STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155738	A. BUILDING 00 B. WING	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILTON HOME, THE	206 E MARION ST SOUTH BEND, IN 46601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00440061, IN00437310 and IN00434826. This visit included a State Residential Licensure Survey. Complaint IN00440061 - No deficiencies related to the allegations are cited. Complaint IN00437310 - No deficiencies related to the allegations are cited. Complaint IN00434826 - No deficiencies related to the allegations are cited. Survey dates: October 9, 10, 11, 15, 16, 17, & 18, 2024. Facility number: 001141 Provider number: 155738 AIM number: 20905640 Census Bed Type: SNF/NF: 24 Residential: 19 Total: 43 Census Payor Type: Medicaid: 22 Other: 2 Total: 24 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/28/24.	F 0000	The facility respectfully requests a desk review for paper compliance with the citations related to this survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hemmington Mwanza	Administrator	11/14/2024

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to develop a person-centered care plan regarding refusal of showers for 1 of 16 residents whose care plans were reviewed. (Resident 16) Finding includes: A record review was completed on 10/10/2024 at 1:45 P.M. for Resident 16. Diagnoses included, but were not limited to: type 2 diabetes mellitus, vascular dementia, and adjustment disorder with depressed mood. A Quarterly Minimum Data Set (MDS) assessment, dated 8/23/2024, indicated Resident 16's cognition was intact. During an interview on 10/11/2024 at 10:06 A.M., CNA 6 indicated showers were charted in the Point of Care (POC) under the showering task. She indicated when a resident refused a shower, it was charted in the POC as refused. She indicated they notified the nurse about the resident's refusal and they also filled out a shower sheet and marked refused. A review of Resident 16's shower sheets was completed on 10/11/2024 at 11:03 A.M. The shower sheets indicated the resident refused showers on 9/16/2024, 9/19/2024, 9/23/2024, 9/26/2024, 10/3/2024, 10/7/2024 and 10/11/2024. The showering task in the POC lacked any documentation to indicate Resident 16 refused any showers within the last 30 days. Instead, not applicable was documented under the resident's POC showering task for the last 30 days.	F 0656	F 656 Develop/Implement Comprehensive Care Plan 1 For Resident 16, a care plan was developed for refusals of showers. 2 Skilled residents have the potential to be affected by the deficient practice. Skilled residents will be reviewed to determine if they have a pattern of refusals. If skilled residents have a pattern of refusals, a care plan will be developed addressing the refusals. 3 Nursing staff and the Interdisciplinary Team will be educated on resident review for refusals of care and development of related care plans through the RAI process. The Interdisciplinary Team will follow the RAI process for care plan development for patterns of refusals of care. Shower documentation will be reviewed twice weekly by the MDSC or designee for necessity of development of care plans for shower refusals. 4 The Director of Nursing or designee will review the refusals audit, weekly to ensure care plans are developed. The Director of Nursing will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance	11/18/2024

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	A current Care Plan, initiated on 12/3/2024, indicated Resident 16 had a self-care performance deficit related to a diagnosis of type 2 diabetes, neuropathy, and adjustment disorder. Interventions included, but were not limited to: the resident preferred showers and required extensive assistance by staff with bathing and showering. Resident 16's Care Plan lacked documentation indicating he refused showers. On 10/11/2024 at 11:17 A.M., a policy regarding refusal of showers was requested but one was not provided prior to the survey exit. 3.1-35(b)(2)		is achieved. The Administrator is responsible to ensure compliance with this citation.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to ensure care plan conferences were completed every quarter for 1 of 4 residents reviewed for care plan conferences. (Resident 16) Finding includes: During an interview on 10/9/2024 at 2:50 P.M., Resident 16 indicated he had never been to a care plan conference since being admitted to the facility on 12/4/2023. On 10/10/2024 at 1:44 P.M., a record review was completed for Resident 16. The record lacked documentation that a care plan conference had been completed for the 2024 year. During an interview on 10/15/2024 at 9:34 A.M.,	F 0657	SkiF657 Care Plan Timing and Revision 1 1. Resident 16 has had a care plan meeting within the last quarter. Ski2. Skilled residents have the potential to be affected by the deficient practice. Skilled residents will be reviewed for the presence of documentation supporting a care plan meeting within the last 90 days. A care plan meeting will be scheduled for those who have not had a meeting. 3. The Interdisciplinary Team will be educated on scheduling of care plan meetings. The IDT will	11/18/2024

