitment, employment screening and workforce qualifications ...TB [tuberculosis] Test (where applicable) ...."	R 0121	1 No residents were negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. No residents displaying any S/SX of symbological distress. 3 Executive Director to be re-educated/In-serviced, in accordance with State Regulation 0121, Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) 4 Heath Service Director or designee will complete audit of current and future employee files to ensure compliance for three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on an audit form. Concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 09/01/2023	09/01/2023
R 0123	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance			

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Bldg. 00	(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to provide required specific job orientation documentation for 5 of 5 employee records reviewed. (Employee 6, 8, 9, 10 &11) Findings include: During an employee record review completed on 8/31/2023 at 10:00 A.M., the following employees had no specific job orientation records. Employee 6, 8, 9, 10, and 11. Employees 8 and 9 had no resident rights education. During an interview on 8/31/2023 at 10:09 A.M., the Executive Director indicated that all employees should have resident rights education and specific departmental education, and this occurs	R 0123	1 No residents were negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. No residents displaying any S/SX of symbological distress. 3 Executive Director and Business Office Manager re-educated in regard to Staff Education Policy and Personal Training. New orientation checks off list to assigned to current and all future hires. Resident Rights acknowledgement added to new hire paperwork. 4 Executive Director or designee to complete audit of all current and future employees to	09/01/2023

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	during the onboarding process. A policy was requested by the Executive Director on 8/31/2023 at 11:55 A.M. The Executive Director indicated she would provide the policy, "Onboarding Guide for Care Staff" via email when received from the corporate office. The email was not received prior to the survey exit.		ensure compliance job specific orientation check off list and completion on Resident Rights training completion for three times per week four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on an audit form. Concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 9/01/2023	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview the facility failed to provide a safe, clean, and comfortable environment for 23 of 46 residential rooms, 1 of 1 dining hall, and 1 of 7 corridors observed. (Room 1, 4, 5, 8, 18, 19, 20, 21, 24, 25, 26, 27, 31, 35, 36, 38, 39, 40, 41, 42, 43, 45, and 46, Dining Room and Corridor 97) Findings include: During an initial tour of the facility on 8/29/2023 at 9:35 A.M., the following was observed: In Rooms 1, 4, 5, 8, 18, 19, 20, 21, 24, 25, 26, 27, 31, 35, 36, 38, 39, 40, 41, 42, 43, 45, and 46 chipped, peeling and scuffed paint was observed on the doors and door frames of the rooms.	R 0144	1 No residents were negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. No residents displaying any S/SX of symbological distress. 3 The Executive Director provided the Maintenance Director with the Maintenance Manual, in reference to repair and touch-up paint on damaged walls, columns, and doors as needed. Schedule time every month to walk all common areas and touch up any paint scuffs or marks as needed. Dining Hall light deficiency has	09/01/2023

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	The Dining Hall had 25 of 68 light bulbs burnt-out or not working. On Corridor 97, outside of Room 2, illegible handwriting in black ink was observed on the wallpaper and paint. During a tour, on 8/29/2023 at 11:10 A.M., the Director of Maintenance (DM) indicated the doors and door frames shouldn't have cracked, peeling, or scuffed paint and painting the doors and frames was on his list of things to do. DM indicated the light bulbs in the dining room should be working, but the facility was out, and he would get more light bulbs. DM indicated that the writing on the paint and wallpaper outside of Room 2, on Corridor 97, should be removed and expected it to be cleaned by end of the week. DM indicated that resident safety is always top priority. Facility uses the building management platform TELS to submit and track work orders, and the system automatically prioritizes the task based on the information inputted. DM indicated that he tours the facility daily to check doors, exit lights, temperatures, and call light system to identify and address any potential concerns. A policy for maintaining the facility and any maintenance task schedules was requested. During an interview, on 8/31/2023 at 9:30 A.M., DM indicated there are no maintenance task schedules because TELS gives him daily tasks that incorporate daily, weekly, and monthly tasks and there was no policy for maintaining the facility.		been completed all light bulbs replaced. Handwriting on wall by resident has been removed. 4 Executive Director and or designee to complete audit of any visual chipped pain, burnt out light bulbs and any further writing on wall by resident, for three times per week four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on an audit form. Concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 9/01/2023	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with			

