STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT HARRISON ALF OPERATIONS	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00453435 and IN00455674. Complaint IN00453435 - No deficiencies related to the allegations are cited. Complaint IN00455674 - State deficiencies related to the allegations are cited at R29, R36, R41, R64, R117, and R144. Survey dates: April 7, 8, 9, 10, 2025 Facility number: 014109 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 17, 2025.	R 0000		
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency Based on observation, interview, and record review, the facility failed to ensure the residents were respected by utilizing uniforms and name badges to easily identify staff personnel. This had the potential to affect 51 of 51 residents that reside in the facility. Findings include: An observation was conducted of the facility lobby on 4/7/25 at 9:35 a.m. A staff person was	R 0029	Executive Director will conduct a in-service on proper dress code per company policy, also ED will have each department head monitor employees in each department to make sure all employees wear proper uniforms. We will have staff education on dress code compliance plus self identification by in-service.	05/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dametria Marshall	Executive Director	05/12/2025

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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	observed sitting in the front office. The staff person was not wearing a uniform or name badge. Two staff members were observed in front of housekeeping carts. They were not observed wearing name badges. During the observation at 9:40 a.m., three male staff members were observed carrying chairs and tables. They were not observed wearing name badges. During a random observation on 4/7/25 at 11:21 a.m., a staff member was observed in the marketing office. She was not observed wearing a name badge. She indicated she was Housekeeper 11. An observation was conducted of the lunch meal in the kitchen and dining room on 4/7/25 at 11:32 a.m. The staff present in the kitchen were not observed to be wearing name badges. Two male staff members were carrying lunch meal trays to the residents in the dining room. At 12:02 p.m., one of the male staff members was observed with black jeans with ripped out holes in the knees and a zipped-up jacket with no name badge. An interview was conducted with that staff person at that time. He stated, "What was the purpose to know his name?" He reported he was Certified Nurse Aide (CNA) 13 and he did have a name badge. He "normally, throws it in his pocket." After, the second staff person passing out trays to the residents was interviewed. He was wearing a black uniform with no name badge. He indicated he was Dietary Aide (DA) 12. An interview was conducted with the Executive Director (ED) on 4/7/25 at 12:15 p.m. She indicated the staff should be wearing uniforms and name badges. An interview was conducted with Resident C on			

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	4/7/25 at 2:30 p.m. She indicated the staff do not wear their name badges. An interview was conducted with Resident CC on 4/7/25 at 3:36 p.m. He indicated the staff do not wear name badges. During a confidential interview, they indicated the staff do not wear uniforms or name badges. The weekends are the worst. Some staff have been observed wearing bonnets on their heads. An interview was conducted with Resident C on 4/9/25 at 9:44 a.m. They indicated the staff wear regular clothes, not uniforms, and they do not put on name badges. A resident rights policy was provided by Dietary Aide 14 on 4/7/25 at 3:59 p.m. It indicated, the residents have the right to "fair and equal services" and "courteous treatment in address and handling." A dress code policy was provided by the ED on 4/9/25 at 10:27 a.m. It indicated, "Uniforms must be clean, neat, and worn according to the community policy...A name tag is provided and must be always worn on your uniform or business attire while on duty..." This citation is related to Complaint IN00455674.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on interview and record review, the facility failed to notify the physician to address residents elevated blood sugar readings for 2 of 5 residents' records reviewed. (Resident 39 and Resident K)	R 0036	Facility failed to notify the physician to address residents elevated blood sugar levels 1. all residents have the potential to be at risk.	05/12/2025

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	Findings include: 1. The clinical record for Resident 39 was reviewed on 4/8/25 at 2:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 8/22/24, indicated Resident 39 was to receive Humalog insulin (fast acting insulin) sliding scale twice a day. The scale was the following units to administer per blood sugar reading: blood sugar readings of 200-300 = 4 units of insulin, and 301-350 = 5 units. If the blood sugar reading was greater than 350, the medical provider was to be notified. The March 2025 Medication Administration Record (MAR) indicated the following days Resident 39's blood sugar was greater than 350: 3/2/25 at 4:00 p.m. - 351 blood sugar reading, 3/20/25 at 4:00 p.m. - 358 blood sugar reading and 8:00 p.m. - blood sugar reading 358, 3/24/25 at 4:00 p.m. - 365 blood sugar reading, and 3/25/25 at 4:00 p.m. - 357 blood sugar reading. The resident's clinical record did not include documentation the physician was notified of resident's blood sugars greater than 350, as ordered, or documentation of insulin administrations at that time. An interview was conducted with the Director of Nursing (DON) on 4/10/25 at 12:03 p.m. She indicated she had spoken to Qualified Medication Aide (QMA) 15 regarding the elevated blood sugars. She reported she did not administer the insulin due to the resident refused on 3/2/25, 3/20/25, 3/24/25 and 3/25/25. 2. The clinical record for Resident K was reviewed on 4/7/25 at 11:30 a.m. The diagnoses included,		2. DON completed proper physician notification for blood sugar levels over 200 mg/dl in-service with staff 3. DON completed proper blood sugar levels documentation for EMARS (PCC) in-service 4. DON completed insulin Injection/Glucometer Reading Policy in-service with staff. DON/RCC will review blood sugar recordings 5 days a week (MON-FRI) indefinitely to ensure proper physician notification and blood sugar notification.	

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	but were not limited to, diabetes mellitus. A quarterly Brief Interview for Mental Status score, dated 2/1/25, indicated Resident K was cognitively intact. A record review conducted on 4/7/25 at 2:14 p.m., revealed Qualified Medication Aide (QMA) 7 charted Resident K had an elevated blood sugar value of 473 milligrams (mg)/deciliter (dL) on 4/5/25 at 4:20 p.m. No documentation of notification to the physician was found in the resident's chart. During the month of March 2025, Resident K had 18 instances of his blood sugar level being above 350 mg/dL. During an interview on 4/8/25 at 12:55 p.m., Nurse Practitioner (NP) 8 indicated she was not notified of an elevated blood sugar of 473 mg/dL on 4/5/25. NP 8 indicated she wanted notified of a blood sugar above 350 mg/dL and believed Resident K had orders to notify the physician of an elevated blood sugar above 350 mg/dL. A record review conducted on 4/8/25 at 1:15 p.m., revealed Resident K did not have orders to notify a physician of an elevated blood sugar above 350 mg/dL. During an interview on 4/10/25 at 1:49 p.m., the DON indicated she was not notified of an elevated blood sugar of 473 mg/dL by staff but would have wanted to be notified. The article "Manage Blood Sugar", dated May 15, 2024, was retrieved on 4/10/25 from the Centers for Disease Control (CDC) at https://www.cdc.gov/diabetes/treatment/index.html. The guidance included: " ... A blood sugar target is the range you try to reach as much as			

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	possible. These are typical targets: Before a meal: 80-130 mg/dL. Two hours after the start of a meal: Less than 180 mg/dL ..." An Insulin Injection/Glucometer Readings Policy was provided by the Executive Director (ED) on 4/9/25 at 10:27 a.m. It indicated if a resident does not have orders based on their blood sugar findings the nurse should be notified for all blood sugars above 200 mg/dL. This citation relates to Complaint IN00455674.			
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency Based on interview and record review, the facility failed to ensure grievances reported by residents/representatives and in resident council meetings were addressed and followed up with action plans timely. This had the potential to affect 51 of 51 residents that reside in the facility. Findings include: 1. The clinical record for Resident B was reviewed on 4/7/25 at 2:30 p.m. The diagnoses included, but were not limited to, dementia. During Confidential Interview 1, they indicated Resident B's Representative had reported to the Executive Director (ED) regarding care concerns in March that were not followed up with regarding resolutions. One of the concerns reported was a staff member, Home Health Aide (HHA) 10, providing care that was rough. An interview was conducted with the ED on 4/8/25 at 10:36 a.m. She indicated she did have a meeting with Resident B's Representative due to	R 0041	personnel 1. immediate action will be to have a meeting with management concerning how to fix all residents' concerns immediately. 2. corrective Action - immediately address concerns and fix any concerns brought to our attention from Resident Council. 3. we will contact all necessary parties with residents' concerns in a timely manner 4. depending on what the concerns are, management has 72 hours to address the concern	05/12/2025

