STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GENTRY PARK	901 S HASTINGS DR BLOOMINGTON, IN 47401

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00386775. Complaint IN00386775- Unsubstantiated due to lack of evidence. Survey dates: August 8 and 9, 2022. Facility number: 013766 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 10, 2022.	R 0000	Agree and Thank You!	
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 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			

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

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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	(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 observation and interview, the facility failed to provide to resident's a posted, readily accessible notice of the location of the most recent annual State survey. Findings include: On 8/8/22 at 11:30 a.m., the most recent annual State survey book was observed to be on a	R 0090	What corrective actions will be accomplished for those residents found to have been affected: 5x7 sign is placed in lobby on the book shelf next to the State Survey Book. How other residents having the	08/10/2022

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	bookshelf to the right receptionist's desk, approximately 4 feet above the ground. No posted sign alerting residents to the survey book location was observed. On 8/9/22 at 10:06 a.m., the most recent annual State survey book was observed to be on a bookshelf to the right receptionist's desk, approximately 4 feet above the ground. No posted sign alerting residents to the survey book location was observed. During an interview on 8/9/22 at 11:10 a.m., the receptionist indicated there was no sign indicating the location of the survey book. On 8/9/22 at 3:45 p.m., the Executive Director provided the facility policy, "Public Information," dated 2015, and indicated it was the policy currently being used. A review of the policy lacked documentation in regard to staff posting survey information in an accessible location.		potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Gentry Park will notify residents by written notice in the Daily Activities Chronicle that states where the State Survey Book is located What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ED and Ops Coordinator will monitor sign for placement and make sure that it is visible on book shelf daily. Should it get faded, we will replace with new sign. How the corrective action will be monitored: ED and Ops Coordinator will monitor sign for placement and make sure that it is visible on book shelf daily for 30 days. After the 1st 30 days, then the Ops Coordinator will monitor the sign placement monthly on the 30th of each month to make sure it is visible to residents and visitors. Should it get faded, we will replace with new sign. This monthly check will be ongoing to remain in compliance.	

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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 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 interview and record review, the facility failed to ensure a minimum of 1 employee with a current First Aid (FA) certification on each shift for 4 of 7 days reviewed. Findings include: On 8/8/22 at 11:23 a.m., the Executive Director (ED) provided the schedule for the week 8/1/22 through 8/7/22 and copies of FA certifications for the employees on the schedule for the week reviewed. A review of the nurses and certified nursing	R 0117	**What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice:** **No residents were found to be affected.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **All residents have the potential**	08/31/2022

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	assistant's schedule, dated 8/1/22 through 8/7/22 indicated the following: -On 8/1/22, there were no staff members on first, second, or third shift that were FA certified. -On 8/2/22, there were no staff members on first shift that were FA certified. -On 8/5/22, there were no staff members on first or third shift that were FA certified. -On 8/7/22, there were no staff members on second or third shift that were FA certified. During an interview on 8/9/22 at 3:30 p.m., the ED indicated shifts on 8/1/22, 8/2/22, 8/5/22, and 8/7/22 lacked staff with FA certifications. On 8/9/22 at 5:00 p.m., the ED indicated the facility did not have a FA certification policy.		**to be affected. As a plan of correction the Business Office Director did a complete audit of nurses and all nursing staff employees were notified immediately to complete First Aid Certification. An online site for certification was given to each nurse affected. Each affected nurse will have certification no later than 9/14 or be taken off the schedule.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** **Business Office Manager will run report every quarter for compliance and see if anyone is near expiration. Business Office Manager will notify employee to complete certification prior to expiration date. Business Office Manager will provide employee with computer and website for the certification. Business Office Manager will also make sure that any new nurse hired will have CPR and First Aid training within their 1st week of orientation.** **How the corrective action will be monitored:** **DOW/ADON/Business Office Manager will be responsible**	

