STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS ASSISTED LIVING, INC	4301 WASHINGTON AVE EVANSVILLE, IN 47714

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00424876. Complaint IN00424876 - State deficiencies related to the allegations are cited at R0090 and R0349. Survey dates: December 27, 28, 29, 2023, and January 2, 2024 Facility number: 013613 Residential Census: 65 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 9, 2024.	R 0000	The Following Plan of Correction for Oasis Assisted Living regarding the statement of deficiencies dated January 02, 2024. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of the best quality health care services and will continue to make changes and improvements to satisfy that objective. The facility is also requesting desk review for compliance in these areas.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Huffman	Administrator	01/20/2024

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

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	a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to report allegation of abuse for 1 of 1	R 0090	1. What corrective action(s) will be accomplished for those residents	02/05/2024

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	residents when notified. The Administrator failed to notify the Indiana Department of Health (IDOH) of allegations of abuse and rudeness, and failed to begin an investigation Findings include: During an interview on 11:18 A.M., the Administrator indicated that the Attorney General had made her aware of employee allegations regarding rudeness and abuse on 11/20/23. She failed to inform the IDOH of those alleged allegations within the necessary time frame, and no investigation was started by the facility On 1/2/24 at 9:15 A.M., LPN 3 provided a current policy "Abuse Identification, Investigation, and Reporting" dated 3/31/16. The policy indicated "...the Administrator... will be responsible for the notification of other officials in accordance with the state law, including the Indiana Department of Health..." This citation relates to complaint IN00424876.		found to have been affected by the deficient practice? To ensure the psycho-social well-being and prevent future occurrence of inappropriate approach and deficient practices all reports of abuse for discharged residents and current residents will be reported to IDOH. Education will be provided on an ongoing basis to all staff of regarding abuse policy, prevention, and reporting process. 2. How will you identify other residents having potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice systematic changes are as follows: All staff will be trained on Abuse policy, prevention, and reporting upon hire and quarterly thereafter. 3. What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not recur? All Employees will be informed upon hire and trained at least quarterly thereafter of their responsibility to intervene when seeing deficient practices to prevent harm to all residents and to report immediately to their supervisor, actual and/or	

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			suspected incidents of resident mistreatment, neglect, physical, sexual, verbal, or mental abuse, or misappropriation of resident property to the Administrator or designee will be responsible for assuring that all alleged violations are thoroughly investigated, and the further potential abuse is prevented while an investigation is in process. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Administrator or designee will complete an audit of all abuse reports to ensure Abuse reporting Checklist of required documentation has been completed weekly for 30 days and then monthly for 6 months. Date of Compliance: February 05, 2024	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on			

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	admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure that self-medication assessments were completed on 2 of 2 residents reviewed for self-administration of medication. (Resident 2, Resident 8) Findings include: 1. On 12/28/23 at 10:15 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, hypertension. Resident 8's service plan indicated the resident was cognitively intact and independent with mobility, transfers, and self-administer medications. Current physicians order included: ok to self-administer medications dated 4/25/23. The chart lacked a self-administration assessment for the resident. 2. On 1/2/24 at 9:00 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but were not limited to, hypertension. Resident 2's service plan indicated the resident was cognitively intact and was independent with dressing, toileting, mobility, and could self-administer. Current physicians lacked an order to self-medicate. The current record lacked a Self-Medication Assessment Evaluation since admission on 10/18/23.	R 0216	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? For all residents affected by the deficient practice a self-administration evaluation was completed and an order to self-administer medications was obtained from the primary care physician. To prevent future occurrences when a resident/responsible party places an inquiry to self-administer medications the CNL/designee administers a self-administration evaluation to determine if the resident can self-administer medications. After evaluation is completed the IDT team will review the results and request an order from their PCP should the resident be determined that they are cognitively able to safely administer their own medications. 1. How will you identify other residents having potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice systematic changes are as follows: All nurses will be trained upon hire and at least	02/05/2024