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	care concerns that was emailed to her. After the investigation was completed with HHA 10, the ED had checked with the resident's representative to see if the care had improved. Resident B's Representative responded it had. She did not fill out a grievance form with Resident B's Representative's concerns that were emailed to her. 2. The January 2025, February 2025, and March 2025 resident council minutes were provided by the Marketing Director on 4/8/25 at 2:20 p.m. The following were concerns addressed in the resident council minutes: January 2025 resident council minutes - maintenance concerns: building in need of repair, pets: barking and out in hallways, dietary concerns, and staff being on phones. February 2025 resident council minutes - dietary concerns, ice machine not working, laundry concerns, and missing items. March 2025 resident council minutes - call lights, staff being on phones, maintenance concerns: carpet cleaning, dignity and respect, ice machine not working, staffing: requesting manager on duty on weekends, dietary concerns, and sanitary concerns The resident council minutes for January 2025 and February 2025 did not have documented resolutions and follow up on concerns reported in resident council. During Confidential Interview 2, they indicated concerns reported by residents in the resident council were not followed up on. The maintenance concerns have been reported repeatedly by the			

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	residents for months and the facility still has not done anything. "The building is filthy and needs repairs." The dishwasher and ice machine had been broken for a long time. The residents were tired of eating on paper plates. The residents wanted to eat on regular dishes. The ED and Director of Nursing (DON) do not follow up or follow through on any resident concerns. Most of the staff that work at the facility were friends and family of the ED. If they were not related; they were connected in some way or another with the ED. During Confidential Interview 3, they indicated the ED does not address concerns reported in the resident council. The ice machine had been broken for a long time and was still not working. "It is frustrating." During Confidential Interview 4, they indicated there was no follow up on any concerns reported in the resident council. "It is ridiculous." The staff were all related to one another that work here, so nothing got addressed. "The building is going downhill." During Confidential Interview 5, they indicated concerns reported to management were not followed up with. It would be nice to have a working ice machine to get ice. Grievance forms from resident council meetings were provided by the ED on 4/9/25 at 11:21 a.m. Five grievance forms were dated in February 2025, regarding residents that were missing money. The grievances included action plans and staff discussion of resolutions with those residents. During an interview with the ED on 4/9/25 at 1:45 p.m., she indicated she did not have any other			

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	grievances that were reported in resident council meetings other than the residents that had reported missing money. A grievance policy and procedure was provided by the ED on 4/9/25 at 10:27 a.m. It indicated the following, "...Policy detail...4. The Executive Director or District/Regional Director of Operations will document actions (i.e., contact with family, dates of contact, action plan, etc.,) taking in response to the grievance..." A resident rights policy was provided by Dietary Aide 14 on 4/7/25 at 3:59 p.m. It indicated the residents have the right to "Have all reasonable requests and inquiries responded to promptly." This citation is related to Complaint IN00455674.			
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance Based on interview and record review, the facility failed to report to the Indiana Department of Health regarding missing personal items and missing money that were reflected on grievances for 4 of 4 residents reviewed for grievances, and an allegation of abuse for 1 of 5 residents records reviewed. (Residents' 22, 25, 29, 31, and B) Findings include: Grievances from resident council were reviewed from January 2025 to March 2025 on 4/9/25 at 11:21 a.m. 1a. A grievance for Resident 31, dated 2/14/25, alleged there was money missing out of their purse. The response was to provide a lock box for the resident to keep their items in. The Executive	R 0064	The facility failed to report to the Indiana Department of Health regarding missing personal items and missing money that were reflected on grievances. Executive Director will report all grievances to management and proper parties in a timely manner. Executive Director bought lock box with keys to all residents to whom that were effective. Executive Director will conduct in-service monthly x 4 for 2 months, monthly x 2 on going thereafter	05/12/2025

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	Director (ED) signed the grievance form to conclude follow-up with the grievance. 1b. A grievance for Resident 25, dated 2/18/25, indicated Resident 25 informed the ED about money that had come missing. The follow-up indicated a lock box was offered and to Resident 25 and denied by the resident. The ED signed the grievance form to conclude follow-up with the grievance. 1c. A grievance for Resident 29, dated 2/15/25, indicated Resident 29 text the ED about them missing $70.00 from their wallet. The follow-up indicated a lock box was offered to the resident. The ED signed the grievance form to conclude follow-up with the grievance. 1d. A grievance for Resident 22, dated 2/16/25, indicated Resident 22 was missing money and believed it was taken from their apartment. The follow-up indicated a lock box was offered to the resident. The ED signed the grievance form to conclude follow-up with the grievance. The four grievances were not reported to the Indiana Department of Health nor was there an investigation conducted into the allegations of missing personal items or money. 2. During a Confidential Interview, they indicated Resident B's Representative had care concerns related to rough care by Home Health Aide (HHA) 10 that the representative had watched on the resident's room camera. She had reported the incident to the ED. A grievance form written by the ED, dated 3/28/25, indicated an "abuse" concern was received by Resident B's Representative. A night staff person,			

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	HHA 10, was "handling resident in a rough manner during care...Resident [Representative] sent me a video of concerns. ED watched video went to speak with resident, resident did not show as if he was in any pain or discomfort..." An interview was conducted with the ED on 4/8/25 at 10:36 a.m. She indicated Resident B's Representative had sent videos and reported she did not like how Resident B was handled during care. She had conducted an investigation to the incident. The ED indicated she did not report the incident to the Indiana Department of Health. After reviewing the video, she did not like how the resident was transferred, but she did not believe it was abuse. A policy entitled "Abuse, Neglect & Exploitation Policy", undated, was provided by the ED on 4/8/25 at 10:36 a.m. The policy indicated the facility should conduct a confidential internal investigation of the incident upon receipt of an allegation of abuse, neglect or exploitation. The reports of abuse, neglect or misappropriation to the Director of Health. This citation is related to Complaint IN00455674.			
R 0086 Bldg. 00	410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency Based on interview and record review, the facility failed to timely submit the application for certification for the Clinical Laboratory Improvement Amendments (CLIA) waiver. This had the potential to affect 9 of 9 residents who required blood glucose monitoring. Findings include:	R 0086	The facility failed to timely submit the application for certification for the Clinical Laboratory Improvement Amendments (CLIA). Ed will work with regional director to ensure particular file is set up for compliance.	05/06/2025

