STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FIVE STAR RESIDENCES OF CLEARWATER	4519 EAST 82ND STREET INDIANAPOLIS, IN 46250

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey Dates: April 24, 25, and 26, 2023 Facility Number: 014016 Residential: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 28, 2023	R 0000	The plan of correction constitutes Five Star Residences of Clearwater's written allegation of compliance for the alleged deficiencies cited. Submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Five Star Residences of Clearwater requests a desk review for this plan of correction. Alleged date of compliance is 5/13/2023.	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shane Patterson	Executive Director	06/29/2023

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

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	accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation, interview, and record review, the facility failed to ensure resident's rights were available in a publicly accessible area for 50 of 50 residents in the facility. Findings include: An environmental tour of the facility was conducted with the Maintenance Director on 4/26/23 at 10:50 a.m. During the tour, the activity room, community room, and front lobby were all observed in an effort to locate the residents rights. They were not located. During the tour, an interview was conducted with the Receptionist and BOM (Business Office Manager) during an observation of the wall in the front lobby near the ED's (Executive Director's) office and receptionist's desk. There was a poem hanging on the wall. The Receptionist and BOM indicated the residents rights used to be hanging where the poem was now hanging. The Maintenance Director indicated they recently painted the front lobby area in the winter and that's when the poem was placed. The Resident Rights policy was provided by the BOM on 4/26/23 at 1:49 p.m. It read, "The community posts a copy of the state/federal resident rights in an area that is easily accessible to all residents, family members and visitors."	R 0026	"Resident Rights for Assisted Living", ordered through IHCA/IHCAL on 5/12/23. Upon receipt, Executive Director will frame and post on wall in community library in enlarged 12+ font. A notice will be sent to all residents with notice of location once received and posted. Posting of Resident Rights' notice will be verified monthly by Executive Director or designated staff member. This will be done for a total of 1 year from the date of reception of poster from IHCA/ IHCAL.	05/15/2023
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the			

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	following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.			
	Based on observation, interview, and record review, the facility failed to ensure advocacy addresses and telephone numbers were posted in an area accessible to residents for 50 of 50 residents in the facility. Findings include: An environmental tour of the facility was conducted with the Maintenance Director on 4/26/23 at 10:50 a.m. During the tour, the activity room, community room, and front lobby were all observed in an effort to locate a posting of the addresses and telephone numbers to the IDOH (Indiana Department of Health,) the office of the secretary of family and social services, the area agency on aging, and a local mental health center. No	R 0033	Grievance procedure including how a resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility has consistently been included in the residency agreement at resident admission referring to the Resident Handbook also given at admission requiring community and resident/ POA signatures. The most recently known addresses and telephone numbers of the department, office of the secretary of family and social services, ombudsman designated by the division of disability, aging, and rehabilitation	05/15/2023

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	posting was located. During the observation of the front lobby area, the BOM (Business Office Manager) was present and interviewed. She indicated she understood the advocacy agencies' information not being posted was a concern and would be taken care of.		services, area agency on aging, local mental health center and adult protective services have consistently been included in the residency agreement given to each resident/ POA at time of admission and signed by both community and resident/ POA. A copy of the last page of this agreement which includes the above mentioned information will be posted in community library in enlarged 12+ font.Grievance procedure including how a resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility has consistently been included in the residency agreement at resident admission referring to the Resident Handbook also given at admission requiring community and resident/ POA signatures. The most recently known addresses and telephone numbers of the department, office of the secretary of family and social services, ombudsman designated by the division of disability, aging, and rehabilitation services, area agency on aging, local mental health center and adult protective services have consistently been included in the residency agreement given to each resident/ POA at time of admission and signed by both community and resident/ POA. A copy of the last	

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			page of this agreement which includes the above mentioned information will be posted in community library in enlarged 12+ font.. A notice will be sent to all residents with notice of location once received and posted. Posting of grievance notice will be verified monthly by Executive Director or designated staff member. This will be done for a total of 1 year from the date of reception of poster, "Resident Rights" from IHCA/ IHCAL.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be			

