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	05/11/2023

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GRAND EMERALD PLACE	4010 S IRONWOOD DR SOUTH BEND, IN 46614

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00395874, IN00399909, IN00407327 and IN00407738. Complaint IN00395874- No deficiencies related to the allegations are cited. Complaint IN00399909- No deficiencies related to the allegations are cited. Complaint IN00407327 - State deficiencies related to the allegations are cited at R0297 Complaint IN00407738 - No deficiencies related to the allegations are cited. Survey dates: May 8, 9, 10 and 11, 2023 Facility number: 013555 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 5/22/2023.	R 0000	Grand Emerald Place respectfully submits this Plan of Correction for 2023 Annual Survey.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills			

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

Leigh Brown 06/03/2023

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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	required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was at least one staff member working on each shift with CPR and First Aid Certification for 16 of the past 21 shifts. This deficient practice potentially affected 55 of 55 residents residing in the facility. Finding includes: During a review of the personnel files and nursing schedule for May 6 through the 13th, conducted on 5/9 and 5/10, 2023, the following was noted: There was only one nurse, LPN 17 with a current certification in CPR (Cardiopulmonary resuscitation) and First Aid. LPN 17 was scheduled to work the night shift on 5/9, 5/10, 5/11 and 5/12/2023. During an interview with the Director of Nursing, during the Exit Conference, conducted on 5/11/2023 at 12:15 P.M., she indicated she felt there were more of the nursing staff with current	R 0117	1. Staff with CPR are identified and the schedule will be noted with CPR/First Aide certified staff 2. Residents of the Community have the potential to be affected by this alleged deficient practice. 3. Executive Director and/or DON have notified and provided education to staff members who do not hold current CPR and First Aide Certification. 4. Schedule will be monitored and identified weekly for 4 weeks by ED or designee for CPR/First Aide Certified Staff on Duty and then monthly ongoing.	06/28/2023

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	CPR and First Aid certifications but the employees had not submitted copies of the certifications for their employee files. A policy and procedure regarding nursing staff requirements was requested on 5/10/2023 and was not provided prior to the survey exit.			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete			

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	a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interviews, the facility failed to ensure 4 of 8 personnel files contained documentation of two step Mantoux testing of new employees. (Housekeeper7, Dietary Cook 8, Qualified Medication Aid (QMA) 9 and QMA 10) Findings include: During a review of the personnel files, on 5/9/2023 at 2:30 P.M., the following was noted: The file for Employee 7, a housekeeper, indicated her start date was 8/29/2022. Employee 7 had documentation of a first step tuberculin Mantoux test, but no documentation she had received the second step Mantoux test. The file for Employee 8, a dietary employee, indicated her start date was 12/02/2022. Employee 8 had documentation she had received a first step Tuberculin Mantoux test, but no documentation she had received a second step Mantoux test. The file for Employee 9, a nursing employee, indicated her start date was 3/8/2023. Employee 9 had documentation she had received a first step Tuberculin Mantoux test, but no documentation she had recieved a second step Mantoux test. The file for Employee 10, a nursing employee,	R 0121	1. Staff members received TB skin testing as needed the week of 5/22/23 2. Residents of the Community have the potential to be affected by this alleged deficient practice. 3. A systematic audit of staff was completed by DON designee to determine need for TB skin testing and tb skin testing was provided by nursing management. 4. New employees will provide a TB skin test within the past year at hire and a tb skin test will be completed as needed. Employees who hav enot had a tb skin test within the last 12 months will have a 2 step tb skin test completed.	06/28/2023

