| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| FORT HARRISON ALF OPERATIONS | 8025 DOUBLEDAY DRIVE<br>INDIANAPOLIS, IN 46216 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included the Investigations of Complaint IN00425193 and IN00421313.<br><br>Complaint IN00425193 - State deficiencies related to the allegations are cited at R117, R148, R268, R269 and R273.<br><br>Complaint IN00421313 - State deficiencies related to the allegations are cited at R117.<br><br>Survey dates: January 18, and 19, 2024<br><br>Facility number: 014109<br><br>Residential Census: 48<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on January 24, 2024 | R 0000 | | |
| R 0092<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - Noncompliance<br>(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:<br>(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 | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Dametria Marshall | Executive Director | 03/11/2024 |

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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| | 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.<br>(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 documented with the names and signatures of the personnel present.<br>Based on interview and record review, the facility failed to ensure fire drills were conducted quarterly on each shift. This had a potential to affect 48 of 48 residents that reside in the facility.<br><br>Findings include:<br><br>The yearly fire drills that were conducted was provided by the Administrator on 1/18/24 at 2:00 p.m. The following months did not indicate fire drills on each shift were conducted:<br><br>January 2023,<br>February 2023,<br>March 2023,<br>April 2023,<br>May 2023,<br>June 2023, and<br>August 2023<br><br>An interview was conducted on 1/18/24 at 3:00 p.m. with the Administrator. She indicated she was unable to provide documentation fire drills had been conducted each shift January 2023 through August 2023. | R 0092 | 1. The facility failed to ensure fire drills were conducted quarterly on each shift. Executive Director will educate Maintenance Director how often fire drill should be conducted. ED will will audit fire drills monthly for four months until 100 percent compliance.<br>2. Maintenance will conduct a in-service on all three shifts until 100 compliance<br>3. Fire Drills that was conducted from January - August were not accessible.<br>4. From September moving forward proper training, drills, and in-service will be conducted according to policy and regulations. | 03/11/2024 |
| R 0117 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency | | | |

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| Bldg. 00 | (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.<br>Based on interview and record review, the facility failed to ensure qualified staff were available on night shift to administer ordered PRN (as needed) medications for 5 of 7 residents whose clinical records were reviewed, and one awake staff person with current CPR (Cardiopulmonary Resuscitation) and first aid were on site at all times. This had a potential to affect 48 of 48 residents that resident in the facility. (Residents' B, C, F, G and H)<br><br>Findings include:<br><br>1. The clinical record for Resident G was reviewed on 1/19/24 at 9:30 a.m. Her diagnoses | R 0117 | 1. Immediate actions taken for those residents identified<br>Director of Nursing and Administrator initiated an on-call rotation for night shift(10pm-6am) medication assistance, including as needed medications, 7 days a week. Director of Nursing and scheduler initiated the hiring process to fill the night shift QMA position for 7 days a week.<br><br>2. How the facility identified other residents<br>Any resident residing in the facility | 03/11/2024 |

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| | included, but were not limited to, hypertension and diabetes.<br><br>The 10/16/23 Resident Evaluation & Level of Care indicated she was not able to manage her medications independently, including taking them, and needed the facility staff to administer her medications.<br><br>Resident G's service plan, last reviewed 7/12/23, indicated she would be supported to take all medications safely and as ordered.<br><br>The current physician's orders for Resident G indicated Loperamide 2 mg tablet to be administered every 6 hours as needed for diarrhea; Miralax 17 gram to be administered as needed for constipation daily; and Hydrocodone-Acetaminophen 5-325 mg tablet every 4 hours as needed for pain.<br><br>During entrance conference with the Administrator and DON (Director of Nursing) on 1/18/23 at 10:01 a.m., they indicated CNA (Certified Nursing Assistant) staff were the only staff in the facility after 10:00 p.m. until 6:00 a.m. Medications were administered to residents until 10:00 p.m. If a resident did not self medicate, they were unable to receive medications which included as needed (PRN) medications after 10:00 p.m.<br><br>2. The clinical record for Resident H was reviewed on 1/19/24 at 10:20 a.m. His diagnoses included, but were not limited to, hypertension, restless leg syndrome, and end stage renal disease.<br><br>Resident H's service plan, last reviewed 7/23/23, indicated he would be supported to take all medications safely and as ordered. | | had the potential to be affected.<br><br>3. Measures put into place/system changes<br>The QMA position has been filled with a full-time and part-time QMA to provide medication administration nightly. PRN medications are being administered as needed and sufficient care will be provided.<br><br>4. How the corrective actions will be monitored<br>The HWD/designee will be responsible for compliance. Any issues identified will be immediately addressed. | |