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	the Social Services Director indicated Resident 16 attended a care plan conference on 12/19/2023, 6/6/2024 and 8/29/2024. She indicated the resident did not have a care plan conference in February or March of 2024 but should have had one completed. On 10/15/2024 at 10:40 A.M., a policy regarding care plan conferences was requested but one was not provided prior to the survey exit. 3.1-35(e)		schedule care plan meetings/reviews per the MDS schedule. Social Service Director or designee will maintain a tracker weekly to ensure care plan meetings occur per the MDS schedule and that the meetings are documented in the medical record.4. The Director of Nursing will review 25% of residents scheduled per the MDS schedule weekly to ensure that residents and families are documented as having been offered attendance at care plan meetings. The Director of Nursing will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview and record review, the facility failed to ensure a resident was provided 1:1 activities per the plan of care for 1 of 1 resident reviewed for activities. (Resident 6) Finding includes: During an observation on 10/10/2024 at 9:56 A.M., Resident 6 was sitting on her sofa folding a small blanket. During an interview on 10/10/2024 at 2:47 P.M.,	F 0679	F679 Activities Meet Interests/Needs of Each Resident 1 For Resident 6, one to one activities have been documented since the survey exit. 2 Skilled residents with a goal of one-to-one activities have the potential to be affected by the deficient practice. Skilled residents will be reviewed for an activity care plan goal of one-to-one activity participation.	11/18/2024

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	Resident 6 was sitting on the sofa in her room and indicated she liked to color and did not know what kind of activities the facility offered. During an observation on 10/11/2024 at 10:30 A.M., Resident 6 was sitting on the sofa looking through a coloring book. During an observation on 10/11/2024 at 1:00 P.M., Resident 6 was sitting on her sofa folding a shirt. During an observation on 10/15/2024 at 9:31 A.M., Resident 6 was sitting on her sofa with her eyes closed. A record review was completed on 10/11/2024 at 10:03 A.M. Diagnoses included, but were not limited to: Parkinson's Disease with dyskinesia, with fluctuations, dysphagia, oropharyngeal phase and Alzheimer's Disease. A current Care Plan, initiated 4/29/2024, indicated Resident 6 liked to color in coloring books and did not like to attend group activities. It indicated she would receive 1:1 activities at least twice a week. Review of the electronic medical record the documentation of activity participation for 1:1; indicated "no data found." During an interview on 10/15/2024 at 11:59 A.M., the Activity Director indicated when a resident did not like to attend group activities she did a 1:1 with them. She would ask the resident what they would like to do, such as, read them a book, play a game, put on music. She then documented in the electronic medical record point of care under activities 1:1. The Activity Director indicated she did not document in Resident 6's chart when she had visited with the resident and should have		One-to-one activity participation will be documented for those residents. 3 The Activity Department will be educated on documentation of one-to-one activity participation. The Activity Department will document one-to-one activity participation in the EMR. The Activity Director will review one-to-one activity participation twice weekly to ensure documentation of one-to-one activity participation. 4 The MDSC or designee will review 2 random residents requiring one-to-one activities, weekly for presence of documentation. The MDSC will present the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	

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	had. On 10/15/2024 at 1:30 P.M. the DON provided a policy titled, "Activities,"dated 5/25/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...4. Activities may be conducted in different ways: a. One-to-One Programs. b. Person Appropriate - activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for. 9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include, but are not limited to, considerations for: e. Residents who have withdrawn from previous activity interest/customary routines, and isolates self in room/bed most of the day....." 3.1-33(a)(8)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to adequately label an over the counter medication stored in a medication cart for 1 of 1 medication cart reviewed. (First Floor Medication Cart) The facility also failed to monitor and maintain proper temperatures of a refrigerator where medications were stored for 1 of 2 medication refrigerators reviewed. (First Floor Medication Refrigerator) Findings include: 1. During an observation of the first floor medication cart on 10/9/2024 at 1:25 P.M. with LPN 8, an opened bottle of Women 50+ Complete Multivitamin with no resident identifying	F 0761	F 761 Medication Storage 1 The items located in the first floor medication refrigerator that were stored improperly and the improperly labelled bottle were destroyed. The refrigerator was replaced. 2 Other medication storage locations have the potential to be affected by this deficient practice. Other medication storage locations were audited for proper medication storage with corrections made as needed for compliance. 3 Nurses and QMAs were	11/18/2024