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	indicated her start date was 11/23/2022. Employee 10 had documentation she had received first step Mantoux test 13 days after her work start date. There was no documentation Employee 10 had received a second step Mantoux test. Review of the policy and procedure, titled, "Mantoux Testing Procedure " provided by the Director of Nursing on 5/11/2023 at 10:10 A.M., included the following: "7. If the first test is negative...a second test should be adminsitered in one week...."			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure kitchen utensils and equipment were maintained in a clean manner in 1 of 1 kitchens. This deficient practice had the potential to affect 55 out of 55 residents consuming food from the facility kitchen. Findings include: 1. During an observation of the kitchen, on 5/8/2023 at 9:30 A.M., the following was noted: the cereal and dessert bowls, saucers and dinner plates were not covered or inverted. During an interview on 5/8/2023 at 9:55 A.M., the Dietary Assistant indicated that they should have been inverted so they did not get contaminated. 2. During an observation of the kitchen and interview, on 5/8/2023 at 10:00 A.M., the Dietary	R 0154	1. The dishes in the kitchen are stored inverted to prevent contamination, the test strips have been replaced and will not expire until 2024. The kitchen staff are provied in servicing regarding the 3 compartment sink and testing the water. Staff is educated on the use of the dish machine on 5/18/23 by the Director of Maint. 2. Residents of the Community have the potential to be affected by alleged deficient practice. 3. Temperature Log for dish machine has been instituted. 4. On 5/18/23 Kitchen staff were educated by Director of Maint and AIT regarding 3 compartment sink use, test strips and a temperature log for the dish machine is in	06/28/2023

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	Manager explained she used the 3 compartment sink to wash the pots and pans and did not run them though the dishwasher after she washed them. She indicated she did not use the test strips to test the disinfectant level of the sink water, but she did use the test strips to test the wash bucket she used to clean the counters. The test strips indicated they had expired on 8/15/2021 and she confirmed she was using them to test the bucket water. She indicated they did not maintain a log of the 3 sink compartment disinfectant levels and she did not realize she needed one. 3. During an observation of the kitchen and interview on 5/9/2023 at 9:30 A.M., Dietary Aide 12 did not know if the dishwashing machine was a high temperature or chemical sanitizing dishwasher, and she did not know what temperature the dishwasher needed to reach during the wash or rinse cycle. In addition, Dietary Aide 12 explained the facility did not keep a daily temperature log regarding the dish washer. She indicated she ran the dish machine when she works, and no one has in-serviced her on the machine. During an interview on 5/10/2023 at 10:05 A.M., the Maintenance Director indicated the new machine was installed prior to his employment and he was sure the staff were in-serviced on the machine's use, but he was unable to obtain documentation of the orientation. He confirmed the dishwashing machine was a high temperature sanitizing machine, which needed to reach 160-165 during the wash cycle and 185 during the rinse. On 5/9/2023 at 3:38 P.M., the Executive Director indicated she did not have policies for storage of dishes, use of 3 sink compartment or dishwasher use. She also indicated there had been no		place.	

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	outbreak of any type of food borne illness in the facility. 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 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.			
R 0216 Bldg. 00	Based on record review and interviews, the facility failed to ensure resident weights were obtained and documented for 5 of 7 residents reviewed. (Residents B, C, D, E and 3) In addition, the facility failed to complete the self administration evaluation for 1 of 1 residents that self-administered medications in a sample of 7. (Resident 1). Finding includes: 1. The record for Resident B was reviewed on 5/8/2023. There was no semi-annual weight documented in the record. The record for Resident C was reviewed on 5/8/2023. There was no admission weight documented in the record. The record for Resident D was reviewed on	R 0216	1. Residents of the Community have been weighed and with current and accurate weight. Evaluations for Residents have been completed as per policy and regulation. 2. Residents of the Community have the potential to be affected by this alleged deficient practice. 3. The ADON was provided training and education regarding the evaluation system and will assist in ensuring that Evaluations are kept up to date, signed and Complete. 4. Evaluations have been updated as per policy and regulation. Accurate Resident weights are documented. Residen'ts who self - medicate are indicated in their	06/28/2023