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	activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility failed to provide showers for 3 of 3 residents reviewed for showers. (Resident B, Resident E, Resident L) Findings include: 1. During a Dining observation completed, 8/29/2023 at 12:22 P.M., Resident B had strong smell of urine while eating in dining hall. A record review was completed, on 8/30/2023 at 3:10 P.M., Resident B's diagnoses included, but were not limited to: dementia, degenerative disc disease, hypertension, and coronary artery disease. Resident B's Service Agreement, dated 4/19/2023, indicated Resident B required physical assistance of one for showering. A review of the shower binder was completed, on 8/31/2023 at 9:17 A.M. Resident B was scheduled for showers on Sundays and Thursdays. In the month of August 2023, Resident B had a shower on 8/10/2023, 8/14/2023, 8/17/2023, 08/21/2023, and 8/28/2023. 2. During an interview, on 8/30/2023 at 11:15 A.M., Resident E's son indicated that when he picked his mother up for church on 8/24/2023, his mother's hair was greasy and uncombed. A record review was completed, on 8/30/2023 at 2:45 P.M., Resident E's diagnoses included, but were not limited to: Alzheimer's Disease, and hypertension.	R 0240	1 No residents were negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. No residents displaying any S/SX of symbiological distress. 3 Health Service Director and or designee to train all Care Staff in reference to 4.8 Hygiene and Grooming Policy, indicating the Policy and Protocol. Skin Motioning, CNA Shower Sheets to be audited ongoing daily, in addition to being signed by both caregivers, charge nurse/lead and HSD. A third request resulting in a refusal will be noted on the shower sheet form and charted in the note section of the resident. 4 Executive Director or designee to audit refused showers sheet to ensure accurate follow up and charting for three times per week four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. Concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 9/01/2023	09/01/2023

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	Resident E's Sunshine Assessment, dated 5/17/2023, indicated Resident E showered independently. A review of the shower binder was completed, on 8/31/2023 at 9:15 A.M. Resident E was scheduled for showers on Mondays and Thursdays. In the month of August 2023, Resident E had a shower on 8/3/2023, 8/7/2023, 8/14/2023, and 08/24/2023. 3. A record review was completed, on 8/30/2023 at 2:48 P.M. Resident L's diagnoses included, but were not limited to: Alzheimer's Disease, anxiety disorder, atrial fibrillation, and hypertension. Resident L's Sunshine Assessment, dated 6/23/2023, indicated Resident L required physical assistance of one for showering. A review of the shower binder was completed, on 8/31/2023 at 9:15 A.M. Resident L was scheduled for showers on Tuesdays and Fridays. In the month of August 2023, Resident E had a shower on 8/8/2023, 8/11/2023, 8/19/2023, 08/21/2023, and 8/28/2023. During an interview, on 8/31/2023 at 9:20 A.M., Qualified Medication Aide (QMA) 6 indicated that showers are given twice a week. QMA 6 indicated showers are documented on shower sheets and stored in the shower binder. When asked if there were any other place showers are documented, QMA 6 indicated no. When asked how showers are documented for residents who are independent or refuse showers, QMA indicated that independent residents get a shower sheet due to their need for reminders and setup, and if a resident refuses a shower, it is documented on the shower sheet as refused.			