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	information was in a drawer. An interview with LPN 8 was completed on 10/9/2024 at 1:27 P.M. LPN 8 indicated she did not know whose medication the Women 50+ Complete Multivitamin was, but the medication should be labeled with the resident's name. An interview with the Unit Manager (UM) was completed on 10/9/2024 at 1:30 P.M. The UM indicated all medication should have a label with the resident's name, date of birth, Physician's name, and dosing information. 2. During an observation of the first floor medication refrigerator on 10/9/2024 at 1:35 P.M. with the UM, the medication refrigerator had two thermometers, one was 29 degrees Fahrenheit (F) and the other thermometer was 36 degrees F. The refrigerator had one bottle of Rezvoglar, three boxes of the facility's supply of influenza vaccinations, eight Bisacoydl suppositories and one bottle of Tuberculin. The temperature logs did not have a temperature logged for the following dates: - 9/21/2024 - 9/22/2024 - 9/26/2024 - 9/27/2024 - 9/30/2024 - 10/5/2024 - 10/6/2024 The temperature logs had out of range temperatures logged for the following dates: - 9/1/2024 11 degrees F - 9/2/2024 20 degrees F - 9/3/2024 21 degrees F - 9/4/2024 22 degrees F		educated on medication storage. Nurses and QMAs will store medications at the proper temperature and with the appropriate labelling. Nurses will complete a medication storage audit 3x/wk. 4 The Unit Managers or designee will complete a medication storage audit 2x/wk. The Unit Managers will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	

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	- 9/5/2024 20 degrees F - 9/6/2024 22 degrees F - 9/7/2024 22 degrees F - 9/8/2024 22 degrees F - 9/9/2024 24 degrees F - 9/10/2024 22 degrees F - 9/11/2024 26 degrees F - 9/12/2024 24 degrees F - 9/13/2024 22 degrees F - 9/14/2024 26 degrees F - 9/15/2024 28 degrees F - 9/16/2024 24 degrees F - 9/17/2024 22 degrees F - 9/18/2024 24 degrees F - 9/19/2024 22 degrees F - 9/20/2024 20 degrees F - 9/23/2024 29 degrees F - 9/24/2024 28 degrees F - 9/25/2024 26 degrees F - 9/28/2024 24 degrees F - 9/29/2024 26 degrees F - 10/1/2024 22 degrees F - 10/2/2024 24 degrees F - 10/3/2024 26 degrees F - 10/4/2024 22 degrees F - 10/7/2024 28 degrees F An interview with the Unit Manager (UM) was completed on 10/9/2024 at 1:37 P.M. The UM indicated the nurse was responsible for checking and logging the medication refrigerator temperatures on the daily log sheets. The UM indicated the temperatures logged on the September and October daily log sheets were within normal range. An interview with the Director of Nursing (DON) was completed on 10/9/2024 at 1:47 P.M. The DON indicated safe temperatures for the medication refrigerator were between 36 and 46 degrees F.			

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	On 10/9/2024 at 1:47 P.M. the DON provided a policy, dated 5/15/2023 and titled, "Medication Storage and Medication Labeling" and indicated it was the policy currently used by the facility. The policy indicated, "...1. General Guidelines: ... f. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 6. Refrigerated Products: ... b. Temperatures are maintained within 36-46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee... Medication Labeling... 2. The medication label includes, at a minimum: a. medication name, b. prescribed dose, c. strength, expiration date, resident's name, route of administration and appropriate instructions and precautions...." 3.1-25 (j) 3.1-25 (m)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to prepare food under sanitary conditions related to a dirty range and oven in 1 of 1 kitchen reviewed. This had the potential to affect 24 of the 24 residents who received their meals from the kitchen. Findings include: 1. During the initial kitchen tour on 10/10/2024 at 11:00 A.M. with the Dietary Director (DD), the gas range had four burners with a black substance on	F 0812	F 812 Food Procurement, Store, Prepare, and Serve Sanitary 1 The stove and oven have been cleaned. 2 Other items used for food service have the potential to be affected by the deficient practice. Kitchen sanitation rounds have been completed with no other deficiencies observed. 3 Kitchen staff have been educated on food sanitation and	11/18/2024