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			for monitoring expiration dates and schedule First Aid Training prior to expiration of certification. The Business Office Manager will monitor ONGOING by running report every quarter for compliance to ensure deficient practice does not recur.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview, and record review, the facility failed to ensure a clean and sanitary environment after the carpet and hardwood floors were observed to be dirty for 2 of 2 days during the survey. Findings include: On 8/8/2022 at 10:00 a.m., during an initial tour of the facility, the floors throughout the facility were observed to be dirty with debris. The carpet had loose debris and the hardwood floors had a dried, black substance embedded into them along with loose debris. The locked dementia unit was observed with many black stains embedded into the hardwood throughout the unit. On 8/8/2022 at 10:15 a.m., the floors in the facility were observed to be dirty with debris throughout. The carpet had loose debris and the hardwood floors had a a dried, black substance embedded into them along with loose debris. The locked dementia unit was observed with many black stains embedded into the hardwood throughout	R 0144	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** No residents were found to be affected. All floors were immediately swept and mopped. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected. Corrective action was immediately mop and swept throughout the building. In addition, a Professional Scrubber was used in Memory Care and Kitchen area on 9/2 and again on 9/5. What measures will be put into	08/31/2022

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	the unit. A black rubber substance was observed on the floor and embedded into the door going into the kitchen on the north hall entrance. The area under the water fountain on the north hall had a large amount of dried food debris under it. On 8/9/2022 at 11:20 a.m., Wellness Partner 1 was observed to try and scrap the black substance off the hardwood floor with a spoon on the locked unit. The black substance was unable to be removed. Wellness Partner 1 indicated at that time the floors needed a "good scrubbing." On 8/9/2022 at 3:47 p.m., the Executive Director provided the facility policy, "Housekeeping Policy and Procedure" with a revised date of 1/1/2019, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Daily ... Vacuum carpets and pick up any clutter in all common areas (hallways, living/activity areas, dining room, etc ..."		place or what systemic changes will be made to ensure that the deficient practice does not recur: Plant Ops Director , Housekeeping and care partners will monitor daily to keep debris off of floor. Cleaning Schedule was put in to place to ensure that carpet and hardwood floors would be cleaned and mopped routinely to ensure they are clear from black markings and debris. The Director Of Plant Ops will monitor floors for cleanliness by walking around each morning and notify housekeeping if there is an area of concern that needs cleaned immediately. Plant Ops Director will professionally buff and scrub Memory Care and Kitchen once a month to ensure floors stay free from tough black markings and debris. How the corrective action will be monitored: The Director Of Plant Ops and the Plant Ops Assistant will monitor floors for cleanliness by walking around each morning and notify housekeeping if there is an area of concern that needs cleaned immediately. This monitoring will be ongoing daily. Plant Ops Director will professionally scrub Memory Care and Kitchen once a month to ensure floors stay free from tough black markings and debris. Professional Scrubber will be monthly ONGOING and will be documented for the next 6 months to ensure compliance. Next	

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			Buffing Scrub is scheduled for 10/3/22.	
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on observation, interview, and record review, the facility failed to ensure an annual veterinary examination was completed in a timely manner for 6 of 9 residents who housed pets in the facility. (Resident 9, Resident 10, Resident 12, Resident 13, Resident 14 and Resident 15) Findings include: On 8/9/2022 at 11:30 a.m., The Executive Director (ED) provided a list of pets housed inside the facility. A review of the animal vaccinations indicated the following: 1. Resident 9 housed a cat. There was no documentation of the cat having had an annual veterinary examination. 2. Resident 10 housed a dog. The last annual veterinary examination had expired and a rabies booster had been due on 1/15/2022. 3. Resident 12 housed 3 cats. The annual veterinary examination had expired for all 3 cats and a rabies vaccination had been due on 6/11/2020 or 6/12/2020. 4. Resident 13 housed a dog. The annual veterinary examination had expired and the rabies booster had been due on 2/12/2022.	R 0151	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Gentry Park notified affected residents current vaccination records were needed to be in compliance with State guidelines. Gentry Park received copies of all vaccinations. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Complete audit was done to ensure that we have all vaccinations for pets. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Measures put into place to ensure compliance will be pet vaccinations monitored by our Ops Coordinator every 3 months to ensure we have the most recent records on file. Ops Coordinator will notify resident if the	08/31/2022