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	During an interview on 1/2/24 at 9:15 A.M., LPN 3 indicated there was not Self -administration assessment for Resident 2 did not have an self-administration assessment evaluation. A current policy "Medication Self-Administration Evaluation" revised on 9/21/16 was provided on 12/28/23 at 11:30 A.M., by LPN 3. The policy indicated..."the initial and any subsequent Medication Self-Administration Evaluation(s) for each resident will be maintained in the clinical record in accordance with state regulations..."		quarterly of the facility policies and procedures for self-administration of medications. 1. What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not recur? To ensure the deficient practice does not recur the facility nursing staff will evaluate each resident upon admission, The CNL/designees will then complete a weekly audit of charts to ensure all assessments and orders are in place to prevent harm to other residents. 1.How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Community Nurse Leader/designee will complete an QAPI audit of all residents and will complete QAPI reports to ensure required documentation is in place. QAPI audit tools will be completed weekly for 30 days and then monthly for 6 months to ensure the deficient practice is corrected. Date of Compliance: February 05, 2024	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be			

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	as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure that medications were given as prescribed for 1 of 5 residents observed for medication administration. Insulin dose for a sliding scale insulin was not given as ordered and an additional 10 units of insulin was given without an physicians order. (Resident 7) Findings include: On 12/27/23, during a medication pass at 12:00 P.M., LPN (Licensed Practical Nurse) 5 was observed giving 10 units of Novolog Insulin in the sliding scale insulin for a blood sugar of 220, medication was given to Resident 7. On 12/28/23, at 9:25 A.M., Resident 7's clinical record was reviewed. Diagnoses include, but were not limited to, diabetes mellitus, anemia, an atrial fibrillation. The Resident is cognitively intact and is independent with eating, dressing, and toileting. Current physician orders include, but were not limited to, Insulin Apart 100 Units/Millie inject SQ (subcutaneous) per sliding scale: Blood sugar (BS) 200-224= 2 Units, BS 225-249 = 3 Units, BS 250-274 = 4 Units, BS 275-299 = 5 Units, BS 300-349 = 7 Units, BS 350-374 = 8 Units, BS 375-399 = 9 Units, BS greater than 399 call the Medical Doctor. The order was dated 10/9/23.	R 0241	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? To correct the efficient practice for those residents found to have been effected the CNL/designee reviewed the current orders in the residents MAR against the paper order to ensure the transcription of the order was input correctly. To prevent future occurrences of the deficient practice all nurses will be trained to review all pending orders against the paper order. Should there be a discrepancy the nurse is to notify the CNL/designee immediately, and call MD for clarification of order to prevent harm to other residents. 1. How will you identify other residents having potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice systematic changes are as follows: The facility will implement that all new orders must have 2 nurses to check orders when received. The facility will provide training upon hire and at least quarterly to prevent the deficient practice from causing	02/05/2024

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	The clinical record lacked an order for additional 10 Units of insulin. The MAR for December 2023 indicated the following dates and times that the resident received the incorrect dose of Novolog insulin: 12/1/23 7 AM Blood Sugar 251 received 7 Units SQ 12/1/23 12 PM not listed received 10 Units SQ 12/1/23 4 PM Blood Sugar 273 received 10 Units SQ 12/4/23 7 AM Blood Sugar 210 received 10 Units SQ 12/5/23 7 AM Blood Sugar 256 received 10 Units SQ 12/5/23 12 PM Blood Sugar 273 received 10 Units SQ 12/6/23 12 PM Blood Sugar 371 received 10 Units SQ 12/9/23 12 PM Blood Sugar 259 received 10 Units SQ 12/10/23 12 PM Blood Sugar 270 received 10 Units SQ 12/11/23 7 AM Blood Sugar 213 received 12 Units SQ 12/12/23 12 PM Blood Sugar 225 received 10 Units SQ 12/13/23 12 PM Blood Sugar 324 received 10 Units SQ 12/14/23 12 PM Blood Sugar 161 received 10 Units SQ 12/14/23 4 PM Blood Sugar 391 received 10 Units SQ 12/15/23 12 PM Blood Sugar 261 received 10 Units SQ 12/16/23 12 PM Blood Sugar 169 received 10 Units SQ 12/18/23 12 PM Blood Sugar 294 received 10 Units SQ		harm to other residents. 1. What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not recur? To ensure the deficient practice does not recur the facility will have 1 nursing staff put orders in the system and have a second nursing staff check orders with paper order to verify the orders match. All Nurses will be trained to notify management if there is a discrepancy and call MD for clarification. 1.How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Community Nurse Leader/designee will complete an QAPI audit of all residents and will complete QAPI reports to ensure required documentation is in place. QAPI audit tools will be completed weekly for 30 days and then monthly for 6 months to ensure the deficient practice is corrected. Date of Compliance: February 05, 2024	