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	5/8/2023. There was no semi-annual weight documented in the record. The record for Resident E was reviewed on 5/9/2023. There was no semi annual weight documented in the record. The record for Resident 3 was reviewed on 5/8/2023. There was no admission or semi annual weight documented in the record. During an interview with the Director of Nursing, on 5/9/2023 at 9:30 A.M., she indicated the weights were in a "Weight Book" located in the former Director of Nursing's office. However, on 5/10/2023 at 2:30 P.M., the Director of Nursing indicated she could not locate the binder and had no documentation of resident weights.2. During an interview with alert and oriented Resident 1, on 5/8/2023 at 1:30 P.M., he indicated that he managed and administered his own medications. A record review, on 5/9/2023 at 11:45 A.M., for Resident 1 indicated there was no self administation medication assessment located in the file. The diagnoses for resident 1 included, but was not limited to: paraoxysmal atrial fibrillation, localized edema, and diabetes. During an interview, on 5/9/2023 at 2:00 P.M., with ADON regarding the self administration of medication policy, she indicated she was new to the position and noticed the assessed was not on the chart. She indicated she had requested a written order for Resident 1 on 5/8/2023, to self administer his medications, as well as had faxed the physician a blank assessment form to complete and sign.		evaluation.	

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	A physician's order for Resident 1 to self-administer his own medications was obtained on 5/8/2023. In addition, an assessment for Resident 1 to self-administer his medicaiton was presented but the assessment was not dated or signed as complete. Review of facility's current policy and procedure titled "Self-Administration," provided by the ED on 5/9/2023 at 3:06 P.M. included the following: "...An alert and self-sufficient resident may request that his or her physician provide a written order to the community/facility indicating an ability to self-administer medications...The nurse at the community/facility must evaluate each resident or family member who self-administers his or her medication by completing the Self Administration of Medication Assessment form..." The policy had been approved for use on 12/20/2022 but there was no review date on the form.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may			

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	request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure the service plans were signed by the resident and/or their representative for 2 of 7 residents reviewed. (Resident B and E) Findings include: 1. The closed record for Resident B was reviewed on 5/8/2023 at 3:10 P..M. The most recent service plan had been completed on 9/16/2022. The service plan was not signed by Resident B and/or her representatives. 2. The record for Resident E was reviewed on 5/8/2023 at 3:40 P.M. The most recent service plan had been completed on 1/12/2023 but was not signed by the Resident and/or their representative. During an interview with the Director of Nursing, on 5/8/2023, she indicated the signed copies of the service plans were kept in a binder in the nursing office. On 5/9/2023 at 9:30 A.M., a large binder was provided with service plans, but there was no plan for Resident B and E.	R 0217	1. Residents of the Community have been weighed and with current and accurate weight. Evaluations for Residents have been completed as per policy and regulation. 2. Residents of the Community have the potential to be affected by this alleged deficient practice. 3. The ADON was provided training and education regarding the evaluation system and will assist in ensuring that Evaluations are kept up to date, signed and Complete. 4. Evaluations have been updated as per policy and regulation. Accurate Resident weights are documented. Residen'ts who self - medicate are indicated in their evaluation.	06/28/2023

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	During an interview with the Director of Nursing, on 5/11/2023 at 9:40 A.M., she indicated she could provide an electronic copy of the service plans, but they would not be signed for Resident B and E. Review of the facility policy and procedure, titled, "Coordination- Individualization of Service Plan" provided by the Administrator on 5/10/2023 at 2:40 P.M. included the following: "...5. The service plan is reviewed and revised at a minimum of every 6 months or following a change in condition and shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request...."			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure authorizations from licensed nurses for as needed medications (PRN) administered by qualified medication aides (QMAs) were documented in the medical record for 2 of 7 residents reviewed for medications. (Resident E and D) Findings include: 1. The record for Resident E was reviewed on 5/8/2023 at 2:30 P.M. Resident E had diagnoses,	R 0246	1. PRN medications given by QMA will have Licensed Nurse or physician approval when given by a Qualified Medication Aide. 2. Resident's of the Community have the potential to be affected by this alleged deficient practice. 3. QMA and Licensed Nurse education was provided on 5/31/23 by the DON regarding the need for licensed nurse approval for QMA to give a prn medication	06/28/2023