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	A document entitled "CLIA Laboratory Details" indicated the CLIA waiver certification was effective from 1/26/23 to 1/25/25. The CLIA waiver had expired. During an interview on 4/7/25 at 11:40 a.m., the Executive Director indicated she was unaware the CLIA waiver had expired. Review of the CLIA Application for Certification, on 4/7/25 at 3:30 p.m., indicated the application was submitted via email on 4/7/25 at 3:05 p.m. Review of the facility provided list of residents with special care needs on 4/7/25 at 1:45 p.m., indicated nine residents required blood glucose testing.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure a criminal background check was conducted for a newly hired employee for 1 of 5 staff personnel files reviewed. (Assistant Director of Nursing) Findings include: Five personal files were provided by the Business Office Manager (BOM) on 4/8/25 at 11:30 a.m. The Assistant Director of Nursing (ADON) personal file indicated she had a start date at the facility of 1/5/24. The file did not include a criminal background check. An interview was conducted with the BOM on 4/10/25 at 10:49 a.m. She indicated she was unable to locate a criminal background check for the	R 0116	The facility failed to ensure a criminal background check was conducted for a newly hired employee for 1 of 5 staff personnel files reviewed. HR has received the ADON's background check. HR will audit employee files weekly 4x, then monthly 5x to ensure compliance. Also will ensure all new employees have the Indiana state background check. Will put up a whiteboard to show HR all outstanding items to complete.	05/06/2025

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	ADON. An employee background check policy was provided by the BOM on 4/10/25 at 10:54 a.m. It indicated the following, "...Background checks. Conducting background checks assists in the promotion of a safe environment for all employees and residents. These checks serve as an important part of the employment selection process by providing additional related information that may help determine an applicant's over employability..."			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure one staff person, on every shift, was certified in cardiopulmonary resuscitation (CPR) and first aid. This had the potential to affect 51 of 51 residents that reside in the facility. Findings include: Upon review of the employee files, on 4/10/25 at 9:00 a.m., there was indication that the Executive Director (ED), Director of Nursing (DON), Qualified Medication Aide (QMA) 2, and QMA 3 were the only staff certified in CPR and first aid. Upon review of the daily nursing schedules, the following date(s) were noted without a staff member with first aid and CPR certification on night shift: 3/25/25, 3/26/25, 3/27/25, 3/31/25, 4/2/25,	R 0117	R-0117 1. Corrective action for those residents affected 2.CPR class was held on 4-25-25 for all nursing and management staff. 3.Documentation of completion of class was giving to Business Office Manager. 4. There will be a hard copy of all completed CPR class in the employee file. BOM will audit each employee file annually to make sure compliance. DON and RCC will make sure there are CPR certified personnel on each shift. Employee will be given a 30-day notice prior to expiration to renewal	05/12/2025

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FORT HARRISON ALF OPERATIONS	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

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	4/3/25, 4/7/25, 4/8/25, and 4/9/25. An interview was conducted with the ED and DON on 4/10/25 at 9:40 a.m. The ED indicated there was a class for CPR and first aid conducted, on 4/8/25, but the classes, for both, were all online. There was no hands-on training for CPR included in the training conducted on 4/8/25. QMA 2 and QMA 3 were the only staff who worked the night shift, who were first aid and CPR certified, but QMA 3 resigned and her last day of employment was 3/24/25. This citation is related to Complaint IN00455674.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to ensure the facility's common areas and residents' apartments were clean and in good repair. This had the potential to affect 51 of 51 residents that reside in the facility. Findings include: An observation was conducted of the community on 4/7/25 at 9:35 a.m. The carpets on the first, second, and third floor were observed to be stained and dirty. The walls and residents' doors were dirty and scraped. The corner walls were gouged with metal framing exposed on the first floor. Resident S's door had a gouged scrape down the width of the door and was dirty. An observation was conducted of the second floor on 4/7/25 at 3:54 p.m. A strong smell of	R 0144	R0144 Maintenance noncompliance 1. immediate action maintenance will do preventive maintenance weekly x 4 and twice monthly thereafter on building maintenance and clean of the community. Maintenance will assign management daily check off sheet for 4 weeks for two months and 3 x weekly monthly and thereafter	05/12/2025

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	ammonia odor in hallway was observed. An interview was conducted with Resident C on 4/7/25 at 2:30 p.m. She indicated there were quite a few environmental concerns discussed for months in resident council meetings. The whole building needed cleaned and repaired. An observation was conducted of Resident B's room on 4/7/25 at 2:54 p.m. The ceiling in the apartment was bubbled and brown stained. During a confidential interview, they indicated the facility was "filthy" and in bad repair. An interview was conducted with Resident E on 4/9/25 at 9:44 a.m. She indicated the entire building needed cleaned and fixed. The carpets were old, and they haven't been cleaned in a long time. She wasn't sure if cleaning the carpets would even remove all of the stains. The walls in the common areas and resident apartments needed repaired with plaster and paint due to large gouges and scrapes. It had been discussed with management and nothing got done. An observation was conducted of Resident J's room on 4/9/25 at 10:25 a.m. The apartment was observed to have stained carpet, and walls were gouged long in length. The heat/air wall unit was hanging away the wall. A gray metal frame piece was hanging from the corner doorframe of the bedroom closet. An interview was conducted with Resident J in her room on 4/9/25 at 10:30 a.m. She indicated the stained carpet, and damaged walls had been there for a while. She has cut her arm on the long metal piece hanging from the corner of the closet before. The whole building was dirty and in need of			

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	repairs. The residents have discussed it with the resident council and nothing has been done. An observation was conducted of Resident DD's room on 4/9/25 at 10:55 a.m. The ceiling was observed with a brown stained spot on the ceiling, and the carpet was stained. The January 2025 and March 2025 resident council minutes were provided, on 4/8/25 at 2:20 p.m., by the Marketing Director. The attendees were the following: Resident C, Resident D, Resident E, Resident G, Resident H, Resident J, Resident K, Resident L, Resident M, Resident N, Resident P, Resident Q, Resident R, Resident B, Resident S, Resident T, Resident V, Resident X, and Resident TT. The January 2025 resident council minutes indicated the residents' had environmental concerns with the building. The residents reported concerns with damaged walls and handrails. The March 2025 resident council minutes indicated the residents' reported having maintenance concerns with the carpet. An environmental tour was conducted with the Maintenance Supervisor (MS) on 4/9/25 at 2:17 p.m. The MS indicated the carpets were stained on all the floors. The residents spill their drinks coming through the community common areas. During the tour, the first floor laundry room was observed. The room was observed with a thick gray substance on the electrical wall socket plates and dangling from cabinets above the washers and dryers. The MS indicated that the housekeepers need to come in here and clean. Then, Resident S's room was observed. The resident's door was observed dirty and with a large, gouged scrape across the width of the door. The room had a strong odor throughout. The kitchen sink was observed with a pile of dishes			

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	with several flying insects. Next, Resident HH's room was observed. A strong ammonia odor was present throughout the apartment. The faucet in the kitchen sink would not turn to the side for hot water. Then, Resident J's room was observed. The apartment was observed with gouges and scrapes. The carpet was stained throughout the apartment. A large metal piece was hanging from the corner door frame of the closet. At that time, the MS placed the wall air/heat unit that was hanging off the wall back on the wall. During the tour, the 2nd floor laundry room was observed. There were large brown stained spots observed on the ceiling tiles and a gray substance on the walls. The third floor was observed. A floor electrical socket was observed exposed in the carpet. The MS indicated at that time; a cover should be over the electrical socket. Then, Resident P's room was observed. The MS turned on the kitchen sink's faucet and water slowly streamed out of the faucet with no pressure. Resident P indicated the faucet hasn't worked for over two years. Next, Resident BB's apartment was observed. The kitchen light did not have light bulbs nor light fixture. After, the outside grounds were observed with the MS. An outside walkway had a roof and two plastic side closures. The plastic sides were observed to be broken. An interview was conducted with the MS on 4/9/25 at 3:30 p.m. He indicated Resident S and Resident HH refuse to have housekeeping come in to assist with cleaning. He has repaired Resident J's closet with the metal piece, but the resident tore off the plastic cover piece. The electrical scooters cause most of the gouges and scrapes throughout the community and their apartments. He planned to remove the broken plastic sides in the walkway outside.			