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	On 8/9/2022 at 10:15 a.m., Resident 14 and Resident 15 were observed to have a sign on the door indicating a furry friend was inside. During an interview on 8/9/2022 at 12:25 p.m., the Administrator indicated she hadn't had Resident 14 and Resident 15 down as having animals. They did not have annual vaccinations for Resident 9 and Resident 10, Resident 12 and Resident 13's annual veterinary examinations had expired. She would check on Resident 14 and Resident 15. During an interview on 8/9/2022 at 4:00 p.m., the receptionist indicated she had been sent an e-mail to check on Resident 14 and Resident 15's animals but she was leaving for the day and had not found an annual veterinary examination for those 2 pets. On 8/9/2022 at 3:05 p.m., the ED provided the policy titled, "Resident Pet Policy" dated 6/24/2021, and indicated it was the one currently being used by the facility. A review of policy did not indicate having an annual veterinary examination on file.		vaccination is expiring within 60 days to give the resident time to get their pet in for vaccination. Residents that do not follow our pet policy will receive notice that they are in violation of pet policy and be subject to their pet moving out. How the corrective action will be monitored: Measures put into place to ensure compliance will be pet vaccinations monitored by our Ops Coordinator every 3 months to ensure we have the most recent records on file. Ops Coordinator will notify resident if the vaccination is expiring within 60 days to give the resident time to get their pet in for vaccination. Residents that do not follow our pet policy will receive notice that they are in violation of pet policy and be subject to their pet moving out. Monitoring will be ongoing every 3 months.	
R 0216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance			

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Bldg. 00	(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. Based on record review and interview, the facility failed to ensure a resident's weight was taken or documented upon admission to the facility for 2 of 7 residents reviewed for admission weights. (Resident 2 and Resident 4) Findings include: 1. On 8/8/2022 at 11:00 a.m., Resident 2's clinical record was reviewed. The diagnoses included, but were not limited to major depressive disorder and hypertension. The resident's admission date was 6/18/2022. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. 2. On 8/8/2022 at 12:00 p.m., Resident 4's clinical record was reviewed. The diagnosis included, but was not limited to dementia. The resident's admission date was 6/18/2022. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. During an interview on 8/8/2022 at 2:15 P.M., the	R 0216	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Nurse on duty weighed and charted vitals on all affected residents to document for compliance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Director of Wellness and ADON performed audit through Point Click Care of other residents to identify any other resident that need weights and vitals. Weights and Vitals have been done on all residents. What measures will be put into place or what systemic changes will be made to ensure that the	08/31/2022

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	Director of Nursing indicated Resident 2 and Resident 4 did not have weights taken or documented upon admission to the facility. On 8/9/2022 at 3:47 p.m., the Executive Director provided the facility policy, "Weight Management Program" with a revised date of 6/11/2020, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Procedure: 1. All residents will be weighed a minimum of once a month ..." The policy did not indicate obtaining a weight upon admission to the facility.		deficient practice does not recur: Wellness Staff educated through in-service on new admissions and monthly weights and vital charting. Weights and Vitals will be taken on admission and charted in PCC. It will be the responsibility of the admitting nurse to document in PCC. Director of Wellness and ADON will check every new admission to ensure that the admission policy which includes weights and vitals is being followed and charted for every admission. How the corrective action will be monitored: The Director of Wellness will perform on-going education with nursing staff to review new move in admissions and monthly vitals charting. The Director of Wellness will audit charts ongoing monthly for all new move ins to ensure we are in compliance.	
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			

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	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 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 service plans were signed and dated by the resident or resident's representative for 7 of 7 of residents reviewed for service plan signatures (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7). Findings include: 1. On 8/8/22 at 11:45 a.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to atherosclerotic (build up in the	R 0217	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Director of Wellness and ADON met with residents to go over and sign off on their service plans. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:	08/31/2022