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	12/19/23 12 PM Blood Sugar 219 received 10 Units SQ 12/20/23 12 PM Blood Sugar 310 received 10 Units SQ 12/23/23 12 PM Blood Sugar 179 received 10 Units SQ 12/24/23 12 PM Blood Sugar 177 received 10 Units SQ 12/25/23 12 PM Blood Sugar 190 received 10 Units SQ 12/27/23 12 PM Blood Sugar 220 received 10 Units SQ 12/27/23 4 PM Blood Sugar 174 received 12 Units SQ During an interview on 12/28/23, at 9:35 A.M., the DON (Director of Nursing) reviewed the MAR for Resident 7, and the indicated the resident should have only received 2 Units of Novolog based on the sliding scale for a BS of 220 not 10 Units that was documented on 12/27/23. There were no orders to cover the 10 Units and that the staff was not following orders. During an interview on 12/28/23 at 10:00 A.M., the Assistant Administrator indicated that there had been a standing order for the 10 units of insulin plus the sliding scale. It had been an understanding by staff that it was to be given with meals. This order apparently was discontinued and never rewritten. On 1/2/2 at 8:30 A.M., the Assistant Administrator presented a current policy "Medication Orders" dated 6/22/17. The policy indicated "....medications are administered only upon the clear, completes and a signed order of a person lawfully authorized to prescribe...elements of the medication order specify the following: name of the medication, strength of medication, where			

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	indicated, dose and dosage form..."			
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, interview, and record review, the facility failed to ensure that all food preparation and serving areas (excluding areas in residents' units) were maintained in accordance with state and local sanitation and safe food handling standards for 1 of 1 dishwasher and for 1 of 1 nursing pantries reviewed. Findings include: 1. During an interview on 12/27/23 at 8:50 A.M., the dietary supervisor indicated the dishwasher is the chemical type. Observation of the temperature gauge during the wash/rinse cycle at that time indicated the wash temperature was 100 degrees F, the rinse temperature was 118 degrees F. The manufacturer label on the machine was observed to indicate the wash temperature was supposed to be between 120-140 degrees F for wash and rinse. A log of the chemical sanitizer results was requested and received from the dietary supervisor. During an observation of the wash/rinse cycle on 12/28/23 at 8:40 A.M., the temperature gauge was observed to indicate the dishwasher temperature was 110 degrees F (Fahrenheit) for both wash and rinse. During observation of the temperature and chemical sanitation log on 12/29/23 at 8:30 A.M.,	R 0273	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. To ensure the deficient practice does not recur the facility will ensure that the temperature gauge is working and recording accurate temperatures. The facility will utilize a holding thermometer to record the dish machine temperatures should the gauge be found to be in not proper working order. All dietary staff will be trained to on obtaining and documenting the temperatures of the dish machine. To ensure that the deficient practice does not recur of utilization of expired sanitizer test strips the dietary manager will record the expiration date on the sanitizer test log monthly to ensure the strips in use are not past the expiration date. 2.To ensure the deficient practice does not recur the facility will audit refrigerator temps daily for all medication room and nursing pantry refrigerators. Night shift staff will be responsible for	02/05/2024