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	documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to conduct 12 fire drills in a year that included the transmission of a fire alarm signal and simulation of emergency fire conditions. This affected 50 of 50 residents in the facility. Findings include: The fire drills binder was provided by the BOM (Business Office Manager) on 4/26/23 at 10:00 a.m. The fire drills conducted from April, 2022 to present were reviewed. There were only 8 fire drills dated 3/30/23, 2/28/23, 1/31/23, 12/30/22, 11/30/22, 5/31/22, 4/30/22, and an undated drill. The 3/30/23 drill, 2/28/23 drill, 1/31/23 drill, 12/30/22 drill, and the undated drill all indicated the method of the drills was table top conference. The other 3 drills indicated the method of the drills was operational on-site. An interview was conducted with the Maintenance Director on 4/26/23 at 1:00 p.m. He indicated for table top conference drills, they went over scenarios with staff to make sure everyone was familiar with their roles. They were not "tripping the system" every month to include the transmission of a fire alarm signal.	R 0092	The Executive Director or designee will audit the fire drill log monthly for 6 months to ensure fire drills are completed including the transmission of a fire alarm signal and simulation of emergency fire conditions per regulatory requirements until 10/26/2023. At the conclusion of each drill, the log will be audited for the above mentioned criteria and reviewed with the Executive Director to ensure compliance. If any non-compliance is noted, the audit will continue a further 6 months from the date of noted non-compliance.	05/15/2023
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.			

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	Based on observation, interview, and record review, the facility failed to maintain water temperatures between 100 and 120 degrees F (Fahrenheit) for 1 of 5 residents whose water temperatures were retrieved. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 4/26/23 at 2:13 p.m. The 10/29/22 BIMS (brief interview for mental status) assessment indicated a score of 7, indicating she was severely cognitively impaired. The 11/28/22 resident evaluation indicated she was independent with ambulation and independent with grooming. An environmental tour of the facility and interviews were conducted with the Maintenance Director on 4/26/23 at 10:50 a.m. During the tour, the Maintenance Director retrieved the water temperature from Resident 2's kitchen sink at 122.5 degrees Fahrenheit and her bathroom sink at 122.6 degrees Fahrenheit. The Maintenance Director indicated Resident 2's room was one of the first rooms nearest to the boiler. They also had their circulation pumps replaced recently and it was a process to get them balanced. He was uncertain of the last time he'd checked Resident 2's water temperature, as he checked residents' water temperatures by quadrant of the facility rather than by room. An interview was conducted with Resident 2 during retrieval of the water temperatures in her room. She indicated she did not regularly use the kitchen sink, but did use the bathroom sink.	R 0187	A licensed third party contractor will be contracted to assess needs for repairs, replacements, or adjustments needed to maintain a consistency of water temperature throughout the entirety of the community. The Maintenance Director will monitor this and audit for compliance by recording water temperatures daily on-going. The locations of the audit will include one area or resident apartment close to the hot water source, in the middle of the plumbing and toward the end of the source. The checks represent a thorough distribution of hot water dispensing faucets. The audit will include: date, location, temperature measured at the source, initials of the person monitoring, and if temperature fall within acceptable range (Yes or No). If "No" is indicated, measures will be taken to correct and follow-up steps for compliance. This will not have an ending date as this is a daily task per policy.	05/15/2023

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	On 4/26/23 at 12:45 p.m., the Maintenance Director provided the water temperature logs from January, 2023 to present. The logs did not include a temperature for Resident 2's kitchen or bathroom. The logs included a temperature of 122.6 degrees Fahrenheit in the front bathroom of the facility on 3/13/23; a temperature of 120.3 degrees Fahrenheit in Resident 4's apartment on 3/21/23; and a temperature of 120.3 degrees Fahrenheit in a currently empty room on 4/20/23. An interview was conducted with the Maintenance Director on 4/26/23 at 12:45 p.m. He indicated he didn't do anything when he got the 120.3 degrees Fahrenheit water temperature on 4/20/23, because he couldn't do much with 3/10 of a degree, and he was still trying to balance out the circuit setters. An interview was conducted with the Maintenance Director on 4/26/23 at 1:40 p.m. He indicated, when the high water temperature was retrieved from the front bathroom on 3/13/23, he started adjusting the mixing valve and circuit setters. They got new circuit setters 3 weeks ago. The water temperatures tended to run higher on the back side of the facility, but he didn't know they were over 120 degrees Fahrenheit. The Water Temperature policy was provided by the SFED (Sister Facility Executive Director) on 4/26/23 at 1:56 p.m. It read, "If the state Department of Health has any particular guidelines for water temperatures and flow (pressure) rates, the Maintenance Director notes those temperatures and follows those guidelines."			
R 0246	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency			

