STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING 00 B. WING	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 10, 11, 12, 13, 14, and 15, 2023 Facility number: 000113 Provider number: 155206 AIM number: 100287670 Census Bed Type: SNF/NF: 64 SNF: 4 Total: 68 Census Payor Type: Medicare: 5 Medicaid: 50 Other: 13 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 22, 2023.	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Brownsburg Health Care Center maintains the alleged deficiencies do not individually jeopardize the health and/or safety of its residents nor are they if such character as to limit the provider's capacity to render adequate resident care. Furthermore, Brownsburg Health Care Center asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the provider's credible allegation of compliance. The facility respectfully request a desk review.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure a resident with non-pressure wounds received treatments upon her admission to the facility for 1 of 1 residents reviewed for non-pressure wounds (Resident 52). Findings include: On 9/11/23 at 10:24 a.m., Resident 52 was observed as she was assisted out of bed and into her recliner chair. She wore an oversized nightgown and as she repositioned herself in the bed, the back of her thighs were observed. The skin was discolored, darker in color than the surrounding healthy tissue and closer to the edge of her brief, was redder in color. During an interview on 9/11/23 at 10:30 a.m., Resident 52 indicated she had previously lived in an assisted living facility, until she developed wounds on her bottom, in her groin area and under the skin fold of her stomach. She went to the hospital, and they got "a lot better" but she had spent so much time in the bed, her legs were weak. She was transferred to the nursing home for rehab to regain strength in her legs. During an interview on 9/14/23 at 9:00 a.m., Resident 52 indicated the wound under her abdominal fold was much better. She raised her gown and pulled a towel out from under her skin fold. She indicated sometimes the staff used towels or pillowcases, and she preferred the pillowcases because they were not as "scratchy	F 0684	**F-684 – Quality of Care** 1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice? a Resident 52 no longer resides at this facility. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice? a All residents with wounds have the potential to be affected, DON/Designee Reviewed Orders and care plans for all residents with wounds and no other residents were affected by the alleged deficient practice. 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a Nursing staff education on admission orders/treatment orders and weekly summaries and person-centered care plans on how/what to do with residents refuse care held on 10/5/2023. b DON/Designee will audit treatment orders, care plans and weekly summaries 2 times weekly x 4 weeks, weekly x 4 weeks, then monthly x 4 months. 4 How will the facility monitor	10/09/2023

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	and itchy." When asked about the use of interdry she indicated it had been used in the hospital but not since she had been back. On 9/13/23 at 11:42 a.m., Resident 52's medical record was reviewed. She admitted to the facility on 5/23/23 with diagnoses which included, but were not limited to heart failure, cellulitis (a type of skin infection) of her lower right and left limbs, and chronic non-pressure ulcers of the skin. A hospital discharge summary, dated 5/23/23, indicated Resident 52 reported she developed a wound in her buttock region and had been received wound care. She required more assistance with wiping and putting on barrier cream. The discharge summary gave new orders for wound management including, " ...Nursing-clean gluteal cleft, buttocks, perineum with no rinse foam wipes, then dab dry and apply a thin layer of zinc oxide-based barrier paste, two times daily and as needed. Avoid time on back." A nursing admission progress note, dated 5/24/23 at 1:58 a.m., indicated Resident 52 was alert and oriented times 4. Her perineal area was excoriated and although no open areas were noted, there was a small amount of bloody drainage, " ...possibly coming from buttock area, and slight redness to both lower extremities ...." An initial nursing admission assessment, dated 5/23/23, indicated Resident 52 had compromised skin integrity in her groin area which was described as, " ...moisture, frequent redness and or excoriation & treatment to gluteal cleft, zinc oxide unable to verify at this time due to lack of visual capability." The record lacked documentation of follow up or a		its corrective actions to ensure that the deficient practice will not recur? a Findings of audit will be reported monthly at the QA/Risk management meeting for any systemic changes x 4 months or until substantial compliance has been maintained.	

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	more comprehensive skin assessment to verify as the area was not fully visualized. An initial physician progress note, dated 5/26/23 at 2:05 p.m., indicated Resident 52 was newly admitted to the facility after she had presented to the hospital from an assisted living facility with reports of perineum wound bleeding and chronic wounds. The wound team was requested to follow and manage. Resident 52's admission physician orders were reviewed. There were no orders corresponding to her hospital discharge instructions to manage her wounds. The record lacked documentation of an initial wound assessment and or weekly follow up. Although there were "weekly skin assessments" recorded, no new areas were noted. A nursing progress note, date 6/23/23 at 10:52 a.m., indicated, Resident 52 had been seen by the wound nurse for new moisture associated skin damage (MASD) to her coccyx and on her thighs under her buttocks. New wound observations were opened on 6/23/23 and indicated: a. Wound #1 - MASD to coccyx and intergluteal cleft, which measured 26 centimeters (cm) long, by 6.5 cm wide and 0.1 cm deep. b. Wound #2 - MASD to the back left thigh, which measured 20 cm long by 20 cm wide and 0.1 cm deep. New orders were placed to cleanse the areas with soap and water, pat dry, and apply antifungal powder and barrier cream mixed, every shift.			