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	arteries) heart disease and seizures. Resident 1's service plan, undated, lacked signature or dated by the resident or resident's representative. During an interview on 8/9/22 at 10:59 a.m.,, the Wellness Director indicated Resident 1's service plan lacked signature or dated by the resident or resident's representative. 2. On 8/8/22 at 11:00 a.m., Resident 2's clinical record was reviewed. The diagnosis included, but was not limited to hypertension. Resident 2's service plan, undated, lacked signature or dated by the resident or resident's representative. During an interview on 8/9/22 at 10:59 a.m.,, the Wellness Director indicated Resident 2's service plan lacked signature or dated by the resident or resident's representative. 3. On 8/8/22 at 11:00 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited mild cognitive impairment, hypertension, and osteoarthritis. Resident 3's service plan, undated, lacked signature or dated by the resident or resident's representative. During an interview on 8/9/22 at 10:59 a.m.,, the Wellness Director indicated Resident 3's service plan lacked signature or dated by the resident or resident's representative. 4. On 8/8/22 at 12:00 p.m., Resident 4's clinical record was reviewed. The diagnosis included, but		Director of Wellness and ADON are auditing charts for compliance and will continue to do so until all current service plans are signed off on. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Inservice was completed with nursing staff to educate on need for signatures on Service Plans. It will be the responsibility of the nurse performing the service plan assessment to discuss and sign off with resident or residents representative their service plan. How the corrective action will be monitored: Director of Wellness and ADON will monitor through reports in PCC and verify that service plans have signatures monthly. This will become a standard practice and will be monitored ONGOING monthly.	

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	was not limited to hypertension. Resident 4's service plan, undated, lacked signature or dated by the resident or resident's representative. During an interview on 8/9/22 at 10:59 a.m.,, the Wellness Director indicated Resident 4's service plan lacked signature or dated by the resident or resident's representative. 5. On 8/8/22 at 11:30 a.m., Resident's 5's closed clinical record was reviewed. The diagnoses included, but were not limited to Alzheimer's disease, atrial afibrillation (rapid heart rate), and hypertension. Resident 5's chart lacked documentation of service plan. During an interview on 8/9/22 at 4:22 p.m.,, the Wellness Director indicated Resident 5's service plan was not available. 6. On 8/8/22 at 12:00 p.m., Resident 6's closed clinical record was reviewed. The diagnoses included, but were not limited to chronic kidney disease and hypertension. Resident 6's service plan, undated, lacked signature or dated by the resident or resident's representative. During an interview on 8/9/22 at 10:59 a.m., the Wellness Director indicated Resident 6's service plan lacked signature or dated by the resident or resident's representative. 7. On 8/8/22 at 2:46 p.m., Resident 7's clinical record was reviewed. The diagnoses included, but			

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	were not limited to bladder cancer, Alzheimer's disease, and diabetes mellitus. Resident 7's service plan, undated, lacked signature or dated by the resident or resident's representative. During an interview on 8/9/22 at 10:59 a.m.,, the Wellness Director indicated Resident 7's service plan lacked signature or dated by the resident or resident's representative. On 8/9/22 at 3:45 p.m., the Executive Director provided the facility's policy, "Individualized Service Plan (ISP)," revised on 6/11/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated,..."The Individualized Service Plan must be signed by the resident or responsible party through telephone or written correspondence with proper documentation of how consent was obtained..."			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1)			

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	year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.			
	Based on observation, interview, and record review, the facility failed to ensure staff maintained a heated tray holding cart in a clean manner for 1 of 1 heated tray carts on the Memory Care unit. Finding include: On 8/8/22 at 11:00 a.m., a heated tray holding cart was observed on the Memory Care unit with food particles and spills on the bottom. On 8/9/22 at 10:09 a.m., a heated tray holding cart was observed on the Memory Care unit with food particles and spills on the bottom. On 8/9/22 at 3:00 p.m., a heated tray holding cart was observed on the Memory Care unit with food particles and spills on the bottom.	R 0274	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Culinary department thoroughly cleaned the heated cart and will continue to do so daily. Culinary Department and Memory Care Support Partners will remove heated box 1 hour after serving meals. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Culinary department thoroughly cleaned the heated cart and will	08/10/2022