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	all the daily temperature readings and test strip results for the month of December were identical. All wash cycles were recorded as 120 degrees F, all rinses were recorded as 130 degrees F, and all chemical sanitization was recorded at 200 parts per million (ppm). All documented values were initialed by various kitchen staff. During an interview with dietary assistant 6 on 12/29/23 at 9:00 A.M. regarding the temperature/sanitizer log, she indicated that she did not know how the temperatures and sanitizer values on the log were obtained, though her initials were on the log at breakfast time on 12/2/23, 12/9/23, 12/10/23, 12/15/23, 12/28/23 and 12/29/23; at lunch time on 12/9/23, 12/10/23, 12/23/23, 12/24/23, 12/28/29, and 12/29/23; and at dinner on 12/1/23, 12/2/23, 12/4/23, 12/5/23, 12/9/23, 12/10/23, 12/15/23, 12/19/23, 12/23/23, 12/24/23, 12/26/23, 12/27/23. During an interview on 12/29/23 at 9:36 A.M. with the maintenance supervisor, he indicated he was not sure where the temperatures on the log came from. He indicated he stops by "once in a while" and looks at the gauge; the last time he looked at it was last week. He indicated he was not sure what the temperature is supposed to be. He does not know who does the chemical test nor who keeps the temperature/chemical logs. He does not have a holding thermometer to check the water temperature. He indicated he was aware the gauge was not working and that he needed to order a new one. During an interview with the dietary supervisor on 12/29/23 at 11:18 A.M., she indicated she had no holding thermometer to double-check the dishwasher temperature. She indicated that kitchen staff all do the temperature and chemical		recording the temperatures daily and documenting their initials on the temperature logs. To ensure the deficient practice of staff food being kept in the nursing pantry all shifts will be responsible to check that the pantry and refrigerators are free of staff food and ensure they are clean daily. Staff will be required to initial a log each shift that the pantry was cleaned. 1. How will you identify other residents having potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice systematic changes are as follows: 1.All dietary staff will be trained on the procedure of obtaining and recording the temperatures of the dish machine utilizing the new gauge installed on 01/02/2024, and utilizing the holding thermometer as a back up method for the gauge. All staff will be educated on how to document their temperature on the logs. All dietary staff will be educated and trained on the purpose of the sanitizer strips for the dis machine, where to check the expiration date of the strips, how to use the strips to monitor the sanitizer levels o9f the dish machine, and how to interpret the color of the strip once used. All dietary staff will be educated on	

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	checks every meal and chart them on the log. During an observation of the dietary supervisor performing the chemical check, she obtained a plastic tube containing test strips, removed a test strip, and prepared to use it. When asked what the expiration date of the strips was, she peeled off a label that was covering the expiration date, which was June, 2021. She obtained another tube of test strips, which also had an expiration date of June, 2021. She indicated they had been using those test strips. She then obtained a roll of different test strips (with no expiration date noted on the container) and tore off a strip and dipped it into the wash cycle. The strip turned blue; the comparison chart for it only showed various shades of yellow and green. She indicated the rep from , the (name of company) that maintains the chemicals, had told her that was good. 2. During an observation of the nursing pantry on the dementia care unit on 12/27/23 at 9:30 A.M., a foul odor was present. The refrigerator temperature was 44 degrees F. There was a pink sticky substance all over the bottom shelf of the refrigerator. Three slices of pizza in a plastic container were not dated nor labeled with a name. The counter by the sink had a brown sticky substance and a pink sticky substance on it. During observation on 12/28/23 at 1:15 P.M. same was observed. Very foul odor in the room. Refrigerator temperature was 46 degrees F. During observation on 12/29/23 at 8:30 A.M. same was observed. Very foul odor in the room. Refrigerator temperature was 44 degrees F. During an interview with LPN 3 on 12/29/23 at 8:45 A.M., she indicated the residents are allowed to store snacks in the nursing pantry refrigerator but		how to document the information obtained from the strip onto the sanitizer strip logs. 2. All nursing staff will be educated on the regulations and procedures for the cleanliness of the nursing pantry. All staff will be educated that the pantry is to be cleaned daily and that all spills are to be cleaned immediately. All staff will be informed that only refreshments for residents can be kept in the panty refrigerator. A log will be kept in the pantry for each shift to verify the pantry was cleaned and to verify that only resident snacks are being stored in the refrigerator. 1. What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not recur? 1. The Dietary manager will complete a weekly audit tool to verify the dish machine temperatures and sanitizer logs are being recorded properly. All staff will be trained upon hire in the proper procedures for these dish machine and the required logs. 2. To ensure the deficient practice does not reoccur all nursing refrigerators temperatures will be recorded by 3rd shift daily on all med room and nursing pantry refrigerators. 1.How will the corrective action(s) be monitored to ensure	