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	During an interview on, 8/31/2023 at 9:26 A.M., Director of Nursing (DON) indicated that residents receive two showers a week and the shower binder contained all the shower sheets for the month of August 2023. When asked if Resident B, Resident E, and Resident L should have been offered a shower twice a week, DON indicated yes. A policy titled, "Hygiene and Grooming" was supplied by the DON and identified as the policy currently used, on 8/31/2023 at 2:44 P.M. The policy indicated, "The Resident's hygiene and grooming needs are met while addressing the Resident's personal preferences and daily routine...A minimum of two showers per week is required, absent of an exception....". The state residental finding relates to complaint IN00400252			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to provide sanitary food service to 17 of 24 residents observed for food delivery service. Finding includes: During an observation on 8/29/2023 at 12:15 P.M., dining room service was observed in the main dining room. The Dietary Manager was observed to have her thumb beyond the rim of the plate when serving the residents main plate.	R 0273	1 No residents were negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. No residents displaying any S/SX of symbiological distress. 3 Dining Room Director/Chef posted in a visible area of the kitchen the chart tittle: “How to Properly Serve Food” and provided a copy to all dinning staff, in	09/01/2023

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		A. BUILDING 00 B. WING	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	1215 TRINITY PLACE MISHAWAKA, IN 46545

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	During an observation on 8/29/2023 at 12:28 P.M., dining room service was observed in the main dining room. The Dietary Manager was observed to have her thumb beyond the rim of the plate when serving the residents main plate. During an interview on 8/29/2023 at 12:36 P.M., the Dietary Manager indicated she was rushing and wasn't paying attention and her thumb should not be over the edge of the plate being served. On 8/31/2023 at 11:47 P.M., the Executive Director provided a policy titled, "Proper Ways to Serve Food", dated 2019, and indicated the policy was the one currently used by the facility. The policy indicated"... There's a right way and a wrong way to carry utensils and serve food. Doing it the wrong way can contaminate food and make people ill...."		addition all Dinning staff were re-educated/in-serviced how to properly carry plates and cups during serving. 4 Executive Director or designee to visually audit food and drinks being served in the Main Dining room and complete audit form for three times per week four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on an audit form. Thereafter, concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 9/01/2023	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on interview and record review, the facility failed to ensure a resident who received a mechanical soft diet did not receive food items other than a soft consistency for 1 of 1 residents reviewed for dietary needs. (Resident G) Finding includes: A closed record review was completed on 8/29/2023 at 3:29 P.M. Resident G's diagnoses included, but were not limited to dementia, Alzheimer's disease, depression, anxiety and	R 0275	1 One resident was negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. One resident was directly affected. 3 Dining Director/Chief was interviewed regarding a complaint regarding an incident that occurred on 11/29/2022, resulting in resident being served brussels	09/01/2023

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	gastro-esophageal reflux disease. A Nurse's Note, dated 11/29/2022 at 2:51 P.M., indicated,"... Late Entry: Was alerted by someone yelling for assistance. Found resident on the floor with staff member behind her. Staff member explained resident was choking on Brussels sprout...." A Dietician Note, dated 12/16/2022, indicated Resident G's diet was a regular, mechanical soft texture with moistening agents, nectar thick liquids. During an interview, on 8/31/2023 at 10:33 A.M., the Dietary Manager indicated that Brussels sprouts are not on a mechanical soft diet and should not be served on that diet. On 8/31/2023 at 2:50 P.M., the Dietary Manager provided a printed 2 page paper, titled, " Soft and Mechanical Soft Diet", updated 9/24/2018. The sheet indicated "...Guidelines for the Soft Diet: Foods to Avoid: Brussels sprouts...." On 8/31/2023 at 2:50 P.M., the Dietary Manager provided the policy titled,"Diet and Nutrition", with a revised date of 1/1/2021, and indicated the policy was the one the facility currently uses. The policy indicated"...Monitor diet to make certain foods offered are moist, easy to chew and swallow...."		sprouts resulting on an episode of choking. Confirmed that Brussel sprout was not on the approved list. 4 Health Service Director or designee to re-educate/in-service all dining staff regarding, the Dining and Nutrition policy. Utilization of individual meal tickets to be issued with each meal indicating any meal modifications that are required. Dining Director /Chief or designee to audit modified diet food preparation, servings and food selections for three times per week four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on an audit form. Thereafter, concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 9/01/2023	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date.			