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	During an interview on 8/9/22 at 3:30 p.m., the Memory Care Director indicated the dietary staff was responsible for the cleanliness of the heated cart. She further indicated the cart should not be outside of the kitchen and in the residents' environment this late into the day. On 8/9/22 at 3:45 p.m., the Executive Director provided the policy, "CULINARY POLICIES & PROCEDURES," dated 2015, and indicated it was the policy currently being used. A review of the policy indicated, "... Cleaning Schedule ... A Culinary Department cleaning schedule ... to ensure all areas of the kitchen and Culinary department are maintained in cleanliness ... "		continue to do so daily. Culinary Department and Memory Care Support Partners will remove heated box 1 hour after serving meals. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Culinary Director and Sous Chef will monitor compliance daily to ensure cleanliness of hot box and placement when it is not in use. Culinary Director and Sous Chef will clean/sanitize hot box daily a part of their routine job duties. Culinary Department and Memory Care Support Partners will remove heated box 1 hour after serving meals. How the corrective action will be monitored: Culinary Director and Sous Chef will monitor compliance daily to ensure cleanliness of hot box and placement when it is not in use, this will be ongoing to ensure compliance.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written			

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	policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview, and record review, the facility failed to ensure a staff were competent to administer a steroid inhaler for 1 of 1 resident observed for inhaled medications in a sample of 5 residents reviewed for medication administration. The staff did not ensure the resident rinsed their mouth following the administration of an inhaled steroid. (Resident 8) Findings include: On 8/8/2022 at 9:35 a.m., Wellness Partner 1 (WP) was observed to administer fluticasone-salmeterol (a steroid) inhaler to Resident 8. Resident 8 was observed to take 1 puff as ordered. WP 1 was then observed to hand Resident 8 a cup of p.o. (by mouth) medications immediately after the inhaler. The WP did not have Resident 8 rinse and spit after the inhaler. Resident 8's clinical record was reviewed on 8/8/2022 at 3:15 p.m. The diagnosis included but, were not limited to pulmonary fibrosis. Physician's order, dated 8/9/2022, indicated Resident 8's medications included, but were not limited to fluticasone-salmeterol 113-14 inhale 1 puff by mouth 2 times a day. "Rinse mouth after use." The start date of the medication was 11/24/2021. On 8/9/2022 at 12:10 p.m., WP 1 indicated she didn't believe the fluticasone-salmeterol inhaler needed to be rinsed but after reviewing the order she indicated she should have had Resident 8	R 0296	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Wellness Staff educated through in-service on administration of an inhaler to include offering water to rinse mouth after each use. Wellness staff Nurses and QMA's signed off on process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Wellness Staff educated through in-service on administration of an inhaler to include offering water to rinse mouth after each use. Wellness staff Nurses and QMA's signed off on process. Annual in-service with nursing staff will be completed by Director of Nursing and documented for compliance training. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Wellness Staff educated through in-service on administration of an inhaler to include offering water to rinse mouth after each use.	08/31/2022

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	rinse and spit after inhaling the medication. The Wolters Kluwer Nursing 2018 Drug Handbook, 38th edition, copyright 2018 indicated, " ... fluticasone-salmeterol ... after administration, have patient rinse his mouth without swallowing ..." On 8/9/2022 at 4:20 p.m., The Director of Nursing provided the policy "Medication Administration" undated, and indicated it was the policy currently being used by the facility. A review of the policy did not indicated having a resident rinse and spit after administering a steroid inhaler.		Wellness staff Nurses and QMA's signed off on process. Wellness Director train new wellness staff the process of medication administration that includes directions for steroid inhalers. Annual in-service with nursing staff will be completed by Director of Nursing and documented for compliance training. How the corrective action will be monitored: Director of Nursing will complete a medication administration in-service ONGOING yearly and with all new hires. Director of Nursing will randomly choose 1 nurse each month to watch administer inhaler to ensure we are remaining compliant for the next 3 months at which time it will be ongoing yearly and ongoing with any new employees during their orientation. Wellness Checklist will be used for this training.	
R 0409	410 IAC 16.2-5-12(d) Infection Control - Noncompliance			