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	A new wound observation was opened on 7/1/23 and indicated: c. Wound #3 - an unspecified ulcer on the left posterior leg which measured 3.1 cm long by 3.5 cm wide and 0.1 cm deep. New orders were placed to cleanse the area with normal saline and apply calcium alginate to ulcer and wrap with kerlix. A nursing progress note, dated 7/2/23 at 1:18 p.m., indicated Resident 52 complained of shortness of breath and had a productive cough with yellow/green mucous. The doctor was notified, and a new order was received to complete a chest x-ray and a COVID-19 swab. A nursing progress note, dated 7/2/23 at 7:14 p.m., indicated Resident 52 still complained of shortness of breath and requested to be sent to the hospital. A new order was received, and she was sent to the hospital. The corresponding hospital admission note was, dated 7/3/23, indicated, " ...patient tell me that she came here because she has new wounds, and these have not been adequately cared for at facility. Patient has had perineal wounds and wound on left posterior leg from her wheelchair for quite some time ... an additional wound on the posterior aspect of her left leg and a wound under her pannus. She feels that her wounds have worsened over time ... Assessment/Plan: multiple ulcers- left posterior leg (2), buttock/perineum, intertrigo with ulceration of pannus ...." Discharge instructions from this visit indicated the following wound care: a. Clean abdominal folds and breast folds with soap and water, then dab dry and apply pieces of interdry alginate into folds in a single layer. Cut large enough to extend out from the folds 2-4			

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	inches for drying to air. Change interdry every 4 days and as needed with saturation. Do not use powder or creams with interdry. b. Clean buttocks/gluteal cleft/perineum with easicleanse wipes, then dab dry and apply a thin layer of triad paste daily and as needed. Avoid time on back. Utilize a Bariatric Low Airloss bed for better moisture management and prevention from pressure. Offload heels using pillows or waffle boots. c. Clean MASD to bilateral inner thighs with easicleanse wipes, then dab dry and apply a thin layer of triad daily and as needed. The record lacked documentation of physician's orders for interdry. A care plan, created 5/24/23 and revised 9/13/23, indicated she required assistance with Activities of Daily Living (ADLs). "Resident/family aware of ability to use spa room for personal and toileting needs. Will refuse care at times." The care plan indicated she required extensive assistance with ADLS which included, but were not limited to, toileting, bathing, and personal hygiene. The care plan lacked revision to include person-centered approaches or interventions on how/what to do when she refused care. A care plan, created 5/24/23 and revised 8/4/23, indicated she had open areas of MASD to gluteus and that the sat in her recliner and lays in bed all day and voids and declines brief changes and repositioning. Catheter placed for wound healing. The care plan lacked revision to include person-centered approaches or interventions on how/what to do when she wore the wrong size brief and/or refused to change her brief. A care plan, created on 6/15/23 and revised on			

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	7/14/23, indicated Resident 52 was "non-adherent to treatment plan, will sleep in w/c and not elevate legs causing wounds. Resident has been educated on risks of non-compliance with elevating legs." An intervention for this plan of care included, but was not limited to, " ...allow the resident to make decisions about treatment regime, to provide sense of control ...." A care plan, created on 8/2/23, indicated a foley catheter was placed temporarily for 14 days for wound healing. Nursing progress notes were reviewed from the date of her admission on 5/24/23 until 6/23/23 when her wounds re-developed. Although there was documentation that she sometimes refused to elevate her legs, the record lacked documentation of her refusal to receive ADL care, (incontinent care, shower/bath and/or personal hygiene). During an interview on 9/14/23 at 9:30 a.m., with the Wound Nurse (WN) and Interim Director of Nursing (I-DON) present, Resident 52's record related to her wound development was reviewed. The record lacked documentation of orders and treatments from her initial hospital admission and lacked documentation that interdry had been ordered from her re-hospitalization. Resident 52 was not seen by the wound team after her initial admission as noted in the physician's initial assessment, and she was not picked up for wound rounds until 6/23 when her wounds re-opened. The I-DON indicated the policy of the facility was to ensure all residents with wounds upon admission were seen by the doctor and wound team to establish a treatment plan, which was not done in this case as the previous Director of Nursing (DON) had been responsible for the wound management program and failed to ensure			

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	Resident 52 was referred or followed up with. The WN indicated when the previous DON walked out without notice, she did an assessment on every resident for wounds, which was when Resident 52's areas were found. On 9/13/23 at 3:32 p.m., the I-DON provided a copy of current facility policy titled, "Pressure Ulcers/Skin Breakdown- Clinical Protocol," revised 4/2018. The policy indicated, " ...the staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions ... the physician will order pertinent wound treatments ... during resident visits, the physician will evaluate and documents the progress of wound healing- especially for those with complicated, extensive, or poorly-healing wounds ...." 3.1-37(a) 3.1-37(b)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to implement interventions added post fall for a resident (Resident 57) for 1 of 1 resident reviewed for falls, and failed to complete a smoking assessment after a resident had a significant change (Resident 40)	F 0689	**F-689 Free of Accident Hazards/Supervision/Devices** 1 How will corrective action be accomplished for those residents found to have been affected by the	10/09/2023