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	(D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to identify over-the-counter medications with proper labeling. (Residents R & S) Finding includes: During an observation of 1 of 2 medication carts on 8/31/2023 at 7:35 A.M., over-the-counter medications were observed without the proper labeling. -Resident R had 2 sealed boxes of Debrox earwax removal with only the resident's name on the box. -Resident S had 3 bottles of Calcium 600 mg (milligrams) and an 8-hour Arthritis Pain Relief tablet 650 mg with only the resident's name written on the bottles. During an interview on 8/31/2023 at 11:01 A.M., the Director of Nursing indicated that the bottle needs to match the electronic medical administration record. She indicated a label would be placed with identifying information. She indicated the bottles of calcium, arthritis pain relief and Debrox should have labels placed on the bottles, and the labels were not present. A current policy, titled "Medication Administration", was provided by the Executive Director on 8/31/2023 at 1:20 P.M., The policy indicated, " ...3. Over-the-counter medications must have the original label attached and be identified with the following: Resident's name, Physician's name, Expiration date, Name and strength of drug, and Directions for use ...."	R 0302	1 No residents were negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. 3 Health service director completed a Med Room and med cart audit on 8/31/2023 and removed all expired and unlabeled medications. 4 Health Service Director or designee will complete a Med storage observation to check for expired and unlabeled medications for three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on a monthly Med storage audit sheet. Thereafter, concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 9/01/2023	09/01/2023
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall			

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	be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 6 of 13 residents. (Residents D, E, F, J, L & M) Finding includes: On 8/30/2023 at 11:42 A.M., the resident emergency binder was reviewed. The following items were observed missing: -6 of 13 face sheets (Residents D, E, F, J, L, & M) lacked the resident's hospital preference. -1 of 13 face sheets lacked the gender, name, and phone number of the resident 's physician, name and phone number of any legally authorized representative, and the name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (Resident M)	R 0356	1 No residents were negatively affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. No residents displaying any S/SX of symbiological distress. 3 Health Service Director to ensure that all information is correctly input in resident face sheets. Business Office Manager alongside with Front Desk concierge will ongoingly audit the insertion and accuracy of Face sheet in Disaster and Emergency Binder. 4 Executive Director or designee to audit compliance of all current and future residents Face Sheets and accuracy of adequate information located in the Disaster	09/01/2023

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	During an interview on 8/31/2023 at 2:52 P.M., the Executive Director indicated that the facility follows the state regulation for emergency binder information, and a policy was not available.		and Emergency Binder for three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on an audit form. Thereafter, concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of compliance 9/01/2023	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility	R 0410	No residents were negatively	09/01/2023

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	failed to ensure a resident received a Mantoux screening for Tuberculosis upon admission for 1 of 13 residents reviewed for Mantoux screening for Tuberculosis. (Resident L) Finding includes: A record review was completed, on 8/30/2023 at 2:48 P.M. Resident L was admitted on 6/13/2023. Diagnoses included, but were not limited to: Alzheimer's Disease, hypertension, atrial fibrillation, and anxiety disorder. The clinical record lacked the documentation to show Resident L had received the 1st and 2nd step Mantoux Tuberculosis test. During an interview, on 8/31/2023 at 1:50 P.M., the Administrator indicated that Resident L should have received a 1st and 2nd step Mantoux Tuberculosis test either before or upon admission. A policy for Mantoux screening for Tuberculosis upon admission was requested, but one was not provided prior to the survey exit.		affected from this practice. 2 Due to the nature of the violation all residents in the facility had the potential to be affected. No residents displaying any S/SX of symbiological distress. 3 Marketing Director and Executive re-educated/in serviced regarding deficiency regarding tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. 4 Health Service Director to complete all TB test upon admissions and to abide by State Regulations regarding regulation protocol for TB for three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on an audit form. Thereafter, concerns or non-compliance to be documented and discussed in monthly Quality Assurance meetings. 5 Date of Compliance 9/01/2023	