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	all of the grates. The single door oven had a build up of grease and a black substance on the inside. 2. During the final kitchen tour on 10/15/2024 at 9:30 A.M., the range had four burners with a black substance on all the grates and below the grates. The single door oven had a build up of grease and a black substance on the inside. During an interview on 10/15/2024 at 9:31 A.M., the DD indicated the range and the oven were dirty and should be cleaned. The facility used a daily cleaning schedule to complete the kitchen cleaning tasks. On 10/15/2024 at 11:00 A.M., the DD provided a cleaning schedule titled, "[Facility Name] Daily Cleaning Schedule" and indicated it was the cleaning schedule currently used by the facility. The daily cleaning schedule included the task, Cleaning the range top/ovens/flat top. On 10/15/2024 at 11:00 A.M., the DD provided an undated policy titled, "Food Safety and Sanitation", and identified it as the policy currently used by the facility. The policy indicated, "...Sanitation...Follow a regular written cleaning schedule and document cleaning...." 3.1-21(i)(3)		following cleaning schedules. Kitchen staff will follow cleaning schedules for kitchen sanitation. Administrator or designee will conduct a kitchen sanitation audit 3x/wk. 4 The Dietary Manager will review the results of the kitchen sanitation audits weekly. The Dietary Manager will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to distribute medication in a sanitary manner during 2 of 4 medication administration observations. (RN 2 & RN 3) Findings include:	F 0880	F 880 Infection Prevention & Control 1 RN 2 & RN 3 have been educated as for #3 below. 2 Skilled residents have the potential to be affected by the	11/18/2024

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	1. During an observation on 10/10/2024 at 9:45 A.M., RN 2 dropped one tablet of Vitamin D onto the medication cart. RN 4 applied hand sanitizer and gloves and then picked up the tablet of Vitamin D and put it into the medication cup with other medications. The resident was given the medication cup and took all the medications. During an interview on 10/10/2024 at 9:47, RN 2 indicated the medication should have been discarded and replaced with a new tablet. 2. During an observation on 10/11/2024 at 8:49 A.M., RN 3 dropped one tablet of Lisinopril onto the medication cart and used a spoon to pick up the tablet and put it into the medication cup. The resident was given the medication cup and took all the medications. During an interview on 10/11/2024 at 8:53 A.M., RN 3 indicated she did not know if the tablet of Lisinopril should have been discarded after it fell onto the medication cart, but she would ask someone and follow-up later. RN 3 did not follow-up before the exit of the survey. During an interview on 10/11/2024 at 9:45 A.M., the Director of Nursing (DON) indicated the facility did not have a policy specific to what to do when a medication was dropped. 3.1-18(b)		deficient practice. Nurses and QMAs will be observed by Nurse Managers for appropriate sanitary measures during medication pass. 3 Nurses and QMAs have been educated on infection control measures for medication pass. Nurses and QMAs will administer medications in a sanitary manner while following standard infection control procedures. Nurse Managers will observe 3 LN/QMAs/wk for sanitary medication administration, while following standard infection control procedures. 4 The Director of Nursing will review the results of the observations weekly. The Director of Nursing will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (t)(3) The facility shall maintain a health record of	F 9999	IN New Hire Physicals 1 The cited staff member received a physical prior to the	11/18/2024

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	each employee that includes: (A) a report of the pre-employment physical examination. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to have a new employee receive a pre-employment physical timely for 1 of 5 new employees reviewed. (Housekeeper 4) Finding includes: A review of Housekeeper 4's employee file was completed on 10/16/2024 at 10:30 A.M. Housekeeper 4's date of hire was 4/10/2024, but her pre-employment physical was not signed by the Physician until 8/28/2024. During an interview with the Director of Nursing (DON) on 10/16/2024 at 10:40 A.M., the DON indicated Housekeeper 4 should have received her pre-employment physical before she started working on 4/10/2024. The facility did not have a policy for maintaining employee records, but they used a checklist. On 10/16/2024 at 11:00 A.M., the Executive Director provided an undated checklist titled, "Folder Contents", and identified it as the checklist currently used by the facility. The checklist included, "Physical/Health Questionnaire/Drug Screen."		survey. 2 Other staff members have the potential to be affected by the same deficient practice. The HR Director will review staff members for the presence of a completed physical form with corrections made as needed for compliance. 3 The HR Director will be educated on timely completion of physical forms on hire. The HR Director will ensure that physical forms are completed during the onboarding process weekly. 4 The Administrator or designee will review 4 new hire documents a month for the presence of a completed physical form. The Administrator will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00440061, IN00437310 and	R 0000	The facility respectfully requests a desk review for paper compliance with the citations related to this survey.	