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| | The current physician's orders for Resident H indicated Guaifenesin extended release 600 mg tablet every 12 hours as needed for cough; Hydrocodone-Acetaminophen 5-325 mg tablet every 6 hours as needed for arm or chest muscle pain; milk of magnesia concentrate suspension 30 ml every 24 hours as needed for constipation; Requip 1 mg tablet every 8 hours as needed for restless leg syndrome; Tylenol 325 mg tablet every 4 hours as need for pain; 2 tablets of Tylenol 325 mg every 4 hours as needed for fever; and Ventolin HFA Aerosol Solution 108 mcg orally every 4 hours as needed for shortness of breath.<br><br>During entrance conference with the Administrator and DON (Director of Nursing) on 1/18/23 at 10:01 a.m., they indicated CNA (Certified Nursing Assistant) staff were the only staff in the facility after 10:00 p.m. until 6:00 a.m. Medications were administered to residents until 10:00 p.m. If a resident did not self medicate, they were unable to receive medications which included as needed (PRN) medications after 10:00 p.m. A self medication lists were provided by the Administrator (ADM) on 1/18/24 at 2:00 p.m. A resident self administration medication list indicated 8 of 48 residents that reside in the facility can safely administer medications without assistance by staff. A diabetic self administer medication list indicated 2 of 48 residents were able to self medicate their diabetic medications without assistance by staff.<br><br>During a Confidential Interview 20, Resident F had returned from a hospital emergency room visit, and Resident F's Representative had requested for Resident F's evening medications that had been missed; to be administered after 10:00 p.m. | | | |

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| | Resident F's Representative was told by the Certified Nursing Assistant (CNA) staff there was no one at the facility that could administer the medications. During that time, CNA staff had contacted the Director of Nursing (DON) by phone and Resident F's Representative was told medication dispensing ended at 10:00 p.m. Resident F was unable to receive her evening medications that night.<br><br>3. The clinical record for Resident F was reviewed on 1/18/24 at 2:00 p.m. The Resident's diagnoses included, but was not limited to, anxiety disorder.<br><br>The October 2023 Medication Administration Record indicated staff was to administer Resident F the following evening mediations:<br><br>7:00 p.m. - 20 milligrams of lasix,<br>7:00 p.m. - 10 milligrams of memantine,<br>8:00 p.m. - 20 milligrams of Simavastin, and<br>8:00 p.m. - 25 milligrams of Seroquel<br><br>4. During an initial tour with the DON on 1/18/24 at 10:58 a.m., Resident B was unable to self administer medications. The staff administer her medications.<br><br>A self-administration review indicated the resident was not able to self medication without the assistance from staff.<br><br>During an interview with Resident B on 1/18/24 at 3:01 p.m., she indicated the staff administer her medications. She was unable to receive medications after 10:00 p.m., so she has stored over-the-counter medications in her room to take as needed.<br><br>5. The clinical record for Resident C was reviewed | | | |