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	for 1 of 1 residents reviewed for smoking. Findings include: 1. On 9/13/23 at 1:30 p.m., a comprehensive record review was completed for Resident 57. He had diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), vascular dementia, psychotic disturbance, essential hypertension, age related physical disability, muscle weakness, and abnormalities of gait and mobility. Resident 57 had a fall on 8/2/23 at 5:00 a.m. He was calling out that he had to use the bathroom. When staff entered the room, they found him lying on the floor with his back next to the bed. He had bruising to this chest and top of right hand, along with abrasions to his left and right buttock and right upper extremity (arm). On 8/2/23 at 9:45 a.m., the IDT (interdisciplinary team) reviewed resident's fall. The note indicated he had non-skid strips on both sides of his bed. New interventions were placed to implement a toileting program to reduce the risk of resident' urgent need to use the restroom. A care plan dated 7/18/23 indicated a problem for Resident 57 was at risk for injury related to falls due to diagnosis of COPD, vascular dementia, diabetes, HTN (hypertension), HLD (hyperlipidemia) and RLS (restless leg syndrome). Resident took antidepressants daily. He was non-compliant with call light use, had a history of non-compliance with call light use. He had a history of removing non-skid footwear. He had poor safety awareness and was impulsive. A goal, dated 7/18/23, indicated that resident would allow staff to provide effective interventions to		deficient practice? a All fall interventions were placed immediately for resident 57 on 9/13/2023. Smoking assessment completed for resident 40 on 9/18/2023. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice? a All residents had the potential to be affected, DON/Designee reviewed care for fall interventions and audited to ensure fall interventions are in place and smoking assessments were reviewed, no other residents were affected by this alleged deficient practice. 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a DON/Designee will audit fall interventions 2 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months until substantial compliance has been maintained. b DON/Designee will audit smoking assessments 2 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months. c DON/Designee provided education to nursing staff on 10/5/2023 on fall risk interventions and smoking assessments. 4 How will the facility monitor its corrective actions to ensure that the deficient practice will not	

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	help decrease the risk of significant injury from falls through the next review. Resident 57's care plan had interventions in place to reduce the risk of injury from falls. On 7/18/23 non-skid strips were added to both sides of his bed. On 7/31/23 a scoop mattress was added to his bed. During an observation on 9/13/23 at 2:28 p.m., Resident 57 did not have a scoop mattress or non-skid strips to each side of his bed as indicated on his fall care plan. On 9/13/23 at 2:28 p.m., The Administrator (ADM) and Interim Director of Nursing (IDON) were made aware that Resident 57 lacked fall interventions in his room. They indicated they would correct immediately to protect resident from falls. 2. On 9/12/23 at 2:51 p.m., a comprehensive record review was completed for Resident 40. She had diagnoses which included but were not limited to unsteadiness on feet, abnormal posture, heart disease, diabetes mellitus (DM) without complications, HLD, PVD (peripheral vascular disease) and COPD. Resident had a smoking assessment dated 5/10/23. She had a significant change on 7/27/23. A new smoking assessment was not completed. On 9/12/23 at 3:12 p.m., a policy was provided by the ADM, it was titled Smoking Policy-Residents. It indicated, " ...A resident's ability to safely smoke will be re-evaluated annually, upon a significant change (physical or cognitive) and as determined by the staff ...." 3.1-45(a)		recur? a Findings of audit will be reported at the QA/Risk management meeting for any needed systemic changes monthly or until substantial compliance has been maintained.	

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F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed on ensure narcotic and non-narcotic drugs were received, administered, and accounted for with facility Controlled Substance Accountability	F 0755	**F-755 Pharmacy Srvcs/Procedures/Pharmacist/Records** 1 How will corrective action be	10/09/2023

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	Sheets and Medication Disposition Sheets according to policy to prevent possible drug diversion for 6 of 6 residents who passed away in the facility (Resident 66, 68, 119, 121, 122, and 123). Findings include: 1. On 9/14/23 at 3:36 p.m., Resident 119's record was reviewed. She was admitted to the facility on 7/10/23, and expired in the facility on 7/29/23 at 5:55 a.m. Her diagnoses included, but were not limited to, acute myeloid leukemia (AML) (bone marrow disorder) and diabetes mellitus (DM) (blood sugar disorder). Her physician ordered medication included, but were not limited to, lorazepam (anti-anxiety) liquid 2 mg/mL give 0.5 mL by mouth every 2 hours as needed for anxiety, and morphine sulfate (severe pain relief) 20 mg/mL give 0.25 mL by mouth every one hour as needed for pain related to AML. A pain care plan, dated 7/12/23, indicated Resident 119 was a risk for pain related to osteoarthritis (joint disorder), AML, general pain, and gastroesophageal reflux disease (GERD) (stomach-esophagus disorder). An intervention indicated to provide medications and monitor for effectiveness as ordered. A limited review of her July Medication Administration Record (MAR) indicated: a. Lorazepam Intensol: Give 0.5 mL by mouth every 2 hours as needed (PRN). On 7/28/23, it was provided at 5:06 a.m., 11:44 a.m., and 5:31 p.m. b. Morphine Sulfate: Give 0.25 mL by mouth ever 1 hour PRN. On 7/26/23, it was given at 10:41 p.m.		accomplished for those residents found to have been affected by the deficient practice? a Residents 119,122,123,121,68 and 66 have been discharged from facility. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice? a All residents have the potential to be affected by this alleged deficient practice. 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a Education provided on controlled medication destruction/and medication destruction on 10/5/2023. b DON/Designee will audit medication destruction/narcotic accountability sheets 2 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months. 4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? a Findings of audit will be reported at the QA/Risk management meeting for any needed systemic changes monthly or until substantial compliance has been maintained.	