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	A resident rights policy was provided by Dietary Aide 14 on 4/7/25 at 3:59 p.m. It indicated, the residents have the right to "live in a safe and clean living environment." This citation is related to Complaint IN00455674.			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency A. Based on observation, interview, and record review, the facility failed to ensure the kitchen and kitchen equipment was maintained, clean, and in good repair, and failed to ensure food was labeled and stored to ensure disposal before expiring. This had the potential to affect 51 of 51 residents that receive food from the kitchen. B. Based on observation, interview, and record review, the facility failed to ensure a high-temperature dishwasher was at the appropriate temperature to disinfect the dishes. This had the potential to affect 51 of 51 residents that receive food from the kitchen. Findings include: A. During the initial kitchen tour conducted on 4/7/25 at 9:45 a.m., there were flying insects flying around the kitchen in close proximity to the boxes that contained onions and potatoes. The vents were covered in a thick layer of dust and grease. The clean dishes had a white film on them. The kitchen floor was dirty with food material, leaves, and debris. The wire racks located in the dry storage area were sticky and had a substance dripping from it. The ice machine was not working, and no ice was present in the machine. The wall and the ceiling, above the steam table, had a black	R 0154	Kichen will team up with maintenance three times a week for two weeks to keep up with repairs and proper ways to keep equipment clean. After two weeks documentation will be audited every two weeks going forward. Polices will be put in affect with documentation to ensure labeling and storage is done properly. Documentation will be done every day for three weeks. After three weeks, documentation will be audited every week going forward.	05/06/2025

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	discoloration on it. The metal spacers, holding the ceiling tiles above the steam table, were discolored. During the initial kitchen tour, the walk-in refrigerator was observed with the following: - Moldy yellow bell peppers that were in an undated box, - Moldy red bell peppers that were in an undated box, - Moldy green bell peppers that were in an undated box, - Moldy yellow squashes that were in an undated box, - A bottle of balsamic vinaigrette with an expiration date of 12/30/24, - Nine pre-made salads, dated 4/4/25, that were partially covered, - Two containers of cottage cheese that expired on 3/31/25, - A bottle of teriyaki sauce that expired on 12/2024, - A container of diced ham that was moldy and dated 2/26/25, - An unopened bag of lettuce that expired on 4/1/25, - A bag of salad mix with wilted lettuce leaves and expired on 3/30/25, - A package of Swiss cheese with a discard date of 4/5/25, and - A package of Swiss cheese with a discard date of 3/16/25. During the initial kitchen tour, the dry storage area was observed with the following: - A plastic container of Romano shredded cheese with no open date. The manufacture recommendation indicated refrigeration after			

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	opening. - St Elmos creamy horseradish sauce, opened 8/1/24, with no use by date. On the label, the manufacturer label indicated refrigeration after opening. - One package of powdered chicken gravy wrapped in plastic wrap with no open date. - Four bags of powdered brown gravy mix wrapped in plastic wrap with no open date. - One bag of powdered beef gravy mix wrapped in plastic wrap with no open date. - Two bags of powdered turkey gravy mix wrapped in plastic wrap with no open date. - One bag of powdered pork gravy mix wrapped in plastic wrap with no open date. - A cardboard box containing Jell-O and drink mixes had what appeared to be spilled Jell-O or drink mix on the bottom. - A can of pineapple and coconut juice with a manufacture expiration date of 3/2025. - An unopened box of potato pearls with a manufacture expiration date of 1/24/25. - One large open box of granulated sugar with no open date. The sugar was in a plastic bag in the box and was not sealed. - Two bottles of Hidden Valley vinaigrette with a manufacture expiration date of 3/26/25 and 2/26/25. - One bottle of Thousand Island dressing with a manufacture expiration date of 3/31/25. - One bottle of balsamic dressing with a manufacture expiration date of 1/18/25. - One cardboard box containing a plastic jug of oil, the box was saturated in oil. - One bag of yellow cake mix, opened 3/10/24, with no use by date. - One package of cream soup base with manufacture expiration date of 3/17/25. - One bag of large, seasoned croutons, opened 2/25/25, and no use by date.			

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	- One bottle of soy sauce with no open date and with a manufacturer recommendation to refrigerate after opening. - One box of undated onions that had some green sprouts and some were moldy. - One box of undated potatoes sprouting and a few were moldy. - One bottle of cinnamon sauce with no open date and a manufacture expiration date 3/20/25. On 4/7/25 at 11:55 a.m., the Dietary Manager (DM) provided copies of the daily cleaning schedule of the kitchen from 2/23/25 to 4/5/25. There were over 50 holes in the logs that indicated the kitchen cleaning task was not signed off, as completed. An interview conducted with the Executive Director (ED), on 4/7/25 at 3:35 p.m., indicated the Maintenance Director was responsible for preventive maintenance on all equipment and surfaces in the kitchen. The food supply/stock was rotated by first in/first out basis. The ED indicated the cook and dietary aide working on the day of the food delivery were responsible for that task of putting away the delivered food items. The ED also indicated the refrigerator, freezer, and dry storage should be monitored daily to weekly for any expired food. B. During the initial kitchen tour, the dishwasher was observed to reach 158 degrees Fahrenheit (F) after running two cycles for the final rinse temperature. The metal plate on the machine indicated 150 degrees F for washing cycle and 180 degrees F for rinse cycle to properly sanitize the dishes. Dietary Aide (DA) 5 provided the dishwasher temperature logs on 4/7/25 at 3:59 p.m. The logs indicated the following:			

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	March 7, 2025; no temperatures were recorded on the dishwasher temperature log. March 8, 2025; no temperatures were recorded on the dishwasher temperature log. March 16, 2025; A.M. (morning) final rinse temperature was recorded as 160 degrees F. March 18, 2025; P.M. (afternoon/evening) final rinse temperature was recorded as 160 degrees F. March 19, 2025; A.M. final rinse temperature was recorded as 160 degrees F. March 22, 2025; no A.M final rinse temperature was recorded. March 27, 2025; A.M. final rinse temperature was recorded as 160 degrees F. March 30, 2025; A.M. final rinse temperature was recorded as 152 degrees F. March 30, 2025; P.M. final rinse temperature was recorded as 170 degrees F. April 3, 2025; P.M. final rinse temperature was recorded as 170 degrees F. April 5, 2025; A.M final rinse temperature was recorded as 140 degrees F. April 5, 2025; P.M. final rinse temperature was recorded as 128 degrees F. An interview conducted with the Executive Director, on 4/7/25 at 3:35 p.m., indicated the Maintenance Director was responsible for preventive maintenance on all equipment and surfaces in the kitchen. An interview conducted with the ED, on 4/8/25 at 9:30 a.m., indicated the dishwasher was not fixed on 4/7/25. She indicated the current dishwasher was being leased, and due to several issues with the dishwasher, she was going to end the lease. A new dishwasher was going to be leased by Gordons Food Service (GFS). The ED indicated she called GFS, again, to have the new dishwasher			