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	including but not limited to insulin dependent diabetes, hypertension and malignant neoplasm of the left breast. The most recent service plan for Resident E, completed on 1/22/2023 indicated the facility administered medication to Resident E. The medication regimen for Resident E included the antinausea medication, Ondansetron 4 mg, one table every 6 hours as needed for nausea and vomiting. The Medication Administration Record (MAR) for April 2023 indicated the resident was administered the medication at 12:49 P.M., on 4/19/2023 by QMA 14. There was no documentation in the electronic record comments on the MAR, nor was there a nursing progress note indicating the QMA had been authorized by a licensed nurse to administer the medication. 2. The record review for Resident D was reviewed on 5/9/2023 at 2:30 P.M. The diagnoses included, but were not limited to: chronic pain, and major depressive disorder. Resident D's Physician Orders, dated 9/19/2022, indicated she was receiving oxycod/apap (narcotic pain medication in combination with acetaminophen) tab 5-325 mg (milligrams) take 1 tablet by mouth three times a daily as needed for chronic pain. A Medication Administration Record dated May of 2023, indicated Resident D had received the pain medication on the following days: 5/1/2023, 5/2/2023, 5/3/2023, 5/4/2023, 5/6/2023, 5/7/2023, 5/8/2023 and 5/9/2023 by a Qualified Medication Aide. During an interview, on 5/10/2023 at 9:30 A.M., the Director of Nursing indicated that there was		4. QMA will notify licensed nurse on duty or on call at the time of a resident requesting the PRN medication and will document on the prn log the notification at the time it is done.	

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	no documentation the pain medication was authorized by a nurse, the documentation would have been found in the progress notes. She indicated the facility did not have a policy regarding authorization to give as needed medications but followed the Qualified Medication Scope of Practice. On 5/10/2023 at 11:38 A.M., the Director of Nursing provided a scope of practice titled, "Qualified Medication Aide Scope of Practice", undated, and indicated it was the one currently used by the facility. The scope of practice indicated "... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility	R 0273	1. The non-pasteurized eggs were	06/28/2023

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	failed to provide Residents with pasteurized eggs. This deficient practice potentially affected 55 out of 55 residents who consumed food prepared in the facility kitchen. Finding includes: During a tour of the kitchen on 5/8/2023 at 9:38 A.M., observed shelled eggs in cartons not stamped with a letter P and the box did not indicate they were pasteurized. During an interview on 5/8/2023 at 9:40 A.M., the Dietary Assistant indicated that she did not know she had to serve pasteurized eggs, she uses the eggs to provide over easy eggs to the Residents. On 5/9/2023 at 3:38 P.M., the Executive Director indicated she did realize they were not purchasing pasteurized eggs and they had no policy on the eggs. She also indicated there had been no outbreak of any food borne illnesses in the facility.		removed immediately from the community, 2. Resident's of the Community had the potential to be affected by this alleged deficient practice. 3. Dietary Assistant Manager and AIT were educated by Executive Director of the need for pasteurized eggs in the community on 5/30/23. Pasteurized eggs will be special ordered from the Food Service with each food order.	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on record review and interview, the facility failed to ensure a diet order was written by the physician for 1 of 7 residents. (Resident 1) Finding includes: The record for Resident 1 was reviewed on 5/9/2023 at 11:45 A.M. Resident 1 had diagnoses including, but not limited to: Paraoxysmal Atrial Fibrillation, localized edema, and diabetes. There was no diet ordered by the physician for Resident	R 0275	1. Resident 1 diet order obtained for Regular Diet 2. Residents of the Community have the potential to be affected by this alleged deficient practice. 3. DON and ADON reviewed Current Residents to ensure that Diet Orders are in place for Residents of the community. 4. Diet Orders will be reviewed with the admission process going	06/28/2023