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	On 7/28/23, it was given at 5:07 a.m., 11:44 a.m., and 5:32 p.m. c. Lidocaine (pain relief) External Gel 4%. Apply to low back topically in the morning. It was applied from 7/19/23 to 7/22/23. d. Remove Lidocaine Patch at bedtime (HS) for pain. The patch was removed from 7/19/23 to 7/21/23 and 7/23/23 to 7/28/23. Resident 119's, "Controlled Substance Accountability Sheet[s]," were reviewed. One document, dated, 7/26, was for morphine sulfate 100 mg/5 mL. The quantity received was 15 mL. No doses were administered. The amount of doses destroyed were 30 mL, on 7/31/23. Only one nursing signature: Assistance Director of Nursing (ADON). No second nursing signature was observed. Another document, with no date, was for morphine sulfate 100 mg/5 mL. The quantity received was unclear. a. The first entry, dated 7/26/23 at 9:30 p.m., indicated 30 mL were received. Signed by illegible, and error was written next to initials only, presumably Nurse 35. This entry had a straight line through it. b. The second entry, dated 7/26/23 at 9:30 p.m., was one dose of 0.25 mL given on 7/26/23, leaving 29.75 mL. This entry had a straight line through it. c. The third entry, dated 7/26 at 9:30 p.m., indicated 15 mL, the 2 illegible nursing signatures were the same, one was for witness destruction/waste only. A straight line was observed through both signatures. d. The fourth entry, dated 7/26/23 at 9:30 p.m., dispensed of 0.25 mL, leaving 14.75 mL left. No nurse signature for this dose was given. e. The fifth entry, dated 7/28 at 6:00 a.m..,			

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	dispensed 0.25 mL, leaving 14.50 mL with an illegible signature. f. The sixth entry, dated 7/28 at 11:50 a.m., dispensed 0.25 mL, leaving 14.25 mL with initials only for Registered Nurse (RN) 30. g. The seventh entry, dated 7/28/23 at 5:30 p.m., dispensed 0.25 mL, leaving 14.0 mL with partial LPN 19 signature. h. The amount of doses destroyed were entered as 14.0 mL, on 7/31/23. Only one nursing signature was observed: ADON. No second nursing signature was observed. Another document, dated 7/28, was for lorazepam 2 mg/mL. The quantity received was 30 mL. The instructions indicated to give 0.25 mL by mouth PRN. One dose, dated 7/28 at 11:50 a.m., the amount given was 0.5 mL, initialed by RN 30, no nursing signature. The second dose, dated 7/28 at 5:30 p.m., the amount given was 0.5 mL, initialed by LPN 19 with no nurse signature. Doses destroyed were entered as 29 mL, on 7/31, one nursing signature: ADON. No second signature observed. Resident 119's, "Medication Disposition Sheet," dated 8/1/23, was reviewed. a. Jentadueto tab 2.5-1000 (lowers blood sugar), dispensed 7/11/23, quantity disposed 33. Reasons: A: Deceased return to pharmacy and D. Destroyed, with no date. Form signed by Medical Records/QMA 21. b. Oxybutynin tab 5 mg ER (bladder relaxant), dispensed 7/11/23, quantity disposed 33. Reason: A and D. Form signed by Medical Records/QMA 21. c. Polyeth Glyc pow 3350 (polyethylene glycol powder) (treats constipation), dispensed 7/13/23,			

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	quantity disposed 17.9 oz (ounces). Reasons: A and D. Form completed by Medical Records/QMA 21. d. Alocane Emer Gel (Alocane Emergency Gel) (pain and itch relief), dispensed 7/18/23, quantity disposed 17.9 oz (ounces). Reasons: A and D. Form signed by Medical Records/QMA 21. On 9/15/23 at 10:39 a.m., the IDON indicated Medical Records/QMA 21 could not sign-out drugs for medication final disposition or medication destruction. On 9/15/23 at 9:35 a.m.., a pharmacy email, dated 9/14/23, was provided by the Interim Director of Nursing (IDON). A review of the email indicated pharmacy medications were received for Resident 119. One 15 mL bottle of Morphine sulfate solution 100 mg/5 mL was pulled from the EMC (emergency medication from the pharmacy dispensary machine) on 7/26/23 at 10:34 p.m., and one 15 mL bottle of Morphine sulfate was sent from the pharmacy on 7/27/23 at 12:26 a.m. It was signed in by RN 33. On 9/15/23 at 10:41 a.m., the IDON indicated the pharmacy documentation showed Resident 119 received from their pharmacy 30 mL lorazepam and 30 mL morphine sulfate. The EMC was the ekit (emergency kit) inside the pharmacy dispensary in the facility and one from the pharmacy from a total of 30 mL. On 9/15/23 at 10:21 a.m., the IDON indicated she talked with LPN 19 regarding signed in medications, missing resident doses, and missing narcotics. She provided Controlled Substance Accountability Sheets for Resident 119. She indicated the ADON did not sign for the destruction of those remaining medications. She			

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	indicated during their investigation, she identified a nurse, LPN 19, as problematic and she was now suspended. LPN 19 denied taking the narcotics and signing the documentation. She was the last one to sign out narcotics given on 7/28/23 and worked nights on 7/28, 7/29, and 7/30. 2. On 9/15/23 at 11:56 a.m., Resident 122's record was reviewed. She was admitted to the facility on 7/17/23, and expired in the facility on 7/31/23 at 10:32 a.m. Her diagnoses included, but were not limited to, heart disease and hypertension (high blood pressure). Her physician ordered medication included, but were not limited to, diazepam (treats anxiety) oral 2 mg give 1 tablet by mouth three time a day for anxiety, and tramadol (treats severe pain) oral tablet 50 mg, give 1 tablet by mouth four times a day for pain. On 9/15/23 at 10:21 a.m., the IDON provided Resident 122's Controlled Substance Accountability Sheets. One document, dated 7/19/23, it indicated 5 tablets of Tramadol 50 mg was received. Eleven times from 7/20 and 7/31, 4 additional tablets were added. Thirteen times the nurse signatures were initials only. Thirty-seven signatures or initials did not indicate nursing credentials. On 7/25/23, 9 tablets were transferred to another accountability sheet per RN 30's initials. The bottom of the third sheet indicated 7 Tramadol 50 mg tablets were destroyed, it was initialed by two RNs. Another document, dated 7/17, indicated 48 tablets of Tramadol 50 mg were received. Four			