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Bldg. 00	(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 annual health statements were documented in the clinical records for 6 of 7 residents reviewed for annual health statements (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5 and Resident 7). Findings include: 1. On 8/8/22 at 11:00 a.m., Resident 2's clinical record was reviewed. The physician did not indicate on the health evaluation the resident was free of communicable diseases. 2. On 8/8/22 at 11:00 a.m., Resident 3's clinical record was reviewed. There were no annual health statements indicating the resident showed no evidence of tuberculosis in an infectious stage. 3. On 8/8/22 at 11:45 p.m., Resident 1's clinical record was reviewed. There were no annual health statements indicating the resident showed no evidence of tuberculosis in an infectious stage. 4. On 8/8/22 at 11:30 a.m., Resident 5's clinical record was reviewed. There were no annual health statements indicating the resident showed no evidence of tuberculosis in an infectious stage. 5. On 8/8/22 at 12:01 p.m., Resident 4's clinical record was reviewed. The physician did not indicate on the health evaluation the resident was free of communicable diseases.	R 0409	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: All identified resident's health statements have been faxed to their physician for signature of free from communicable disease. Director of Wellness has been in contact with Doctors office who have not responded and a follow fax has been sent. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Director of Wellness did complete audit of other residents and has been in contact with their physician and faxed over health statement for annual review and signatures stating free from communicable diseases. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff educated through in-service on checking the health evaluation form to ensure that the physician	08/31/2022

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	6. On 8/8/22 at 2:46 p.m., Resident 7's clinical record was reviewed. There were no annual health statements indicating the resident showed no evidence of tuberculosis in an infectious stage. During an interview on 8/9/22 at 2:50 p.m., the Director of Nursing indicated she could not obtain the annual health statements for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 7.		indicated free of communicable diseases. The Director of Wellness will run reports monthly to ensure that we have annual health statements and that they are clearly marked free of communicable disease. The Director of Wellness will verify upon admission that health statement is clearly marked free from communicable disease and signed by provider. How the corrective action will be monitored: The Director of Wellness will run reports through PCC monthly to ensure that we have annual health statements and that they are clearly marked free of communicable disease signed by physician. This monitoring will be ongoing to remain in compliance.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing			

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	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 interview and record review, the facility failed to ensure a second step tuberculin skin test was completed prior to or upon admission for 2 of 7 residents reviewed for completion of tuberculin health screening. (Resident 2 and Resident 4) Findings include: 1. On 8/8/2022 at 11:00 a.m., Resident 2's clinical record was reviewed. The diagnoses included, but were not limited to major depressive disorder and hypertension. The resident's admission date was 6/18/2022. A first step tuberculin skin test was administered on 6/18/2022. The clinical record lacked documentation of the resident having a second step tuberculin skin test. 2. On 8/8/2022 at 12:00 p.m., Resident 4's clinical record was reviewed. The diagnosis included, but was not limited to dementia. The resident's admission date was 6/18/2022. A first step tuberculin skin test was administered on 6/18/2022. The clinical record lacked documentation of the resident having a second step tuberculin skin test. During an interview on 8/8/2022 at 2:15 p.m., the Director of Nursing indicated Resident 2 and Resident 4 did not have a second step tuberculin	R 0410	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: All affected residents have had their 2 step TB and are now in compliance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Complete audit through Point Click Care has been done and all residents are in compliance with 2 step TB. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Wellness Staff educated through in-service on the need for two step TB screen for all new admits. 1st TB should be placed on day one and then repeat from day 7-21. It will be the responsibility of	08/31/2022

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	test prior to or upon admission. On 8/9/2022 at 3:47 p.m., the Executive Director provided the facility policy, "TB Tracking: Residents" with a revised date of 6/11/2020, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Procedure: At move-in or on the date of the pre-assessment the Wellness Nurse completing the move-in or the assessing nurse will also administer the first step of a two step TB screen ... The second step must be administered no less than 7 days after the initial step is read ..."		the ADON and DOW to ensure that this policy is being followed. How the corrective action will be monitored: It will be the responsibility of the ADON and DOW to ensure that this policy is being followed and they will check all new admissions to ensure that the TB's were placed and followed up with in the time frame allowed. A calendar reminder will be made on work computers and reminder on residents chart. This will be monitored ongoing to ensure we remain compliant.	