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	1. A progress note dated 11/30/2022 at 2:41 P.M. indicated that dietician recommended updating "admit height and weight" and to "clarify diet order". During an interview, on 5/11/2023 at 8:06 A.M., DON indicated that Resident 1 should have had a written diet order in chart. Review of facility policy and procedure titled "Diet Orders" provided by the ED on 5/9/2023 at 3:06 P.M. included the following:.."Each resident shall have a diet order prescribed by a physician...Nursing will communicate all diet orders to Dining Services using a Diet Order Communication form..."		forward by the DON or Adon Prior to move in.	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review and interviews, the facility failed to ensure medications were administered as ordered for 2 of 7 residents reviewed. (Residents C and E) Finding includes: 1. The closed clinical record for Resident C was reviewed on 5/9/2023 at 10:40 A.M. Resident C was admitted with diagnoses, including but not limited to: hypertension, diabetes, overactive bladder and venous insufficiency. The most recent service plan for Resident C was	R 0297	1. Resident C order for Colace was clarified and Colace is available for the Resident in Medication Cart 1 as ordered. 2. Residents of the Community have the potential to be affected by this alleged deficient practice. 3. Medication Cart Review to be completed the week of 6/5/23 by QMA and ADON to ensure that Residents of the Community have medications as ordered by physicians. ADON Receives copy of new orders obtained in previous	06/28/2023

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	completed on 1/27/2023 and indicated the facility handled and administered medications for Resident C. Review of the medication regimen for Resident C indicated there was an order, initiated on 1/16/2023 for Donepezil 10 mg one tablet every evening. The orders dated 12/31/2023 indicated the resident was to receive Aricept (the trade name for Donepezil) 10 mg daily. Review of the Medication Administration Record (MAR) for January 16 - March 27, 2023, indicated the resident was receiving the medication twice a day, double the dose ordered, instead of once a day. The MAR had Aricept documented as being given during the AM time frame and Donepezil given at either 4 pm or 8 pm. In addition, the resident had the antibiotic, Macrobid 100 mg twice a day ordered on 3/31/2023. Review of the MAR for April 2023 indicated on 4/5/2023 and 4/6/2023 the resident received 100 mg of Macrobid during the AM and PM time frames and also received the antibiotic, Nitrofuran/Mono?Macro (the generic equivalent to Macrobid) 100 mg at 8:00 A.M. and 4:00 P.M. on 4/4/2023 and 8:00 A.M. and 7:00 P.M. on 4/5/2023. During an interview with the Director of Nursing, on 5/11/2023 she confirmed there had been issues with the way medication orders were entered into the electronic MAR. She indicated she had recently hired an Assistant Director of Nursing and she was going to start reviewing medication administration records and systems to ensure the orders and administration records were correctly transcribed. 2. The clinical record for Resident E was reviewed on 5/8/2023 at 2:40 P.M. Resident E had diagnoses, including but not limited to: insulin		shifts daily M-F to review that medications are ordered properly, EMAR is correct and Medication is ordered and available. AdON will monitor M-F new orders - ongoing.	

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	dependent diabetes, hypertension and malignant neoplasm of the left breast. Resident E was receiving Hospice services. The most recent service plan for Resident E, completed on 1/12/2023 indicated the facility was handling and administering medication for the resident. Review of the May 2023 Medication Administration Record indicated an order, from the facility's Nurse Practitioner, for Colace 100 mg twice a day had been initiated on 5/1/2023. The MAR for May 2 - 9 indicated "unavailable" had been documented on the administration record. During an observation of the Medication Cart and interview with QMA 14, on 5/10/2023 at 9:40 A.M., indicated there was no Colace in the medication cart for Resident E. QMA 14 indicated she had not seen any Colace for Resident E. In addition, the EDK (Emergency Drug Kit) box was observed in the medication room. The box did contain the generic equivalent to the Colace, docusate sodium 100 mg tablets. QMA 14 indicated if a medication was not available she would call the pharmacy or reorder the medication from the pharmacy. She indicated the MAR contained a comment section when documenting not available to document if the pharmacy had been contacted. During a telephone interview with a pharmacy technician from the facility's pharmacy, on 5/10/2023 at 11:00 A.M., she confirmed the pharmacy had not received any orders for Colace for Resident E and no charge slips for the medication for Resident E from the EDK had been submitted to the pharmacy. During an observation of the medication room,			