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| | on 1/18/24 at 3:00 p.m. The Resident's diagnoses included, but was not limited to, arthritis.<br><br>An interview was conducted with Resident C on 1/18/24 at 3:28 p.m. She indicated staff will not bring medications at night if needed. She has tried to get some pain medications for her arthritis late one night and was unable. She had to prop up on some pillows and finally was able to get to sleep. She would have liked to have had an "aspirin" to relieve the pain.<br><br>A self-administration medication assessment indicated Resident C was unable to self medicate safely.<br><br>A physician order dated 12/26/23 indicated the staff was to provide Resident C 220 milligrams of Naproxen Sodium (Aleve) every 12 hours as needed for arthritis pain.<br><br>During Confidential Interview 21 and Confidential Interview 22, they indicated nursing staff are not available after 10:00 p.m. They are "uncomfortable" with it. If they need assistance that require a nurse, they have to call 911 emergency service.<br><br>During entrance conference with the ADM and DON on 1/18/23 at 10:01 a.m., they indicated CNA staff are the only staff in the facility after 10:00 p.m. until 6:00 a.m. Medications were administered to residents until 10:00 p.m. If a resident does go out, and staff are notified in advance the resident will miss their evening medications it can be pulled and given to the family to administer. If a resident does not self medicate they are unable to receive medications which includes as needed (PRN) medications after 10:00 p.m. The residents are told on assessment prior to admission verbally | | | |

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| | medications are not available after 10:00 p.m. The admission agreement does not include that process. If a resident was in need of nursing services in an emergency situation, 911 would be notified by the CNA staff. The DON indicated there was an incident a resident returned to the facility after 10:00 p.m., and was upset she was unable to receive her medications that had been missed. That resident has "moved out." There had not been any other residents upset about the 10:00 p.m. deadline to receive medications.<br><br>6. The staff worked scheduled dated the week of 1/7/23 through 1/14/24 was provided by the ADM on 1/18/24 at 2:00 p.m. It indicated the following days and shifts there was not a staff person that was working in the facility each shift that was certified in CPR and First Aid:<br><br>Sunday, 1/7/24 - first, second, and third shift.<br>Monday, 18/24 - third shift,<br>Saturday, 1/13/24 first, second, and third shiftAn anonymous complaint sent to Indiana Department of Health was received on 1/2/24. It indicated, on 1/1/24, they were in the facility to visit a resident during the night shift and they found a staff member asleep and noted it was CNA (Certified Nursing Assistant) 5 via her name tag.<br><br>The timecard for CNA 5 during the time period of 1/1/24 - 1/15/24 was provided by ADM on 1/19/24 at 11:45 a.m. A review of the timecards indicated, CNA 5 was the only staff member on duty during the night shift on 1/1/24 from 10:02 p.m. through 6:23 a.m.<br><br>The facility was unable to provide evidence of CNA 5's current certifications for CPR or first-aide.<br><br>An anonymous interview was conducted with | | | |

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| | Anonymous 3. They indicated, they had witnessed staff sleeping during the night shift on at least 6 occasions in the last 6 months.<br><br>An anonymous interview was conducted with Anonymous 4. They indicated, they had went downstairs one night and witnessed staff sleeping during the night shift.<br><br>An interview was conducted with the ADM on 1/19/24 at 10:30 a.m. She indicated she was unable to provide documentation there was a staff person on each shift that was certified in CPR and First Aide.<br><br>A "Daily Schedule Night Shift Only" sheet dated 10/31/23 indicated, "This is REQUIRED ITS NOT AN OPTION THIS SHIFT IS NOT FOR YOU TO SLEEP..."<br><br>This citation relates to Complaints IN00421313 and IN00425193. | | | |
| R 0123<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(h)(1-10)<br>Personnel - Nonconformance<br>(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:<br>(1) The name and address of the employee.<br>(2) Social Security number.<br>(3) Date of beginning employment.<br>(4) Past employment, experience, and education, if applicable.<br>(5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable.<br>(6) Position in the facility and job description.<br>(7) Documentation of orientation to the facility, including residents' rights, and to the | | | |