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	placed on 4/8/25. On 4/9/25 at 1:07 p.m., the ED provided an invoice from a vendor. The invoice indicated the ED was looking to purchasing or leasing a dishwasher and needed a quote. During Confidential Interview 2, they indicated the dishwasher had been broken for a while. The residents were tired of eating off paper plates and wanted to utilize regular dishes. An undated and unnamed policy for the kitchen was provided by Dietary Aide (DA) 5 on 4/7/25 at 3:39 p.m. The policy indicated "Policy: It is policy of [name of facility] to ensure food and chemicals are stored in compliance with applicable Federal, State and Local regulations regarding sanitary and safe storage conditions to minimize the right of spoilage or contamination. Procedures: 1. Staples or "dry goods" are stored in an area, which meets the following specifications... Well maintained, neat and orderly... Free from insects and rodents ... 3. Date dry good when received and when opened (i.e.: rice and beans.) ... 6. Cover all stored foods. Label and date any leftover foods. ... 7. Make sure that any leftover food are not left in refrigerator after 7 days of labeled date ...."			
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to ensure the dumpster lids and gates were kept closed and the area around the dumpster was free of rubbish. This had the potential to affect 51 of 51 residents that reside in the facility.	R 0155	Personnel non- compliant 1. corrective action dumpster area dumpster lid 2. maintenance will in-service monthly x4 and thereafter on keeping dumpster lids, gates closed and free of rubbish.	05/12/2025

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	Findings include: On 4/8/25 at 8:43 a.m., an observation was conducted of the left top lid of the dumpster being open. On 4/8/25 at 10:30 a.m., an observation was conducted of the dumpster and the dumpster lids were open. On 4/8/25 3:56 p.m., an observation was conducted of the dumpster area with both gates along the fence surrounding the dumpster were open, and both lids on the dumpster were open. On 4/9/25 at 8:53 a.m., an observation was conducted of Cook 6 throwing a box and trash bag into the dumpster without attempting to close the lids or gates afterwards. On 4/9/25 at 9:36 a.m., an observation was conducted of Cook 6 throwing a box into the dumpster and no attempt was made to close the lids or gates. On 4/9/25 at 9:40 a.m., Dietary Aide (DA) 12 threw a bag of trash into the dumpster and no attempt was made to close the lids or gates. On 4/9/25 at 10:49 a.m., Cook 6 threw a bag of trash into the dumpster and no attempt was made to close the lids or gates. On 4/9/25 at 1:37 p.m., Cook 6 threw a bag of trash into the dumpster and no attempt was made to close the lids or gates. During an environmental tour on 4/9/25 at 3:30 p.m., the dumpster lids and gates were observed to be opened. There was trash on the ground in		3. maintenance will do random checks throughout daily and thereafter	

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	the fenced area. A mattress and box springs were on the right side leaning on the fence. The Maintenance Director indicated the mattress has been there for at least a week. The trash company will not pick it up because it was not in the dumpster. A red orange food like substance was seen splattered on the mattress, box springs, and on the ground in front of the dumpster. The Maintenance Director indicated the area should be clean of trash and debris. The lids on the dumpster and the gates should be always closed. A policy titled "Garbage and Waste Disposal Policy" was obtained from the Business Office Manager on 4/10/25 at 9:04 a.m. The policy indicated, "Purpose: To ensure the safe, sanitary, and efficient collection, handling, and disposal of garbage and waste within the assisted living facility to maintain a clean environment and minimize health hazards... Policy: All garbage and waste generated in resident rooms, common areas, kitchens, offices, and other facility spaces must be disposed of promptly and in compliance with local health and sanitation regulations ...Waste storage areas must be cleaned and sanitized regularly. Outside dumpsters should be kept closed, located away from resident living areas, and emptied by the designated waste removal service according to schedule ...."			
R 0189 Bldg. 00	410 IAC 16.2-5-1.6(m) Physical Plant Standards - Noncompliance Based on observation and interview, the facility failed to ensure the ice machine was functioning to ensure ice was always readily available to the residents. This had the potential to affect 51 of 51 residents who reside in the facility. Findings include:	R 0189	Kitchen has gotten approval to get a new ice machine. This will guarantee every resident will have ice.	04/29/2025

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FORT HARRISON ALF OPERATIONS	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

(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
	During the initial kitchen tour on 4/7/25 at 9:45 a.m., the ice machine was out of order, and no ice was present in the bin to retrieve any ice. An interview was conducted with Cook 6 on 4/7/25 at 11:30 a.m. She indicated the ice machine had been broken for several months. The facility had purchased ice for the residents and the ice was kept in the freezer. There was no ice present in the freezer during the initial kitchen tour. During Confidential Interview 2, they indicated the ice machine has been broken for "a long time". During Confidential Interview 3, they indicated the ice machine had been broken for a while and was still not working. During Confidential Interview 5, they indicated it would be nice to have a working ice machine to get ice. On 4/9/25 at 1:41 p.m., an invoice from a vendor was provided by the Executive Director (ED). The invoice indicated the ice machine was fixed. The invoice indicated four fans had failed, the ice machine needed to be cleaned and sanitized, and the filter needed to be replaced.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on interview and record review, the facility failed to update a resident's evaluation of needs semiannually for 2 of 5 records reviewed. (Resident K and Resident 47)	R 0214	Resident evaluation of needs completed semi - annual all residents have a potential to be at risk Care Plans will be completed and	05/06/2025

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	1. The clinical record for Resident K was reviewed on 4/08/25 at 1:47 p.m. It revealed his record did not contain a current semiannual evaluation. The last evaluation was completed on 11/02/23, after admission on 10/27/23. During an interview on 4/10/25 at 1:49 p.m., the Director of Nursing (DON) indicated evaluations and service plans should be re-evaluated and signed every six months. 2. The clinical record for Resident 47 was reviewed on 4/8/25 at 2:00 p.m. The diagnoses included, but were not limited to, chronic pain. Resident 47 was admitted to the facility on 2/23/24. No semiannual assessments were found in Resident 47's clinical record. An interview was conducted with the DON on 4/9/25 at 1:50 p.m. She indicated she did not know why semiannual assessments were not completed for this resident. She indicated they should have been done semiannually. A policy regarding resident evaluations was not provided by the facility.		signed upon admission and semi-annually for each resident DON will audit residents on a rotation to ensure that Resident Evaluation of Needs are completed and signed weekly x4 weeks, monthly x4 months and semiannually thereafter	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to provide a signed service plan for 2 of 5 records reviewed. (Resident K and Resident 47) 1. The clinical record for Resident K was reviewed on 4/08/25 at 1:47 p.m. It revealed his record did not contain a signed service plan.	R 0217	Care plan will be completed and signed upon admission and semiand semiannually for each resident. DON will audit residents on a rotation to ensure that Care Plans are completed and signed weekly times four weeks, monthly times four months and semiannually	05/09/2025

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	On 4/09/25 at 10:27 a.m., the Executive Director (ED) provided a service plan for Resident K, initiated on 11/02/23, and signed by the resident and the Director of Nursing (DON) on 4/09/25. During an interview with the DON on 4/10/25 at 1:49 p.m., she indicated service plans should be re-evaluated and signed every six months. 2. The clinical record for Resident 47 was reviewed on 4/8/25 at 2:00 p.m. The diagnoses included, but were not limited to, chronic pain. Resident 47 was admitted to the facility on 2/23/24. A service plan was initiated for Resident 47, on 2/23/24, but was not completed until 4/8/25. On 4/9/25 at 10:27 a.m., the ED provided a copy of the completed service plan. The signature for the service plan was dated 4/8/25. An interview was conducted with the DON on 4/9/25 at 1:50 p.m. The DON indicated she did not know why the service plan was not completed upon admission. She indicated the service plan should have been completed upon admission and reviewed every six months. A policy regarding service plans was not provided by the facility.		thereafter.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based on observation, interview and record review, the facility failed to ensure a resident was transferred respectfully and appropriately by the staff personnel, timely address a resident's elevated blood sugar, and obtain weights as ordered for 3 of 5 records reviewed. (Resident 47,	R 0240	Weight monitoring documentation in-service will be completed. DON will audit residents with weight orders to ensure that documentation is completed into PCC and PCP notified if necessary. Audit will be	05/09/2025