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	times the nurse signatures were initials only. Five signatures or initials did not indicate nursing credentials. On 7/31/23, 37 tablets indicated 7 of Tramadol 50 mg tablets were destroyed, it was initialed by two RNs. Another document, dated 7/17, indicated 34 tablets of diazepam 2 mg were received. Twelve times the nurse signatures were initials only. Twenty-five signatures or initials did not indicate nursing credentials. On 7/31/23, 3 tablets of diazepam 2 mg tablets were destroyed, it was initialed by two RNs. Another document, dated 7/19, indicated 9 diazepam tablets were received and signed in by LPN 19. Two times the nurse signatures were initials only. Eight signatures or initials did not indicate nursing credentials. On 7/23/23, all tablets of diazepam 2 mg tablets were administered. 3. On 9/15/23 at 12:05 p.m., Resident 123's record was reviewed. She was admitted to the facility on 3/27/23, and expired in the facility on 8/25/23 at 1:54 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease (progressive, degenerative brain dysfunction) and hypertension. Her physician ordered medication included, but were not limited to, lorazepam intensol oral concentrate 2 mg/mL give 1 mg by mouth every 2 hours as needed for anxiety per hospice, and Morphine sulfate 20 mg/mL give 0.5 mL by mouth every 4 hours for pain/labored breathing. On 9/15/23 at 10:21 a.m., the IDON provided Resident 123's Controlled Substance Accountability Sheets.			

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	One document, dated 8/18/23, it indicated 30 mL of Lorazepam 2 mg/mL was received. There was no nursing signature of who received it. No doses were given. The amount destroyed on 8/31/23, was 10.25 mL. One signature, with no credentials was observed, no second signature was found. No explanation for what happened to the 19.75 mL missing. Another document consisting of three pages, the first page, dated 6/19/23, indicated 30 mL of Lorazepam 2 mg/mL was signed in by LPN 19. The second page did not list the medication given, no resident or pharmacy information. The doses were signed out by initials 27 times, not nursing signatures with titles. Four count corrections were observed accounting for 7.5 mL missing: bottle leaking on 7/15, bottle spilled 8/10 and 8/11, or unexplained 8/22. Inconsistence doses were given. The orders indicated from 8/18 to 8/20, to give 0.25 mL. On 8/21, a handwritten dosage change to 0.5 mL. On 8/24, QMA 14 gave 0.25 mL. The doses destroyed were 10.25 mL on 8/31/23, illegible initials by one staff member with no credentials. No second signature was observed. Another document, dated 6/18/23, indicated 30 mL morphine sulfate was received by LPN 19. Three doses were given and initialed only, no nursing signature or credentials. The doses destroyed were 25.50 mL on 8/31/23, illegible initials by one staff member with no credentials. No second signature was observed. 4. On 9/13/23 at 12:26 p.m., Resident 68's record was reviewed. He was admitted to the facility on 6/20/23, and expired in the facility on 7/13/23 at 7:18 a.m.			

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	His diagnoses included, but were not limited to, heart disease and COPD. His physician ordered medication included, but were not limited to, lorazepam intensol oral concentration 2 mg/mL give 0.5 mL by mouth every 2 hours PRN, morphine sulfate oral solution 20 mg/mL give 0.5 mL by mouth every 2 hours PRN, and oxycodone oral tablet 10 mg give 1 tablet by mouth every 4 hours PRN. On 9/15/23 at 10:21 a.m., the IDON provided Resident 68's Controlled Substance Accountability Sheets. One document, dated 7/13, was for morphine sulfate 20 mg/mL. Handwritten instructions indicated to give 0.25 mL every 2 hours PRN. It was marked out with two straight lines and rewritten. Changed to 1 mL every 2 hours PRN on 7/13 by LPN 35. Five doses were given and initialed only, four with no nursing signature or credentials. The doses destroyed were 27 mL on 7/14/23, illegible initials by one staff member with no credentials. An illegible second initials was observed with no credentials. One document, dated 7/13, was for lorazepam 2 mg/mL. Handwritten instructions indicated to give 0.25 mL every 6 hours PRN. It was marked out with two straight lines and rewritten. Changed to 1 mL every 2 hours PRN on 7/13. Five doses were given and initialed only, four with no nursing signature or credentials. The doses destroyed were 27 mL on 7/14/23, illegible initials by one staff member with no credentials. An illegible second initials was observed with no credentials. A "Medication Disposition Sheet," dated 7/12/23, indicated 27 mL of Lorazepam 2 mg/mL and 29 mL			