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| | specific job skills.<br>(8) Signed acknowledgement of orientation to residents' rights.<br>(9) Performance evaluations in accordance with facility policy.<br>(10) Date and reason for separation.<br>Based on interview and record review, the facility failed to ensure staff personnel files contained current and accurate documentation related to job descriptions, orientation, resident rights and dementia training, and an activity director certificate for 5 of 5 personnel files reviewed. (Qualified Medication Aide (QMA) 2, Certified Nursing Assistant (CNA) 3, CNA 4, CNA 5, CNA 6 and Activities Director (AD)<br><br>Findings include:<br><br>The personnel files for QMA 2, CNA 3, CNA 4, CNA 5 and CNA 6 were provided on 1/19/24 at 9:30 a.m., by the Administrator. The following was information was in the personnel files:<br><br>QMA 2 - start date of 9/4/23 - missing resident rights training, dementia training, job description and orientation paperwork,<br>CNA 3 - start date of 1/5/24 - missing resident rights training, job description and orientation paperwork,<br>CNA 4 - start date of 5/22/23 - missing resident rights training, dementia training, job description and orientation,<br>CNA 5 - start date of 9/23/19 - missing resident rights and dementia training,<br>CNA 6 - start date of 11/1/23 - missing resident rights training, dementia training, orientation and job description paperwork, and<br>AD - start date 3/29/22 - missing completion of a activities division course | R 0123 | The facility failed to ensure staff personnel files contained current and accurate documentation related to job descriptions, orientation, resident rights and dementia training, and an activity director certificate for 5 of 5 personnel files.<br>1. Executive Director will educate Business Office Manager to make sure proper documentation is added to each individual file upon hire and then after.<br>2. Executive Director will audit each personnel file monthly for 4 weeks until 100 percent in compliance.<br>3. All new hires will be in-service and trained quarterly and annually there after.<br>4. ED will make sure that all personnel has proper license in their file and then after.<br>5. ED and BOM will audit each personnel file monthly for 4 week and then after and make sure all license is accurate and in compliance with guidelines. | 03/11/2024 |

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| | An interview was conducted with the Administrator on 1/19/24 at 10:30 a.m. She indicated the facility had changed ownership at the end of November 2023. She was unable to have access to personnel files that included annual in-service trainings of resident rights and dementia training. As of December 2023, the new owner was in the process of updating personnel files. The current AD did not have documentation of completing an activities course. | | | |
| R 0148<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(e)(1-4)<br>Sanitation and Safety Standards - Deficiency<br>(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:<br>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.<br>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.<br>(3) All plumbing shall function properly and comply with state plumbing codes.<br>(4) At least yearly, heating and ventilating systems shall be inspected.<br>Based on observation and interview, the facility failed to ensure the building, grounds, and equipment was in clean condition, in good repair and free of hazards and plumbing was functioning properly by ensuring the dumpster's doors were closed, the ground area around the dumpster was free of rubbish debris, the plumbing in the kitchen was functioning properly and comply with state plumbing codes, walk-in fridge was in good repair, | R 0148 | 1. Maintenance will in-service staff to make sure that staff is placing trash in dumpster and not around or behind dumpster. Also make sure all lids are down and gates are locked after each use.<br>ED will audit for a month for four weeks to make sure all staff is placing trash in dumpster and not | 03/11/2024 |

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| | electrical plates were in use, and reach in coolers were keeping foods cold enough to prevent food spoilage. This had a potential to affect 48 of 48 residents that reside in the facility.<br><br>Findings include:<br><br>1. An observation of the facility's dumpster was conducted on 1/18/24 at 2 p.m. The wooden gates surrounding the dumpster were open and one of the dumpster's lids was left open. A mattress was on the ground leaning toward the dumpster as well as trash and debris noted on the ground behind the dumpster including, but not limited to, empty plastic bottles and gloves.<br><br>2. A kitchen tour was conducted on 1/18/24 at 10:40 a.m. with DM (Dietary Manager). During the tour, the following plumbing issues were observed:<br>a. The kitchen disposal connected to the dishwasher had food debris on the floor underneath the disposal. An interview with DM and Cook 1 immediately following the observation indicated, at the connection of the disposal and the dishwasher sink, when in use, the disposal leaks from their connection and leaks onto the floor. They indicated, this has been an issue for months.<br><br>b. Kitchen ceiling tiles were missing or ajar exposing pipes and wiring above the dishwasher<br><br>c. When turning on the cold water tap on the handwashing service sink in the kitchen, very hot, steaming water comes out of the faucet and the staff must run the water for a while before cold water will come out of the faucet. An interview with DM conducted at the same time as the observation, indicated, the cold water from that | | around or behind dumpster until compliance with policy and procedures<br><br>2. disposal was repaired on 02/08/24 by City Wide Facility Solutions. maintenance will conduct a preventative maintenance quarterly.<br>ED will audit preventative maintenance for four weeks until compliance with policy and procedures<br>b. maintenance repaired titles in kitchen. There are no pipes or wires exposed.<br>maintenance<br>ED will audit weekly for four weeks until compliance with policy and procedures and there after<br>c. Dm will inservice staff to use proper sink when cooking or rehydrating food.<br>maintenance was able to fix prep sink and will conduct preventative maintenance quarterly<br>d. maintenance repaired eyewash sink and now can be used properly.<br>ED and Maintence will audit all kitchen equipment weekly for 4 weeks and quarterly there after until 100 percent compliance<br>e. maintenance repaired prep sink and Mogheny grease solution vacuum drain on 02/05/24 and now can be used properly<br>f. maintenance replace hole in fridge with a patch there is no leakage coming from ceiling. | |