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	Resident B, and Resident K) Findings include: 1. The clinical record for Resident B was reviewed on 4/7/25 at 2:30 p.m. The diagnoses included, but were not limited to, dementia. A fall service plan, dated 1/21/25, indicated Resident B had a history of falling due to gait imbalance. The interventions were to provide reminders to use call light for assistance. A mobility service plan, dated 10/7/24, indicated Resident B needed assistance to ambulate. During Confidential Interview 1, they indicated Resident B's Representative had repeatedly been told by Resident B a staff member was rough handling him during care. Resident B's Representative installed a camera in the resident's room. The representative had observed care provided by Home Health Aide (HHA) 10 that she felt was not appropriate and rough handling. They indicated Resident B's Representative did report the incident and sent the videos to the Executive Director (ED). An interview was conducted with Resident B on 4/7/25 at 2:54 p.m. He indicated he had not been abused. He was able to provide his pendant that was around his neck. He utilized his pendant when he needed assistance. An interview was conducted with the ED on 4/8/25 at 10:36 a.m. She indicated Resident B's Representative had sent two recorded videos by email and reported she felt the resident was provided rough care by HHA 10. An investigation was initiated at that time. After reviewing the		completed weekly times four weeks, monthly times four months and monthly thereafter.	

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	videos, HHA 10 was educated on appropriate transferring of a resident with utilizing a gait belt as well with the rest of the staff to be educated. The staff were to use gait belts with transfers. An observation was conducted of two recorded videos of Resident B on 4/8/25 at 10:40 a.m. The video observed indicated that the resident was leaving the bathroom with assistance by HHA 10 to return to bed. During that time, HHA 10 did not provide any instructions to the resident prior to touching his upper extremities to assist with the resident to grab the mobility bar on the bed. She grabbed his arm and placed his arm on the mobility bar herself without instruction to the resident. After the resident was in bed, HHA 10 did not provide any instructions to the resident and placed her hands on his head and moved his body to the center of the bed. An investigation of the incident was provided by the ED on 4/8/25 at 10:30 a.m. The investigation did not include HHA 10's signature that she had been provided education on proper body mechanics during a transfer. A one-person transfer policy was provided by the ED on 4/8/25 at 10:30 a.m. It indicated the following, "...Purpose: Transfer a resident safely from one position to another with one person. When providing care, associates will: Knock before entering the resident's apartment and identify yourself to the resident...Adjust your approach to the activity based on the resident's level of mental alertness. Explain the procedure to the resident...Ask what the resident prefers. Gather equipment before starting. Return equipment when completed...Equipment: Gait/transfer belt...Suggested Guidelines: 1. Explain procedure to resident..."			

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	2. The clinical record for Resident K was reviewed on 4/7/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus. A quarterly Brief Interview for Mental Status, dated 2/1/25, indicated Resident K was cognitively intact. A record review conducted on 4/7/25 at 2:14 p.m., revealed Qualified Medication Aide (QMA) 4 charted Resident K had an elevated blood sugar level of 524 milligrams (mg)/deciliter (dL) on 4/7/25 at 10:30 a.m. During the month of March 2025, Resident K had 18 instances of his blood sugar level being above 350 mg/dL. A progress note, created on 4/7/25 at 2:37 p.m., documented by the Director of Nursing (DON), indicated staff had reported the resident's elevated blood sugar to the resident's physician. During an interview, on 4/7/25 at 3:07 p.m., the DON indicated QMA 4 notified her of Resident K's elevated blood sugar that morning (4/07/25). Afterward, the DON notified the resident's physician. The physician indicated to the DON they would fax an order for additional units of insulin to be administered. During an interview on 4/8/25 at 12:55 p.m., Nurse Practitioner (NP) 8 indicated she had been notified by the facility of Resident K's elevated blood sugar the afternoon of 4/7/25. NP 8 indicated she would want to be notified of a blood sugar above 350 mg/dL and believed Resident K had orders to notify the physician of an elevated blood sugar above 350 mg/dL. A record review, conducted on 4/8/25 at 1:15 p.m., revealed Resident K's clinical record did not			

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	contain orders to notify a physician of an elevated blood sugar above 350 mg/dL. The article, "Manage Blood Sugar", dated May 15, 2024, was retrieved on 4/10/25 from the Centers for Disease Control (CDC) at https://www.cdc.gov/diabetes/treatment/index.html. The guidance included: " ... A blood sugar target is the range you try to reach as much as possible. These are typical targets: Before a meal: 80-130 mg/dL. Two hours after the start of a meal: Less than 180 mg/dL ..." An Insulin Injection/Glucometer Readings Policy was provided by the Executive Director (ED) on 4/09/25 at 10:27 a.m., it indicated if a resident does not have orders based on their blood sugar findings the nurse should be notified for all blood sugars above 200 mg/dL. 3. The clinical record for Resident 47 was reviewed on 4/8/25 at 2:00 p.m. The diagnoses included, but were not limited to, chronic pain. Resident 47 was admitted to the facility on 2/23/24. A physician's order, dated 4/18/24, indicated obtaining a weekly weight every Thursday for the diagnosis of congestive heart failure. The weights obtained for Resident 47 were reviewed and there were no weekly weights obtained on a consistent basis. Resident 47 had 13 weights documented since their admission to the facility. An interview was conducted with the Director of Nursing on 4/9/25 at 1:50 p.m. She indicated Resident 47 may refuse their weight to be obtained at times.			

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R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency Based on interview and record review, the facility failed to ensure an administration of insulin was documented, as received, by the staff member who administered it for 1 of 5 residents observed for medication administration. (Resident K) Findings include: An interview conducted with Qualified Medication Aide (QMA) 4, on 4/8/25 at 8:50 a.m., indicated she obtained Resident K's blood sugar, on 4/7/25 in the morning, and it was elevated. QMA 4 notified the Director of Nursing (DON) of the elevated blood sugar. The DON instructed QMA 4 to administer the scheduled insulin to Resident K, continue to monitor his blood sugar, and ensure he eats. QMA 4 indicated she was not certified to administer insulin. A physician's order, dated 12/23/24, indicated the use of Humalog (short-acting insulin); inject eight units subcutaneously three times a day; hold if the resident was not eating. The April 2025 medication administration record (MAR) indicated the 7:00 a.m. dose of the scheduled Humalog was signed off by the DON. An interview conducted with the DON, on 4/9/25 at 1:49 p.m., indicated she did not administer the dose of insulin for Resident 48 on 4/7/25 at 9:53 a.m. The DON was not in the facility at that time.	R 0243	Insulin Documentation completed and PCP/Nurse notification for blood sugars over 200 all residents that require blood sugar monitoring insulin dependent have the potential to be at risk Insulin policy In-Service will be completed with QMA's and Nurse Don will complete an audit for all residents that require blood sugar monitoring or insulin dependent to ensure that all blood sugar over 200 are reported to the primary provider Don will follow up and audit for the effected residents twice weekly x4 weeks and then weekly DON and ED will assist QMA"s will completing insulin Certification on a rotation	05/06/2025
R 0245 Bldg. 00	410 IAC 16.2-5-4(e)(5) Health Services - Offense	R 0245	Insulin certified staff will	05/02/2025