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Bldg. 00	(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure as needed (PRN) medications administered by a QMA (qualified medication assistant) were authorized by a licensed nurse prior to administration for 1 of 5 residents reviewed. (Resident 51) Findings include: The clinical record for Resident 51 was reviewed on 4/25/23 at 10:51 a.m. Resident 51's diagnoses included, but not limited to, DVT (deep vein thrombosis, blood clot), insomnia, and GERD (gastroesphogeal reflux disorder). A physician's order dated 7/5/22 indicated, to give Resident 51 thirty ml (milliliters) of milk of magnesia once a day as needed for constipation. Resident 51's October 2021 MAR (medication administration record) received on 4/26/23 at 10:27 a.m. from DON (Director of Nursing) indicated, Resident 51 received a dose of milk of magnesia on 10/20/22 from QMA 4. The MAR did not indicate the time at which Resident 51 received the medication nor did it indicate if prior authorization from a licensed nurse was obtained prior to its administration. Resident 51's progress notes for October 2022 did not contain information regarding who or if a	R 0246	The licensed nurse authorizing the administration of PRN medication by a QMA will sign the back of the resident MAR. If the authorization is provided by a licensed nurse who is not on the premises (by telephone), the authorization is also documented in the nurse's notes to include the time and date of contact/ authorization. Director of Resident Care or designated licensed nurse will audit all PRN administrations via audit of all MARs weekly. If noted the the signature of the authorizing licensed nurse is not found, then the chart of that resident will be audited for notation of authorization of licensed nurse's authorization including time and date of contact/ authorization. The weekly audits will be conducted for a total of 3 months and then continued 1 x monthly for the following three months until 10/26/2023.	05/15/2023

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	licensed nurse had given prior authorization for QMA 4 to administer the milk of magnesia. An interview with DON on 4/26/23 at 11:11 a.m. indicated, she was unaware that all contacts with a licensed nurse for authorization to administer PRN's should be documented in the nursing notes indicating the time and date of contact. A Medication Management Guidelines policy received on 4/25/23 at 12:37 p.m. from DON indicated, "PRN/AS-Needed Medications...Documentation of the Medication Supervision/Assistance and/or Medication Administration is completed on the resident's individual medication administration record. Documentation included the date, time, dose, reason and effect/outcome...PRN Medication is administered by a QMA upon authorization by a licensed nurses. The nurse's authorization is documented on the back of the MAR. If the authorization is provided by a licensed nurse who is not on the premises (by telephone), the authorization is also documented in the nurses notes to include the time and date of contact/authorization."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to store food properly; ensure trash bins were covered when not in use; wear hair/beard covers; ensure clean pots and pans were stored inverted; and ensure kitchen staff were without signs and symptoms of	R 0273	Executive Director or designee will conduct a "Weekly Executive Director/ Administrator Sanitation Checklist" and the Food and Beverage Director or designee will also conduct a "Sanitation/ Food	05/12/2023

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	communicable illness in the kitchen. This affected 50 of 50 residents in the facility. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 4/25/23 at 10:55 a.m. When the DM entered the kitchen, she was not wearing a hair cover, but put one on after walking to the other side of the kitchen. There was a trash bin near the dishwasher, full of trash, uncovered with no lid, and not in use. There was a rack of clean pots and pans near the refrigerators. The pots on the top shelf were not stored inverted. There was a vent directly above these pots and pans. There were 2 pans, not stored inverted, on the second from the top rack and 2 pans, not stored inverted, on the bottom rack. The DM stated, "Do they need to be stored inverted?" The trash bin lid near the 2 compartment sink was stuck open and not in use. There were 2 boxes of dry beans in the dry storage area with open spouts on the side of the boxes, exposed to air. The food temperatures were retrieved by Cook 8 during the tour. Cook 8 plated food for serving. DA (Dietary Aide) 7 was retrieving the plated food from the counter above the steam table and serving it into the dining room. DA 7 was not wearing a beard cover and had one inch chin hairs. The DM indicated DA 7 did not normally wear a beard cover and stated, "Does he need to? We don't have any here."		Safety Checklist" weekly. These checklists will include monitoring of the covering of trash and bins, inversion of clean pots and pans, proper covering and storage of all food items, the proper wearing of hair/ beard covers. This audit will be completed weekly for 3 months. The audits will then continue monthly through the following 3 months and then will be re-assessed for further need. All dining staff will adhere to the front screening tool to the entrance of the community and follow protocol with notification of signs or symptoms of illness per community policy until 10/26/2023.	