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| | sink was<br>used for cooking and rehydrating foods as the only other sink in the kitchen that was working was for the three compartment sink used for washing of kitchen wares.<br><br>d. The plumbing for the eyewash sink was disconnected under the sink and was in need of repair. DM indicated, it required repair and was not functional at the time of the observation. The eyewash faucets were taped up and sink was blocked off to prevent its use.<br><br>e. The kitchen prep sinks were missing a drain pipe connecting the sink to the in floor drain. According to DM, the drain was clogged and they had to use a wet vacuum to try and suck out the clog as water had been coming up from the drain. The prep sinks are unable to be utilized without the necessary drainage tubing.<br><br>f. The walk-in fridge had a rag stuffed into a hole in the ceiling and the floor was glossy and slick. According to DM, the fridge was leaking from that hole onto the floor in the fridge.<br><br>g. An electrical socket located behind the ice maker failed to have a outlet plate attached and electrical wires were visible.<br><br>h. A reach in cooler, in the kitchen, had an internal temperature of 54 degrees Fahrenheit. An interview with DM conducted at the same time, indicated, she was not aware the cooler wasn't keeping the temperature cold enough to prevent food spoilage.<br><br>This tag relates to complaint IN00425193. | | koorsen has been notified about the repair and services for repair is pending.<br><br>g. maintenance repaired electrical socker there is no wires visible to be seen.<br><br>h. DM and ED will inservice staff to monitor temp in cooler twice a day for 4 weeks until 100 percent compliance | |

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| R 0152<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(i)<br>Sanitation and Safety Standards - Deficiency<br>(i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection.<br>Based on observation, interview, and record review, the facility failed to store linen in a safe and sanitary manner in 1 of 3 laundry rooms observed.<br><br>Findings include:<br><br>An environmental tour of the facility was conducted with the Maintenance Director on 1/19/24 at 11:00 a.m.<br><br>During the tour, the 3rd floor laundry room was observed. There were 2 large garbage bags full of table cloths on the floor underneath the counter on the clean side of the laundry room. The bags were open and exposed to air, and there was a hole in the side of one of the bags.<br><br>An interview was conducted with the Maintenance Director during the above observation of the 3rd floor laundry room. He indicated he was uncertain if the table cloths inside of the garbage bags were clean or dirty.<br><br>An interview was conducted with the Administrator on 1/19/23 at 12:37 p.m. She indicated the bags of table cloths should not be stored on the floor. They should have been returned to their proper location after laundering.<br><br>The Handle Contaminated Laundry policy was provided by the Administrator on 1/19/24 at 12:48 p.m. It read, "Place in leak-proof regulated bag or waste container." | R 0152 | ED in-service staff on how to properly store linen and to return items to residents as soon as possible according resident clothing policy<br><br>All staff on all shifts have been in-service on how to properly wash dry fold and return laundry to the proper resident.<br><br>Signs have been displayed reminding staff and residents of the designated days and time to put out and receive their laundry.<br><br>A laundry log has sense been created to keep track of how and to whom laundry task should be delegated to.<br><br>The log will be checked and signed off monthly to ensure these task are being completed.<br>All linen will be stored properly.<br><br>Clean linen will be stored separately from dirty linen and clean linen will be returned to the proper place in a timely manner.<br><br>ED and Housekeeping lead will audit all laundry areas daily for four weeks to make sure there is | 03/11/2024 |