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	Based on observation, interview, and record review, the facility failed to ensure staff administering insulin was a nurse or Qualified Medication Aide (QMA) that was certified to administer insulin for 2 of 6 residents observed for medication administration. (Resident 25 and Resident K) Findings include: 1. The clinical record for Resident 25 was reviewed on 4/8/25 at 2:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 2/21/25, indicated Resident 25 was to receive a scheduled eight units of Humalog (fast acting) insulin with a flex pen before meals. A physician order, dated 2/21/25, indicated Resident 25 was to receive additional Humalog insulin with a flex pen utilizing a sliding scale before meals. The insulin scale was as follows: blood sugar readings of 141-180 = 6 units of insulin, 181-220 = 8 units of insulin, 221-260 = 10 units of insulin, 261-300 = 12 units of insulin, 301-350 = 14 units of insulin, 351-400 = 16 units of insulin, 401 or greater = 18 units of insulin. A medication administration with QMA 9 was conducted on 4/8/25 at 11:15 a.m. An observation was made of Resident 25 receiving his Humalog insulin by flex pen. QMA 9 was observed preparing and setting up the Humalog flex pen. During that time, QMA 9 attached the needle without utilizing an alcohol wipe and dialed up the insulin amount of 22 units of Humalog insulin. She was not observed priming the flex pen prior to dialing up the insulin amount. Then, she handed the flex pen to Resident 25. He pulled up his shirt		successfully complete the Insulin Administration for Qualified Medication Aide Competency Checklist with DON weekly then times four weeks, biweekly times four weeks, then monthly thereafter.	

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	and stuck the needle in his abdomen. She did not provide or educate the resident to utilize an alcohol wipe to disinfect the area of skin prior to the insertion of the insulin pen in his abdomen. After, an interview was conducted with QMA 9. She indicated she was not certified in insulin administration. She was able to set up the insulin pen and give such to the resident to administer himself. An interview was conducted with the Director of Nursing (DON) on 4/9/25 at 1:45 p.m. She indicated she was unaware QMA staff members were unable to set up an insulin flex pen for residents when he or she was not certified to administer insulin. QMA 9 should have primed the insulin pen prior to dialing up the insulin. 2. An interview conducted with QMA 4, on 4/8/25 at 8:50 a.m., indicated she obtained Resident K's blood sugar, on 4/7/25 in the morning, and it was elevated. QMA 4 notified the DON of the elevated blood sugar. The DON instructed QMA 4 to administer the scheduled insulin to Resident K, continue to monitor his blood sugar, and ensure he eats. QMA 4 indicated she was not certified to administer insulin. A physician's order, dated 12/23/24, indicated the use of Humalog (short-acting insulin); inject eight units subcutaneously three times a day; hold if the resident was not eating. The April 2025 medication administration record (MAR) indicated the 7:00 a.m. dose of scheduled Humalog was signed off by the DON. An interview conducted with the DON, on 4/9/25 at 1:49 p.m., indicated she did not administer the dose of insulin for Resident K on 4/7/25 at 9:53 a.m. The DON was not in the facility at that time.			

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	The April 2025 MAR indicated the following date(s)/time(s) where QMA 4 signed off as administering insulin for Resident K: 4/2/25 at 4:00 p.m., 4/3/25 at 7:00 a.m., 4/3/25 at 11:00 a.m., 4/7/25 at 11:00 a.m., 4/8/25 at 7:00 a.m., and 4/8/25 at 11:00 a.m. Upon reviewing QMA 4's certification on 4/10/25 at 11:35 a.m., it indicated she was not certified to administer insulin. An insulin pen policy was provided by the ED 4/9/25 at 10:27 a.m. It indicated the following, "...Packaging and Storing...3. Safety needles must be used and disposed of in pre-approved containers...For a general idea of how pens work, here are the basic steps that are common to most models and types: i. remove the pen cap. ii. check the insulin (amount and appearance). iii. clean the injection site with an alcohol swab. iv. attach the safety pen needle and remove cap. v. Prime the pen. vi. dial the dose and inject. vii. Remove the needle from the pen and dispose of properly..."			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure Qualified Medication Aide (QMA) staff members received authorization by a nurse prior to administering an as needed (PRN) medication for 3 of 5 residents records reviewed. (Resident 27, Resident 39 and Resident K)	R 0246	all residents that receive PRN medication have the potential to be at risk Medication Administration in-service will be completed DON will complete an audit for all resident that receive PRN medication weekly to ensure that	05/06/2025

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	Findings include: 1. The clinical record for Resident 39 was reviewed on 4/8/25 at 2:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 8/22/24, indicated Resident 39 was to receive 5-325 milligrams of hydrocodone-acetaminophen every four hours PRN for pain. During an observation of medication administration with QMA 9 on 4/8/25 at 11:17 a.m., she was observed preparing pill medication for Resident 39. During that time, QMA 9 was observed dropping pill medications from the packets in the medication cup. QMA 9 indicated at that time, the resident always wants her 5-325 milligrams of hydrocodone-acetaminophen to be added to the cup to administer with that medication administration. When she goes into the room she will ask the resident about her level of pain. She then pulled the hydrocodone-acetaminophen out of the narcotics drawer and put the pill medication in the cup with the other pill medications. After, she went into the resident's room and administered the medications. During that time, the resident did not indicate she was in pain or inquired about the pain medication. QMA 9 did ask the resident about their pain level or location of pain. After, QMA 9 left the room and returned to the cart. There was no observation of QMA 9 contacting a nurse for approval to administer the as needed hydrocodone medication prior or after the administration. The April 2025 Medication Administration Record for Resident 39 indicated 5-325 milligrams of		a nurse was notified before administering PRN medications and proper documentation completed. The audit will be completed twice weekly for 4 weeks then weekly thereafter	

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	hydrocodone-acetaminophen PRN medication was administered on the following days with no documented prior authorization by a nurse to administer: 4/3/25 at 11:17 a.m. - administered by QMA 9 - resident's pain level was documented as a 7, 4/4/25 at 2:55 p.m. - administered by QMA 9 - resident's pain level was documented as a 7, and 4/8/25 at 11:17 a.m. - administered by QMA 9 - resident's pain level was documented as a 7. An interview was conducted with the Director of Nursing on 4/9/25 at 1:45 p.m. She indicated she was unaware of QMA staff members needing prior authorization by a nurse to administer PRN medications. 2. The clinical record for Resident K was reviewed on 4/7/25 at 11:30 a.m. The diagnoses included, but were not limited to, chronic gout. Resident K's Medication Administration Record (MAR) was reviewed on 4/9/25 at 10:35 a.m. It indicated QMA 14 administered Tylenol Extra Strength 500 milligrams (mg), on 4/09/25 at 9:06 a.m., and documented the resident's pain level as a 7. Resident K's clinical record indicated Tylenol Extra Strength 500 mg was ordered to be given as needed every eight hours for left foot pain. The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of Tylenol given by QMA 14. During an interview on 4/10/25 at 1:49 p.m., the Director of Nursing (DON) indicated QMA staff should not be administering as needed medication without notification and authorization from a			