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	of morphine sulfate 20 mg/mL had no disposition or destruction information. The form was completed by the ADON, no date observed. Two Medication Disposition Sheets, dated 7/18/23, for drugs dated from 6/21 to 7/12, the form was signed by the Medical Records/QMA 21. There were 25 drugs listed. No destruction date or nursing signatures were observed. One Medication Disposition Sheet, dated 7/25/23, for drugs dated on 6/22/23, the form was signed by the Medical Records/QMA 21. There was one drugs listed: Trulicity. No destruction date or nursing signatures were observed. One Medication Disposition Sheet, dated 8/1/23, for drugs dated on 6/22/23, the form was signed by the Medical Records/QMA 21. There was one drugs listed: enoxaparin. No destruction date or nursing signatures were observed. On 9/15/23 at 10:44 a.m., the IDON indicated she destroyed Resident 68's lorazepam with RN 30 and destroyed his morphine sulfate with the ADON. She indicated medication disposition or medication destruction forms were completed. Medical Records/QMA 21 indicated to the IDON that she filled out the destruction papers but did not forge the ADON's name. On 9/15/23 at 10:50 a.m., the IDON indicated drug instructions should not be marked out and the label changed. A new drug sheet should be used with the new instructions. 5. On 9/14/23 at 2:08 p.m., Resident 121's record was reviewed. She was admitted to the facility on 5/26/23/23, and expired in the facility on 6/4/23 at 10:22 a.m.			

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	Her diagnoses included, but were not limited to, Alzheimer's disease and DM. Her physician ordered medication included, but were not limited to, morphine sulfate 20 mg/mL. Give 0.25 mL by mouth every two hour as needed for severe pain and lorazepam liquid 2 mg/mL. Give 0.5 mL by mouth every 4 hours as needed for anxiety. Three Controlled Substance Accountability Sheets, with no date, indicated Resident 121 had three bottles of 30 mL of morphine sulfate 100 mg/5 mL with instructions to give 0.25 mL by mouth every 2 hours PRN. There was no date or amount for drug destruction. An S was signed in the destruction area, with no other nursing signature. The ADON indicated he did not sign these documents. A Controlled Substance Accountability Sheet, with no date, indicated Resident 121 had 30 mL of morphine sulfate 100 mg/5 mL. Give 0.25 mL by mouth every 2 hours PRN. There was no date or amount for drug destruction, but it was signed by the ADON and the former DON 17. A Controlled Substance Accountability Sheet, dated 5/27, indicated Resident 121 had 30 mL of lorazepam 2 mg/mL. Give 0.25 mL by mouth every 4 hours PRN. One dose was given on 5/27, leaving 29.75 mL. There was no date or amount for drug destruction, but it was signed with an S by the ADON. He indicated it was not his signature. A Controlled Substance Accountability Sheet, dated 6/1, indicated Resident 121 had 30 mL of lorazepam 2 mg/mL. Give 0.25 mL by mouth every 4 hours PRN. It was signed in by QMA 18. There			

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	was no date or amount for drug destruction, but it was signed with an S by the ADON. He indicated it was not his signature. The second nursing signature was the former DON 17. On 9/15/23 at 9:49 a.m., the IDON indicated Resident 121 did not have any medication disposition sheets. Only sign off sheets for destruction. She indicated she did not have any information regarding their destruction. She believed someone tried to duplicate the ADON's signature. On 9/15/23 at 9:56 a.m., the IDON indicated QMA 18 signed in 30 mL of lorazepam on 6/1/23 and it should have been witnessed by a nurse. 6. On 9/13/23 at 7:05 a.m., Resident 66's record was reviewed. She was admitted to the facility on 6/5/23 and expired in the facility on 6/24/23. Her diagnoses included, but were not limited to, chronic kidney disease and atrial fibrillation (heart rhythm disorder). Her physician ordered medication included, but were not limited to, acetaminophen 500 mg, amlodipine besylate (treats high blood pressure) tablet 5 mg, aspirin capsule 81 mg, ibuprofen 200 mg, melatonin 5 mg, and Metamucil chewable fiber tablets. On 9/13/23 at 2:01 p.m., the IDON indicated the facility had no medication destruction sheets for Resident 66. On 09/14/23 at 3:57 p.m., the IDON indicated the facility should have had drug disposition information for all drugs, narcotics and non-narcotics. The information should be on both			

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	the controlled substance accountability sheet and drug disposition sheet. The nursing staff should be following the facility's drug disposition policies. On 9/15/23 at 11:01 a.m., the ADON indicated his signature was forged on three of Resident 119's Controlled Substance Accountability Sheets and on Resident 68's medication disposition/destruction sheets too. He did not sign those documents. He did not destroy medication as a Licensed Practical Nurse (LPN), but only with an RN. His expectation of the nursing staff was to always use an RN and LPN or two RNs to destroy medications. He indicated his signature on medication documents was a gigantic S. He indicated it was not an appropriate signature for signing off on medication and would sign his name with credentials now. On 9/15/23 at 9:58 a.m., the IDON indicated the ADON should have signed more than an S as his official signature on medication documents because it was too easy for others to duplicate. On 9/15/23 at 10:00 a.m., the Administrator (Adm) indicated the potential for drug diversion was reported to their corporate staff, the Nurse Practitioner, their pharmacy, Indiana Department of Health (IDOH), and the Brownsburg Police department. On 6/19/23, the former DON 17, left her job in the middle of the night. On 9/15/23 at 10:06 a.m., the IDON indicated the narcotic accountability sheets should have been filled out in their entirety, from who received it into the facility, who administered it and who destroyed it. A current policy, titled, "Administering			