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	Towards the end of the tour, an interview was conducted with the DM. She indicated the trash was piled up outside, because they recently switched companies, and the trash hadn't been picked up in a week, so she had to pull trash bins without covers into the kitchen, as the ones with covers were all full. She stated, "It's horrible," and she knew the trash was supposed to be covered when not in use. The DM coughed during this interview. She indicated she was not feeling well. Her stomach was bothering her, but she had to come into work. It came on "all of a sudden" at 12:00 a.m. the previous night. Her chest and stomach hurt, and she was going to go to the emergency room as soon as she left the facility, because, "It's not normal." An interview was conducted with the SFED (Sister Facility Executive Director) on 4/25/23 at 12:10 p.m. She indicated she didn't know the DM was sick, as the DM did not inform anyone of this, and that she should go home. An interview was conducted with the DON (Director of Nursing,) who was in charge of the facility's infection control program, on 4/26/23 at 12:29 p.m. She indicated if a manager wasn't feeling well, they were to tell the ED first. The ED would then inform her. She encouraged everyone to stay home, if they were not feeling well, and not come into the facility. If the staff ember was already here and began not feeling well, she would send them home. Sometimes, they would swab the staff member for Covid, prior to them leaving. She was not informed about the DM being sick in the facility until she was leaving the building yesterday. The BOM (Business Office Manager) reached out to the DM after she left, but they hadn't received an update yet.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FIVE STAR RESIDENCES OF CLEARWATER	4519 EAST 82ND STREET INDIANAPOLIS, IN 46250

(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
	An interview was conducted with the BOM and SFED on 4/26/23 at 1:55 p.m. The BOM indicated she'd texted with the DM, who informed her she wouldn't be into work today, but was not informed of any diagnosis. The SFED indicated the DM was aware of her obligation to report immediately if she had Covid. She thought the DM misunderstood her need to be present at the facility, as she was not expected to be present if she was sick. The Food Safety in Receiving and Storage policy was provided by the SFED on 4/25/23 at 2:38 p.m. It read, "Food is stored in its original packaging as long as the packaging is clean, dry, and intact....Open packages are resealed tightly to prevent contamination and dated with the open date." The Sanitation and Infection Control Standards policy was provided by the SFED on 4/25/23 at 2:38 p.m. It read, "POLICY GUIDELINES...8. Hair is completely covered and restrained with a hair net or hair booffants [sic] while in the food preparation area and/or kitchen. 9. Beard coverings where applicable for facial hair covering....13. Employees with communicable diseases or infected skin lesions are prohibited from having direct contact with the residents or their food." The Team Member Health policy was provided by the SFED on 4/25/23 at 2:38 p.m. It read, "Work Restrictions...Team members are required to report exposure to, or the presence of, any infectious disease to the Director of Resident Care (or designee), or the team member's supervisor."			
R 0296	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance			