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	155738	A. BUILDING 00 B. WING	10/18/2024

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	IN00434826. Complaint IN00440061 - No deficiencies related to the allegations are cited. Complaint IN00437310 - No deficiencies related to the allegations are cited. Complaint IN00434826 - No deficiencies related to the allegations are cited. Survey dates: October 17 & 18, 2024 Facility number: 001141 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/28/24.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on record review and interview, the facility failed to ensure as needed, or PRN, medications were administered by a Qualified Medication Aide (QMA) after authorization by a licensed nurse for 1 of 5 residents reviewed for PRN medications. (Resident 2) Finding includes: A record review was completed on 10/17/2024 at 10:15 A.M. for Resident 2. Diagnoses included type 2 diabetes mellitus, major depressive disorder and general anxiety disorder. Physician Orders included, but were not limited to:	R 0246	R 246 QMA Authorization to Administer PRNs 1 For Resident 2, QMA 7 has been educated on obtaining authorization from a nurse for administration of PRNs and method of documentation. 2 Other PRNs administered by a QMA have the potential to be affected by the same deficient practice. The Medical Director is aware of the deficiency with no follow-up required. 3 Nurses and QMAs have been educated on the requirement	11/18/2024

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	- 6/6/2024 loperamide 2 milligrams (mg) give 1 tablet by mouth every 4 hours as needed for loose stools. - 6/6/2024 hydrocodone-acetaminophen 6-325 mg give 1 tablet by mouth every 6 hours as needed for pain. Medication Administration Records and Nursing Progress Notes indicated that QMA 7 administered the following PRN medications without authorization from a licensed nurse: - 6/15/2024 loperamide - 8/2/2024 hydrocodone-acetaminophen - 9/10/2024 hydrocodone-acetaminophen During an interview on 10/18/2024 at 8:55 A.M., the Director of Nursing (DON) indicated authorization should have been received, and documented, before administering a PRN medication and was not. During an interview on 10/18/2024 at 9:55 A.M., the DON indicated she did not have a policy for PRN medications administered by a QMA.		for QMAs to obtain authorization from a nurse prior to administering a PRN and the associated documentation required. QMAs will obtain authorization from a nurse prior to administering PRNs and document it in the EMR. The Nurse Managers will review up to 3 QMA shifts (as available) per week to ensure nurse authorization is received and documented prior to PRN administration. 4 The Director of Nursing will review the results of the audit weekly. The Director of Nursing will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview and record review, the facility failed to prepare food under sanitary conditions related to a dirty oven and range in 1 of 1 kitchen reviewed. This had the potential to affect 19 of the 19 residents who received their meals from the kitchen. Findings include: 1. During the initial kitchen tour on 10/10/2024 at 11:00 A.M. with the Dietary Director (DD), the gas range had four burners with a black substance on	R 0273	R 273 Food and Nutritional Services 1 The stove and oven have been cleaned. 2 Other items used for food service have the potential to be affected by the deficient practice. Kitchen sanitation rounds have been completed with no other deficiencies observed. 3 Kitchen staff have been educated on food sanitation and	11/18/2024