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	Medications," dated April 2019, was provided by the IDON, on 9/13/23 at 8:46 a.m. A review of the policy indicated, " ...Medications are administered in accordance with prescriber orders ...." A current policy, titled, "Discarding and Destroying Medications," dated April 2019, was provided by the IDON, on 9/13/23 at 3:32 p.m. A review of the policy indicated, " ...Non-controlled and Schedule V (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications ...Schedule II, III, and IV (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous controlled medications ...For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA [Environmental Protection Agency] recommends destruction and disposal of the substance with other solid waste following the steps below: a. Take the medication out of the original containers. b. Mix medication, either liquid or solid, with an undesirable substance. Undesirable substances include sand, coffee grounds, kitty litter, or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage. c. Dispose with the solid waste (i.e., regular trash) in the presence of two witnesses. d. Document the disposal on the medication disposition record. e. Include the signature(s) of at least two witnesses ...The medication disposition record will contain the following information: a. The resident's name: b. Date medication disposed; c. The name and strength of the medication; d. The name of the dispensing pharmacy; e. The quantity disposed; f. Method of disposition; g. Reason for disposition;			

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	155206	A. BUILDING 00 B. WING	09/15/2023

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	and h. Signature of witnesses ...Completed medication disposition records shall be kept on file in the facility for at least two (2) years ...." A current policy, titled, " Miscellaneous Special Situations Discrepancies, Loss and/or Diversion of Medications," dated 12/17, was provided by the IDON, on 9/15/23 at 1:00 p.m. A review of the policy indicated, " ...Upon the discovery or suspicion of a discrepancy or suspected loss through diversion, the Administrator, Director of Nursing (DON) and Consultant Pharmacist are notified and an investigation conducted. The Director of Nursing leads the investigation. 1) The information is not to be discussed with other individuals. 2) During the process, the Consultant Pharmacist will verify suspected loss ...The dispensing pharmacy should be notified and the pharmacy should verify that the medication was actually dispensed ...." 3.1-25(o) 3.1-25(p) 3.1-25(q) 3.1-25(r) 3.1-25(s)(1) 3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include			

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	the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to destroy expired and outdated tuberculin serum and single dose influenza vaccinations for 1 of 3 medication rooms observed. Findings include: On 9/10/23 at 1:16 p.m., the rehab medication room refrigerator was observed with the IDON (Interim Director of Nursing). There were 4 boxes of individual influenza serum that had an expiration date on the boxes for June 2023. There were 2 bottles of tuberculin serum that were opened but lacked a date to indicate when the bottles were opened.	F 0761	**F-761 Medication storage** 1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice? a Expired and outdated medications were destroyed on 9/10/2023. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice? a All medication rooms were audited for expired medications with no other medications noted, no residents were affected by this alleged deficient practice.	10/09/2023

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	On 9/10/23 at 1:32 p.m., the IDON removed the tuberculin serum and influenza serum from the refrigerator and indicated they should be dated and removed when expired. On 9/15/23 at 11:37a.m., the IDON provided a copy of the information insert of the tuberculin serum. The serum was named Aplisol. It indicated, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation may effect potency." 3.1-25(j) 3.1-25(m) 3.1-25(n)		3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a Education provided on medication storage completed on 10/5/2023. b Medication room audit to be completed 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months. 4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? a Medication room audits to be reviewed at the QA/Risk Management meeting for any systemic changes monthly or until substantial compliance has been maintained.	
F 0851 SS=F Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or			

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	maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule.			

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	The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to ensure mandatory staffing information for the payroll-based journal (PBJ) was submitted by the required deadline for 1 of 1 quarters reviewed for PBJ submission. Findings include: The facilities Certification and Survey Provider Enhanced Reports, (CASPER) was reviewed. The report indicated 1-star staffing had been triggered for the 2nd quarter of 2023. During an interview on 9/12/23 at 11:43 a.m., the Regional Director of Operations (RDO) indicated, PBJ data was submitted out of the company's home office in Florida. Unfortunately, an administrative error had been made when the individual home-office staff responsible for the data submission missed the deadline by one day. The company filed an appeal which was denied by the Centers for Medicare and Medicaid Services (CMS).	F 0851	F851 Payroll Based Journal CFR(s): 483.70(q)(1)-(5) **1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a Appeal was submitted to CMS on August 15th, 2022. **2 How will the facility identify other residents having the potential to be affected by the same deficient practice?** a All residents had the potential to be affected by this alleged deficient practice. No residents were affected. **3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a Administrator/ Designee will complete a payroll-based journal audit twice a week for a month, once weekly for a month and then monthly until substantial compliance has been maintained. **4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a Payroll Based Journal audits to be reviewed at the QA/Risk Management meeting for any systemic changes monthly or until substantial compliance has been	10/09/2023

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			maintained. Facility respectfully requests an IDR due to facility missing deadline for PBJ reporting in Quarter 3 of 2022 and not Quarter 2 of 2023 which is stated in the 2567.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to			

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	identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as			