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	must first ask staff so the snacks can be dated, and the resident's name put on them. She indicated that keeping the snack room tidy is everyone's responsibility. They keep it locked to keep staff from putting their stuff in it. She indicated that cleaning the room is night shift's job, if it needs to be mopped, they let housekeeping know. On 12/28/23 at 1:15 P.M., a copy of the temperature log for the nursing pantry refrigerator on the dementia unit was obtained. The log indicated the temperature had not been recorded on: 12/4/23 12/11/23 12/13/23 12/14/23 12/15/23 12/16/23 12/17/23 12/18/23 12/20/23 12/21/23 12/22/23 12/27/23 12/28/23 On 1/2/2024 at 11:00 A.M., a food storage policy was obtained from the dietary supervisor. The policy indicated that refrigerated, ready-to-eat, potentially hazardous food...shall be clearly marked to indicate the date by which the food shall be consumed on the premises or discarded. The food must be held at 41 degrees F or less for a maximum of 7 days. On 1/2/24 at 11:00 A.M., a Food Service Specific policy was obtained from the dietary supervisor. The policy indicated the dishwasher water		the deficient practice will not recur? 1. The dietary manager will complete an QAPI audit of all temperature and sanitizer logs weekly and will complete QAPI reports to ensure required documentation is in place. QAPI audit tools will be completed weekly for 6 months to ensure the deficient practice is corrected. 2. Community Nurse Leader/designee will complete an QAPI audit of all residents and will complete QAPI reports to ensure required documentation is in place. QAPI audit tools will be completed weekly for 30 days and then monthly for 6 months to ensure the deficient practice is corrected. Date of Compliance: February 05, 2024	

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	solution temperatures will be maintained within the parameters established by the manufacturer of washing and sanitizing solutions.			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.			
	Based on observation, record review, and interview, the facility failed to ensure proper storage of medication in 1 of 2 medication carts in the Oasis Dementia Care Unit. (7 loose pills in the even numbered rooms medication cart and unlabeled cup of white powder) Findings include: On 12/28/23 at 7:45 A.M., there were the following loose pills observed in the even numbered Medication Care: 1 gray round with the numbers 597 2 1/2 white pills no identification 1 large oblong pill no numbers 1 small orange pill with the numbers 2/1/2 on pill 1/2 yellow pill 1 small gray pill no numbers 1 small round orange pill with P1	R 0301	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? To correct the deficient practice for all the residents found to have been affected an Audit of the medication carts on all units will be completed. All staff will be trained upon hire and at least every 6 months on proper practice of medication storage and disposal. 1. How will you identify other residents having potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient	02/05/2024