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	all of the grates. The single door oven had a build up of grease and a black substance on the inside. 2. During the final kitchen tour on 10/15/2024 at 9:30 A.M., the range had four burners with a black substance on all the grates and below the grates. The single door oven had a build up of grease and a black substance on the inside. During an interview on 10/15/2024 at 9:31 A.M., the DD indicated the range and the oven were dirty and should be cleaned. The facility used a daily cleaning schedule to complete the kitchen cleaning tasks. On 10/15/2024 at 11:00 A.M., the DD provided a cleaning schedule titled, "[Facility Name] Daily Cleaning Schedule" and indicated it was the cleaning schedule currently used by the facility. The daily cleaning schedule included the task, Cleaning the range top/ovens/flat top. On 10/15/2024 at 11:00 A.M., the DD provided an undated policy titled, "Food Safety and Sanitation", and identified it as the policy currently used by the facility. The policy indicated, "...Sanitation...Follow a regular written cleaning schedule and document cleaning...."		following cleaning schedules. Kitchen staff will follow cleaning schedules for kitchen sanitation. Administrator or desginee will conduct a kitchen sanitation audit 3x/wk. 4 The Dietary Manager will review the results of the kitchen sanitation audits weekly. The Dietary Manager will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance Based on observation, interview and record review, the facility failed to properly secure medications in a resident's room, for 1 of 4 residents who were reviewed for medication storage. (Resident 6) Finding includes:	R 0295	R 295 Pharmaceutical Services 1 For Resident 6, a lock box was made available in resident's closet to store his medications securely. The lock to the entry door of the apartment has been repaired. 2 Other residents who	11/18/2024

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	During an observation and interview on 10/17/2024 at 2:30 P.M., Resident 6 indicated that he self-administered his medication and kept them in his dresser drawer. He had oral medication in bubble packed medication cards lying in the second dresser. Resident 6 indicated the drawer did not lock nor did his bedroom door. He had not locked his bedroom door because the only way you would be able to get back in was through the window. A record review was completed on 10/17/2024 at 11:00 A.M. Diagnoses included, but not limited to: anxiety disorder, major depressive disorder and chronic obstructive pulmonary disorder. A Self Administration of Medication Assessment, dated 8/15/2024, indicated medication was stored in a lock box. Resident 6 demonstrated the opening and closing of the locked box, and understood safety rules for storage of medications in the room. During an interview on 10/17/2024 at 3:00 P.M., the DON indicated they did not have to be locked up because the residents had locks on their doors. She found out 20 minutes ago that Resident 6's door lock was not working. During an interview on 10/17/2024 at 3:04 P.M., the Maintenance Director indicated Resident 6's door lock was on order. The door lock was ordered on 10/3/2024 and would take approximately 4 weeks to obtain. The only way to get into the room once the door was locked was through the window unless someone was inside. On 10/18/2024 at 8:53 P.M., the DON provided a policy titled, "Self-Administration of Medications and Treatments," dated 6/30/2024, and indicated		self-administer medications may have the potential to be affected by the deficient practice. Other residents who self-administer medications were reviewed. All medications are secured. 3 Nurses have been educated on securing medications for residents who self-administer medications. Nurses will ensure that medications are kept secure for those residents who self-administer medications. 4 Nurse Managers or designee will complete an audit on 2 random residents, with self-administration orders, 2x/wk to ensure that medications are kept secure. The Director of Nursing will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to ensure compliance with this citation.	

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	the policy was the one currently used by the facility. The policy indicated "...e. Storage of self-administered medications or treatments will comply with state and federal regulations. All bedside medications will be maintained in a secured location in the resident's room....."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure a resident had a health statement by a physician indicating the resident was free of communicable diseases, including tuberculosis in an infectious stage, at admission and yearly thereafter for 1 of 5 residents reviewed for health statements. (Resident 2) Finding includes: A record review was completed on 10/17/2024 at 10:15 A.M. for Resident 2. Diagnoses included type 2 diabetes mellitus, major depressive disorder and general anxiety disorder. The record lacked a statement indicating Resident 2 was free of communicable diseases, including tuberculosis in an infectious stage. During an interview on 10/18/2024 at 9:25 A.M., the Director of Nursing indicated the health statement should have been present in the medical record but was not. On 10/18/2024 at 9:55 A.M., a policy for the health statement was requested but one was not provided.	R 0409	R 409 Infection Control 1 For Resident 2, MD has provided the health statement. 2 Other residents have the potential to be affected by the deficient practice. An audit was conducted to ensure residents have an annual statement of health with corrections made as needed for compliance. 3 Nurse Managers and nurses have been educated on obtaining the annual health statement. The annual health statement has been triggered in the EMR to populate on admission. The Nurse Managers or designee will review the health statement orders monthly to ensure that the Practitioner has addressed these annually. 4 The Director of Nursing will review the results of the audit. The Director of Nursing will bring the results of the audits to the facility's Quality Assurance Performance Improvement meeting monthly X 6 months or until 100% compliance is achieved. The Administrator is responsible to	11/18/2024

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