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	necessary. Based on observation, interview, and record review, the facility failed to ensure the glucometer was cleaned prior to resident use, before being placed in a staff member's pocket, cleaned appropriately before being put away, and before it being used on the next resident for 2 of 2 residents observed for glucometer use (Resident 32 and 29). Finding include: On 9/13/23 at 7:38 a.m., Qualified Medication Aide (QMA) 14 was observed taking the glucometer out of the 400 hall medication cart (med cart). She did not clean it before taking Resident 32's blood sugar (BS). Afterward, she dropped it into the right pocket of her scrub shirt. Back at the medication cart, she did not clean it and laid it on top of the medication cart. On 9/13/23 at 7:40 a.m., QMA 14 was observed putting it into the top drawer of the medication cart without further cleaning. On 9/13/23 at 3:23 p.m., Resident 32's record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus (DM) (blood sugar disorder) and dementia (progressive brain disorder). A physician's order indicated to complete accu-checks (device with a drop of blood to determine blood sugar levels) twice a day related to DM. On 9/13/23 at 7:42 a.m., QMA 14 was observed taking the glucometer out of the 400 hall medication cart. She did not clean it before taking Resident 29's BS. Afterward, she dropped it into	F 0880	**F-880 Infection Prevention and Control** 1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice? a Nursing staff immediately educated on glucometer cleaning on 9/13/2023. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice? a All residents who have their blood glucose checked had the potential to be affected by this alleged deficient practice. 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a Education completed on 10/5/2023 on glucometer cleaning with return demonstration. a DON/Designee will audit glucometer cleaning 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months 4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? a Glucometer cleaning audits to be reviewed at the QA/Risk Management meeting for any systemic changes monthly or until substantial compliance has been maintained.	10/09/2023

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	the right pocket of her scrub shirt. On 9/13/23 at 7:52 a.m., QMA 14 was observed as she wiped the glucometer with an alcohol wipe for 3-5 seconds. She put the glucometer in the top drawer of the medication cart. On 9/13/23 at 8:00 a.m., QMA 14 indicated to clean the glucometer, use an alcohol pad after every resident. Then, the glucometer would be clean going into the drawer, so it did not need to be cleaned again when it came out of the drawer because it was already clean. On 9/13/23 at 3:23 p.m., Resident 29's record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus (DM) and chronic obstructive pulmonary disease (COPD) (breathing disorder). A physician's order indicated to complete accu-checks twice a day related to DM. On 9/13/23 at 8:23 a.m., Interim Director of Nursing (IDON) indicated to clean the glucometer, the staff should be using the wipe that comes in the purple container, Micro Kill. A current policy, titled, "Obtaining a Fingerstick Glucose Level," dated October 2011, was provided the IDON, on 9/13/23 at 8:46 a.m. A review of the policy indicated, " ...Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses ...Wear clean gloves ...Clean and disinfect reusable equipment between used according to the manufacturer's instructions and current infection control standards of practice ...Remove gloves and discard into designated container ...Wash hands ...."			

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	Manufacturer's instructions for, "Micro Kill One Germicidal Alcohol Wipes," with no date, was provided by the IDON, on 9/13/23 at 8:46 a.m. A review of the instructions, indicated, " ...use one or more wipes, as necessary, to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed on this label ...." A current policy, titled, "Administering Medications," dated April 2019, was provided the IDON, on 9/13/23 at 8:46 a.m. A review of the policy indicated, " ...Medications are administered in accordance with prescriber orders ...." 3.1-18(a)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a criminal record check was completed 1 of 10 employees reviewed for criminal background checks. This deficiency had the potential of effect 68 residents.	F 9999	F999 Final Observations **1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a Employee immediately removed from schedule until Indiana State Police Criminal background check was complete. **2 How will the facility identify other residents having the potential to be affected by the same deficient practice?** a All residents had the potential to be affected, Human	10/09/2023

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	Findings include: On 9/12/23 at 9:55 a.m., Dietary Aide (DA) 7 employee record was reviewed. For criminal record review, it was only found to have her fingerprints and a local police departments information regarding a criminal record review. On 9/13/23 at 11:11 a.m., regarding the criminal background check, the Administrator (Admin) indicated they usually sent the 16 year old employees to get their fingerprints. On 9/13/23 at 2:21 p.m., the Dietary Manager (DM) indicated she completed the interview process and offered the position, if appropriate, and Human Resources (HR) did the orientation, criminal background check and all the paperwork. She indicated DA 7 had to get her own criminal background check and fingerprints, but HR followed up that everything was completed prior to employment. She indicated she did not teach DA 7 anything about getting a criminal background check but was aware that she would have needed a State Police criminal background check. On 9/13/23 at 2:29 p.m., HR 15 indicated she had made a mistake. The local police department did the digital fingerprinting for DA 7. But she did not know she needed the paper from the Indiana State Police department for a criminal background check. On 9/13/23 at 2:39 p.m., HR 15 provided documentation of DA 7's employee hours for the last 30 days, between 8/8/23 and 9/11/23, DA 7 worked 17 days.		resource Director completed total audit of employee background screening with no findings. No residents were affected by this alleged deficient practice. **3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a Human Resource Director in-serviced on background screening. b Human Resource Director/ Designee will complete an employee background screening audit twice a week for a month, once weekly for a month and then monthly until substantial compliance has been maintained. **4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a Employee Background audits to be reviewed at the QA/Risk Management meeting for any systemic changes monthly or until substantial compliance has been maintained.	

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	On 9/15/23 at 11:35 a.m., the DM provided documentation of DA 7's effort to get her Indiana State Police criminal background check. The document indicated to allow 30 days for results. The DM indicated she would not return to work until the background check was provided. A current policy, titled, "Licensure, Certification, and Registration of Personnel," dated April 2007, was provided by the Administrator (Admin), on 9/13/23 at 1:21 p.m. A review of the policy indicated, " ...Our facility conducts employment background screening checks, reference checks, license verifications and criminal conviction investigation checks in accordance with current federal and state laws ...."			