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Bldg. 00	(b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation and record review, the facility failed to administer insulin from an insulin pen according to the manufacturer's instructions for 1 of 5 residents reviewed during medication administration. (Resident 43) Findings include: An observation of medication administration for Resident 43 was conducted on 4/25/23 at 11 a.m. with LPN (Licensed Practical Nurse) 3. LPN 3 had previously checked Resident 43's blood glucose and found it to be 208. LPN 3 indicated, Resident 43 had a sliding scale for Humalog (short acting insulin) which indicated, for a blood glucose of 208, she was to receive 6 units of Humalog. Resident 43's Humalog was dosed from a pen. LPN 3 removed the Humalog's pen cap, scrubbed the hub of the pen, then attached the needle. She dialed up 6 units of Humalog then administered the medication to Resident 43. LPN 3 however, failed to prime the needle prior to dialing up the 6 units of insulin. A Flex Pen Usage Guidelines policy received on 4/25/23 at 3:44 p.m. from DON (Director of Nursing) indicated, "Procedures 1. Follow the manufacturer's instructions attached to this procedure...Documents...Novo Log Flex Pen Manufacturer's Guidelines." The Instructions for Use Humalog KwikPen received on 4/26/23 at 10:27 a.m. from DON indicated, "Priming you pen Prime before each injection. Priming your pen means removing the	R 0296	Director of Resident Care will conduct re-education to all licensed nursing staff member of insulin medication administration with the tool, "Skills Checklist 8: Insulin Medication Administration". Director of Resident Care or designee will also this tool to all newly hired licensed nurse staff members. Director of Resident Care or designee will audit minimum of one administration of insulin to a resident via licensed nursing staff weekly. The weekly audits will be conducted for a total of 3 months and then continued 1 x monthly for the following three months until 10/26/2023.	05/15/2023

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	sir from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin...To prime you Pen, turn the Dose Knob to select 2 units...Hold you Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top...Continue holding you Pen wit Needle pointing up. Push the Dose Knob inn until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming...no more than 4 times...If you still do not see insulin, change the Needle and repeat priming..."			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, interview, and record review, the facility failed to dispose of expired and/or discontinued medications for 2 residents	R 0306	Director of Resident Care will conduct re-education to all licensed nursing staff members of	05/15/2023

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	whose medications were stored in the medication room refrigerator. (Resident 30 and 43) Findings include: An observation of the facility's medication room/nursing station was conducted on 4/25/23 at 11:53 a.m. with LPN (Licensed Practical Nurse) 3. During the observation, the medication refrigerator was reviewed for medication storage and the following was found: 1. Three unopened vials of Humulin R (regular insulin) for Resident 30 were located inside a large, plastic bag. The vials of Humulin R were still in their boxes. The expiration date on all three boxes of the Humulin R were 3/23/23. LPN 3 was asked to verify the expiration dates of the three vials of Humulin R at the time of the observation. LPN 3 not only agreed the 3 vials were expired, she then reviewed Resident 30's current medication orders and discovered that Resident 30 no longer had an order for the Humulin R. A faxed physician's communication sheet received on 4/26/23 from DON at 10:29 a.m. and dated 9/26/22 indicated, a concern for Resident 30 which stated, "We Rec'd [sic, received] paperwork with orders that have been D/C'd [sic, discontinued]. She does not get accu[sic, checkmark, blood glucose checks] 3 x [sic, three times] daily. Just once at 11 a.m. daily. She does not have a Humulin R sliding scale order D/C'd [sic]." 2. An unopened emergency Glucagon kit for Resident 43 with an expiration date of 12/21/22. A physician's order for Resident 43 dated 8/14/20		medication management guidelines which includes, "Discharged/ Discontinued Medications" in section "J" of policy. Director of Resident Care or designee will also use this tool to all newly hired licensed nurse staff members. Director of Resident Care or designee will use the tool, "MAR/ TAR Audit Tool", which includes: Name of Resident, Date, Expired Medication, Action. The Director of Resident Care or designee will conduct this audit weekly for a total of 3 months and then continued 1 x monthly for the following three months until 10/26/2023.	

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	indicated, to give Resident 43 one vial subcutaneously as needed if blood sugar was less than 70 and to repeat ever 15-20 minutes as needed. An interview with DON (Director of Nursing) was conducted on 4/26/23 at 11:28 a.m. DON indicated, expired and discontinued medications should be disposed of timely. A Medication Management Guidelines policy was received on 4/25/23 at 12:37 p.m. from DON. The policy indicated under medication storage, "7. Drugs are stored in an orderly manner in cabinets, drawers or carts. i. No discontinued, outdated or deteriorated drugs may be retained for use. All drugs must be returned to the issuing pharmacy or destroyed in accordance with state laws and regulations governing the destruction of medication. J. Discharged/Discontinued Medications...2. Upon receipt of a physician's order to discontinue a medication...Remove the discontinued medication from the medication storage car/cabinet and store in the designated secure area for drugs awaiting return/destruction. Destruction occurs within the time frame proscribed by state law or regulation (30 days)"			