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	1 cup of white powder unlabeled or dated During an interview on 12/28/23 at 8:15 A.M., QMA (Qualified Medicine Aide) 7 indicated there should be no loose pills and unlabeled medications in the cart. On 1/2/24 at 9:16 A.M., a current policy "Medication Administration" was presented by LPN Licensed Practical Nurse) 3. The policy indicated ..." it is the policy of this Community to establish and maintain a safe and effective medication delivery system... all medications will be stored in a locked space...stored in an orderly manner, for example, by time pass and apartment number..prepouring of medication is allowed only directly prior to the time of the medication pass and in accordance with the Community policy and State regulations..."		practice systematic changes are as follows: The CNL/designee will audit all medication carts on an ongoing basis. The CNL/designee will provide education/coaching when needed to prevent the deficient practice from recuring and causing harm to other residents. 1. What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not recur? To ensure the deficient practice does not recur the CNL/designee will audit all medication carts on an ongoing basis. The CNL/designee will provide education/coaching when needed to prevent the deficient practice from recuring and causing harm to other residents. 1.How will the corrective action(s) be monitored to ensure the deficient practice will not recur? To ensure the deficient practice does not recure the Community Nurse Leader/designee will monitor complete an QAPI audit of all residents and will complete QAPI reports to ensure required documentation is in place. QAPI audit tools will be completed weekly for 30 days and then monthly for 6 months to ensure the deficient practice is corrected.	

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R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to ensure that the clinical records for 1 of 1 resident reviewed for discharge was accurate and complete. (Resident Q) Findings include: On 12/28/23 at 2:21 P.M., Resident Q's clinical record was reviewed. Diagnoses included, but were not limited to Alzheimer's early on set, COPD (Chronic Obstructive Pulmonary Disease), and bladder disease. There was no current service plan listed in the record but reported as cognitively intact and independent. Current physician order for a discharge was received on 11/27/23 was faxed to MD office on 11/21/23. The record lacked discharge information including: released medications and medication	R 0349	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? To correct the deficient practice for all the residents found to have been affected an Audit will be completed of all discharges in the past 6 months to ensure that all have the complete discharge summary scanned into the chart. 1. How will you identify other residents having potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice systematic changes are as follows: The facility has updated the Nurses Quick reference Guidebook to include a resident	02/05/2024

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	administration. During an interview on 12/29/23 at 3:12 P.M., the Administrator indicated Resident Q did not return after leaving with family on 11/16/23. The daughter returned on 11/17/23 to gather belongings and medications. The daughter called back later on 11/17/23 and indicated the medication bundle received contained another residents medication card. She returned the medication card later that day. She indicated when a resident is sent home there should be a list of medications sent, and the list is verified and signed by the care giver (staff member). The family and staff will sign a form acknowledging the acceptance of belongings and medications. During an interview on 12/29/23 at 3:30 P.M., LPN (Licensed Practical Nurse) 3 indicated the discharging QMA(Qualified Medicine Aide) 12 did not give the daughter a medication list and was not aware that a list was to be given to the family. On 1/2/23 at 8:30 A.M., LPN 3 provided a current police "Leave of Absence (LOA). Discharge Medications, or Resident Death." The policy indicated..." when a resident is moving out of the community and needs medication for administration... before the resident leaves the community, the community staff should... review the medication orders and directions for use with the resident or the representative. Document this review in the resident's record in appropriate note section...have the resident or responsible party sign for receipt of the LOA/move out medications. This citation relates to complaint IN00424876.		transfer/discharge to another facility/home checklist which includes the instructions on the release of resident medications and the administration if medication instructions. 1. What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not recur? To ensure the deficient practice does not recur the facility has updated the Nurses Quick reference Guidebook to include a resident transfer/discharge to another facility/home checklist which includes the instructions on the release of resident medications and the administration if medication instructions. The CNL/designee educate all nurses upon hire and at least quarterly thereafter to ensure the proper procedures are followed for all discharges from the facility. 1.How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Community Nurse Leader/designee will complete an QAPI audit of all residents and will complete QAPI reports to ensure required documentation is in place. QAPI audit tools will be completed weekly for 30 days and	

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