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	nurse. 3. The clinical record for Resident 27 was reviewed on 4/8/25 at 3:14 p.m. The diagnoses included, but were not limited to, hypertension. A physician's order, dated 5/6/24, indicated to administer two tablets of 500 milligrams of Tylenol every six hours as needed for pain. On 4/9/25 at 10:27 a.m., the Executive Director (ED) provided the MAR for March and April of 2025. On March 2, 2025, QMA 14 administered acetaminophen (Tylenol) two 500 milligrams (mg) tablets to Resident 27. The clinical record did not reflect the licensed nurse was made aware or received authorization from a licensed nurse prior to administering the as needed acetaminophen. The pain assessment that was completed at the time of administration indicated Resident 27 had a pain level of 0 (0 being no pain and 10 being the worst pain possible). During an interview with the DON on 4/9/25 at 1:50 p.m., she indicated the QMAs normally notify her that PRN medication was being administered. She could not recall if she was notified of the PRN acetaminophen administration for Resident 27. She indicated a progress note should have been completed to indicate the QMA notified a nurse prior to the medication being administered. The facility did not provide a policy for PRN medication administration.			
R 0271 Bldg. 00	410 IAC 16.2-5-5.1(d) Food and Nutritional Services - Deficiency Based on interview and record review, the facility failed to have a diet order for 1 of 5 records reviewed. (Resident K)	R 0271	All residents have potential to be at risk DON will complete a review each	05/06/2025

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	Findings include: The clinical record for Resident K was reviewed on 4/7/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus. On 4/08/25 at 1:47 p.m., review of Resident K's clinical record indicated a diet had not been ordered by an attending physician. A transfer and discharge form from the resident's previous living facility, dated 10/26/23, indicated Resident K's diet included diabetic restrictions. During an interview on 4/09/25 at 1:49 p.m., the Director of Nursing (DON) indicated Resident K should have a diet ordered and believed he was on a regular diet.		resident electronic chart to ensure diet orders are uploaded into PCC as ordered DON will provide the ED with an updated diet order report weekly x4 weeks, monthly x4 months then after census changes thereafter	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense Based on observation, interview, and record review, the facility failed to ensure infection control was maintained while administering insulin to a resident utilizing a flex pen for 1 of 6 residents observed during medication administration. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 4/8/25 at 2:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 2/21/25, indicated Resident 25 was to receive a scheduled eight units of Humalog (fast acting) insulin with a flex pen before meals.	R 0406	R-0406 Noncompliance Infection Control corrective action for those residents affected 1) All residents that receive insulin have the potential to be at risk. 2) DON and ED completed an infection control and insulin administration in-service with staff. Don ordered safety needle and extra sharps containers for each medication cart. 3) All insulin certified staff successfully completed Insulin Administration for Qualified Medication Aide (QMA)	05/12/2025

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	A physician order, dated 2/21/25, indicated Resident 25 was to receive additional Humalog insulin with a flex pen utilizing a sliding scale before meals. The insulin scale was as follows: blood sugar readings of 141-180 = 6 units of insulin, 181-220 = 8 units of insulin, 221-260 = 10 units of insulin, 261-300 = 12 units of insulin, 301-350 = 14 units of insulin, 351-400 = 16 units of insulin, 401 or greater = 18 units of insulin. During a medication administration with Qualified Medication Aide (QMA) 9 on 4/8/25 at 11:15 a.m., an observation was made of Resident 25 receiving his Humalog insulin. QMA 9 was observed preparing and setting up the Humalog flex pen. During that time, QMA 9 was not observed disinfecting the rubber seal with an alcohol wipe on the flex pen prior to inserting the needle. Then, she handed the flex pen to Resident 25. He pulled up his shirt and stuck the needle in his abdomen. QMA 9 did not provide or educate the resident to utilize an alcohol wipe to disinfect the skin area prior to the insertion of the insulin pen in his abdomen. After the administration, QMA 9 was observed discarding the used needle in the trash instead of the sharp's container. An interview was conducted with the Director of Nursing on 4/9/25 at 1:45 p.m. She indicated QMA 9 should have disinfected the rubber seal with an alcohol wipe and discarded the needle in the sharp's container. An insulin pen policy was provided by the Executive Director on 4/9/25 at 10:27 a.m. It indicated the following, "...Packaging and Storing...3. Safety needles must be used and disposed of in pre-approved containers...For a general idea of how pens work, here are the basic		Completed checklist. 4) DON and ED completed an in-service with residents that self-administer insulin to ensure proper infection control. 5)DON and ED will complete Insulin Administration for Qualified Medication Aide (QMA) Competency Checklist with insulin certified staff weekly for 4 weeks,bi-weekly for 4 weeks, then monthly thereafter.	

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	steps that are common to most models and types: i. remove the pen cap. ii. check the insulin (amount and appearance). iii. clean the injection site with an alcohol swab...vii. Remove the needle from the pen and dispose of properly..."			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency Based on observation, interview, and record review, the facility failed to maintain infection control practices by utilizing hand hygiene for 4 of 6 residents observed during medication administration. (Resident 14, Resident 17, Resident 25, and Resident 39) Findings include: 1. The clinical record for Resident 25 was reviewed on 4/8/25 at 2:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 2/21/25, indicated Resident 25 was to receive a scheduled eight units of Humalog (fast acting) insulin with a flex pen before meals. A physician order, dated 2/21/25, indicated Resident 25 was to receive additional Humalog insulin with a flex pen utilizing a sliding scale before meals. The insulin scale was as follows: blood sugar readings of 141-180 = 6 units of insulin, 181-220 = 8 units of insulin, 221-260 = 10 units of insulin, 261-300 = 12 units of insulin, 301-350 = 14 units of insulin, 351-400 = 16 units of insulin, 401 or greater = 18 units of insulin. During a medication administration with Qualified Medication Aide (QMA) 9 on 4/8/25 at 11:15 a.m.,	R 0414	infection Control, proper hand washing techniques and safe sharps disposal all residents have potential to be at risk DON will conduct a monthly in-service for Infection Control to all staff and upon hire DON will conduct monthly handwashing checks and monthly in-service to all staff	05/12/2025

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	an observation was made of Resident 25 receiving his Humalog insulin. QMA 9 was observed preparing and setting up the Humalog flex pen. During that time, QMA 9 was not observed utilizing hand hygiene prior or after the administration. 2. The clinical record for Resident 39 was reviewed on 4/8/25 at 2:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus. An observation was conducted of Resident 39's medication administration with QMA 9 on 4/8/25 at 11:17 a.m. QMA 9 was observed preparing pill medication for the resident. During that time, QMA 9 was observed dropping pill medications from the packets in the medication cup. After, she indicated the resident does not like to take the iron medication. At that time, she reached in the medication cup of pills and removed the iron medication from the cup with her bare hands. Then, she administered the medications to the resident. QMA 9 was not observed utilizing hand hygiene before or after the administration of the resident's pill medications. An interview was conducted with the Director of Nursing on 4/9/25 at 1:45 p.m. She indicated QMA 9 should have used appropriate hand hygiene during medication administration and not reached in the cup of pill medications with her bare hands. 3. On 4/8/25 at 12:00 p.m., QMA 4 was observed administering medication to Resident 14. QMA 4 did not perform hand hygiene prior to, or after administering the resident's medication. High traffic surfaces were touched such as a laptop, medication cart, and water pitcher. 4. During an observation of QMA 4, on 4/8/25 at 12:06 p.m., hand hygiene was not performed			

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	before administering medication to Resident 17. While attempting to dispense a tablet from a medication bottle, QMA 4 inserted her bare finger into the medication bottle and partially removed a cotton insert and dispensed a tablet into a medication cup. She then entered Resident 17's room and placed the medication cup on her table. Hand hygiene was not performed during or after medication administration. During an interview conducted on 4/10/25 at 1:49 p.m., the Director of Nursing indicated hand hygiene should be performed during medication administration. A handwashing policy was provided by the Executive Director on 4/9/25 at 10:27 a.m. The policy indicated, " ...All associates should wash their hands to prevent the spread of infection and disease to other residents, other associates and visitors ... Suggested Guidelines: ...Before preparing or handling medications ... If soap, water, or towels are unavailable, the associate should use an antimicrobial hand gel according to manufacturer's guidelines ..."			