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	with QMA 14, on 5/10/2023 at 11:10 A.M., a file for faxed pharmacy orders and a binder of orders to be signed for the nurse practioner, did not reveal any orders for Colace for Resident E. During an interview with the Director of Nursing, on 5/10/20223 at 2:30 P.M. she indicated she felt like the Hospice nurse had possibly called in the order to the facility and the nursing staff had transcribed the order into the computer MAR and inadvertently assigned the order to the facility's Nurse Practitioner. During an interview with the Assistant Director of Nursing, on 5/11/2023 at 10:00 A.M., she indicated the Hospice nurse had verbally called and then faxed an order for the Colace to the facility and an unknown staff member had received the order. The faxed order could not be located and so a new order had been faxed to the facility on 5/11/2023 and sent to the pharmacy. The facility policy, titled "Medication Treatment Administration Assistance," provided by the Director of Nursing and indicated as the current policy, on 5/11/2023 at 12:27 P.M. included the following: "...3. Medication assistance and administration should be in accordance with the prescriber's orders...." The facility policy titled, "Verbal Physician Orders/Procedure, " provided by the Director of Nurssing and indicated as the current policy, on 5/11/2023 at 12:27 P.M., included the following: "...1. Physicians and nurses must identify themselves professionally. 2. Order must include: a. Resident's full name b. Date of order c. Medication name, dosage, route, time, frequency d. Physician's Name e. Nurse's Signature f. Nurse to read back order to the physician for clarity. 3.			

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	Orders are then communicated to the pharmacy or resident's choice by the nurse to be filled. 4. Orders are transposed (sic) to record for administration....6. Copy of order kept in residents chart. 7. Order sent for Physician's signature...." There was no policy regarding accessing the Emergency Drug Kit for medication's not available or for contacting the pharmacy for medications not received timely. This state residential finding relates to complaint IN00407327.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to complete an accurate Resident Emergency File for 1 resident in a sample of 7. (Resident 1).	R 0356	1. Resident 1 Emergency File was updated including Pharmacy and Hospital of Choice. 2. Residents of the Community	06/28/2023

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	Finding includes: The record for Resident 1, with diagnoses, including but not limited to: paroxysmal atrial fibrillation, localized edema and diabetes, was reviewed on 5/9/2023 at 2:00 P.M. A copy of the emergency file was provided on 5/10/2023 at 3:06 P.M. by the Administrator. The Emergency File information for Resident 1 had missing hospital and pharmacy preference information and no medical diagnoses, or allergies were listed. During an interview on, 5/11/2023 at 8:12 A.M., the DON indicated that pharmacy, POA and hospital information should be included on file. A policy on Resident Emergency Files was requested on 5/9/2023. 5/10/2023 and 5/11/2023 but was not provided prior to the survey exit.		have the potential to be affected by this alleged deficient Practice. 3. The Emergency File was updated the week of 5/22/23 for residents currently residing in the community. The Face Sheets will be reviewed week of 6/5/23 and updated as needed and reprinted to the emergency files. 4. Monthly the Emergency File will be reviewed by the Receptionist and results will be reported to the Ait/ED and updates made as needed ongoing.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure there were annual health statements completed for 5 of 7 residents reviewed. (Resident 1, 2, 3, C and D) Finding includes. The record for Resident's 1 was completed on	R 0409	1. Resident 1, 2 and 3 C have updated Annual Health Statements in their records. 2. Residents of the Community have the Potential to be affected by the alleged deficient practice. 3. Audit of Community Current Residents was Completed the	06/28/2023

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	5/9/2023 and there was no annual health statement located in the record. The record for Resident 2 was completed on 5/8/2023 and there was no annual health statement located in the record. The record for Resident 3 was completed on 5/9/2023 and there was no annual health statement located in the record. The closed record for Resident C was completed on 5/8/2023 and there was no annual health statement located in the record. The closed record for Resident D was completed on 5/9/2023 and there was no annual health statement located in the record. During an interview on 5/9/2023 at 2:02 P.M., the Director of Nursing indicated there were no annual health statements for most of the facilty residents and they should have had one. The facility policy regarding obtaining and documenting annual health statements for residents was requested on 5/9/23, 5/10/23, and 5/11/2023 and was not received prior to the survey exit.		week of 6/5/23. 4. Annual Health Statements were obtained and updated for Residents missing annual health Statements. DON or designee will monitor monthly the need for updated Annual Health Statements ongoing.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a			

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	documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on observation, record review and interviews, the facility failed to ensure Mantoux testing was completed upon admission for 3 of 7 residents reviewed. (Residents C, D and 1) Findings include: 1. The closed record for Resident C was reviewed on 5/9/2023 at 10:40 A.M. Resident C had been admitted during the previous year. There was no documentation a Mantoux tuberculin skin test had been performed and documented for Resident C upon his/her admission. During an interview, on 5/10/2023 at 9:30 A.M., the Director of Nursing indicated there was no Tuberculin skin test completed for Resident C upon his/her admission.2. The record review for Resident D was reviewed on 5/9/2023 at 2:30 P.M. During an interview on 5/10/2023 at 9:30 A.M., the Director of Nursing indicated that Resident D did not have a 1st and 2nd step Tuberculin Test completed upon admission and should have,3.The record review, on 5/9/2023 at 11:45 A.M,. for Resident 1 indicated there was no Mantoux	R 0410	1. Resident C D and 1 have updated tuberculin test completed. 2. Residents of the Community have the potential to be affected by alleged deficient practice. 3. Audit of Current residents completed week of 5/30/23 by DON/ADON. 4. Annual Tb testing completed week of 6/5/23 for residents by ADON and designee.	06/28/2023

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	tuberculin testing completed prior to, on or after admission to the facility. During an interview, on 5/9/2023 at 3:00 P.M., with the Administrator regarding tuberculin testing of Resident 1, she indicated residents have always just had a chest x-ray completed and it had "never had an issue". On 5/9/2023 at 3:20 P.M., the Administrator indicated there was no record of tuberculin testing in Resident 1's chart. During an interview, on 5/11/2023 at 9:00 A.M., QMA 9 indicated residents had tuberculin test completed when they were admitted. Review of facility policy and procedure titled "Tuberculosis Screening" provided by ED on 5/9/2023 at 3:06 P.M. included the following: "...Testing should be performed on each new resident within 24 hours of admission and read 48-72 hours after administration...The baseline TB test shall employ the 2-step method. If the first step is negative, a 2nd step shall be performed within 7-21 days of the first step...Subsequent years will be followed by a single step/annual test..."			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review and interview, the facility failed to follow infection control practices during medication pass for 1 of 2 nursing staff observed. (QMA 13)	R 0414	1. QMA 13 was counseled on handwashing and hand sanitizer use on 5/31/23. 2. residents of the community have th epotential to be affected	06/28/2023

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	Finding includes: During an observation of a medication administration pass, conducted on 5/9/2023 at 9:30 A.M., QMA 13 was observed to prepare and administer oral medication to Resident 8. QMA 13 then proceeded to use her keys to unlock the medication cart, move her computer tablet, pull out the medication box for Resident 9's medications. After placing the correct medications into a medication cup, QMA 13 then knocked on Resident 9's door and administered the medications to the resident. Resident 9 accidently dropped a few pills onto her lap and the floor, QMA 13 picked up the pills with her bare hands, at the request of Resident 9, and handed them back to Resident 9. After exiting the room, QMA 13 went back to the medication cart and prepared the medicaitons for Resident 10. QMA 13 did not wash her hands at any time during the observation of the medication pass. During an interview with the Director of Nursing, on 5/11/2023 at 10:00 A.M., she confirmed the QMA should have washed her hands. The DON indicated QMA 18, who was observed passing medications during a second medication pass observation on 5/9/2023 at 11:30 A.M., had commented that there was no hand sanitizing rub available during the medication pass on the medication carts and she had to wash her hands with soap and water at a sink during the medication pass. The facility's current policy and procedure, titled, "Handwashing" provided by the Administrator on 5/10/2023 at 2:47 P.M. and indicated as the current policy, included the following: "...Handwashing will be performed:...3. Before and after performing resident care...."		by this alleged deficient practice. 3. Handwashing in service was provided to Clinical Staff at Inservice on 5/31/23 by the DON. 4. Staff will have monthly reminder on handwashing at monthly staff meetings ongoing.	

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