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| | The How To Launder Resident's Clothing policy was provided by the Administrator on 1/19/24 at 12:48 p.m. It read, "Return laundered items as soon as possible to resident room..." | | no laundry or belonging stored or left on the floor.<br><br>ED will audit daily for four weeks all areas of community to make sure no items are placed on floor or until 100 percent compliance with policy and regulations | |
| R 0187<br><br>Bldg. 00 | 410 IAC 16.2-5-1.6(k)<br>Physical Plant Standards - Deficiency<br>(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.<br><br>Based on observation, interview, and record review, the facility failed to maintain water temperatures between 100 and 120 degrees Fahrenheit for 3 of 5 residents whose room water temperatures were retrieved. (Residents 8, 17, and 21)<br><br>Findings include:<br><br>An environmental tour of the facility was conducted with the Maintenance Director on 1/19/24 at 11:00 a.m.<br><br>During the tour, the Maintenance Director retrieved the water temperatures from Resident 21's kitchen sink at 122.5 degrees Fahrenheit and restroom sink at 123.4 degrees Fahrenheit. The Maintenance Director retrieved the water temperatures from Resident 8's kitchen sink at 122.9 degrees Fahrenheit and restroom sink at 122.3 degrees Fahrenheit. The Maintenance | R 0187 | ED will in-service MD on proper water temp for each apartment in community.<br><br>ED will audit water temp for each apartment in community weekly for 4 weeks until 100 percent compliance with policy and regulation.<br><br>maintenance will audit the room temp for proper temperature for 5 days for 4 weeks and thereafter until 100 percent compliance with regulations<br><br>Water inspection has been conducted temperatures have been adjusted and maintenance will do thoroughly routine checks daily and sign off on a temperature log to ensure every residents | 03/11/2024 |

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| | Director retrieved the water temperatures from Resident 17's kitchen sink at 121.2 degrees Fahrenheit and restroom sink at 122.9 degrees Fahrenheit.<br><br>During the tour, an interview was conducted with the Maintenance Director. He indicated he checked one resident's room water temperatures per week, since he began working at the facility approximately 4 months ago. He documented these temperatures in the computer. Temperatures were usually between 117 and 122 degrees Fahrenheit.<br><br>On 1/19/24 at 12:35 p.m., the Maintenance Director provided various residents' room water temperature logs from 12/7/23 to 1/15/24. The temperatures ranged between 115.5 and 121.4 degrees Fahrenheit.<br><br>The Water Temperature policy was provided by the Maintenance Director on 1/19/24 at 12:35 p.m. It read, "Water temperature levels in resident areas will be maintained between 105 and 120 degrees Fahrenheit....1. Maintenance will also monitor the temperature of water from randomly selected resident bathroom faucets. 2. The temperature gauge will be adjusted when necessary to assure proper water temperature is maintained." | | water is between the appropriate temperatures as stated. | |
| R 0216<br><br>Bldg. 00 | 410 IAC 16.2-5-2(c)(1-4)(d)<br>Evaluation - Noncompliance<br>(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:<br>(1) The resident ' s physical, cognitive, and mental status. | | | |

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| | (2) The resident ' s independence in the activities of daily living.<br>(3) The resident ' s weight taken on admission and semiannually thereafter.<br>(4) If applicable, the resident ' s ability to self-administer medications.<br>(d) The evaluation shall be documented in writing and kept in the facility.<br>Based on interview and record review, the facility failed to ensure the resident needs assessment included an evaluation of the resident's ability to self-administer medications and a physician's order for the residents to self-administer medications for 1 of 5 residents reviewed for self-administration of medications. (Resident D)<br><br>Findings include:<br><br>An interview with Resident D conducted on 1/18/23 at 2:23 p.m. indicated, she administers her own insulin and pain medication.<br><br>The clinical record for Resident D was reviewed on 1/19/24 at 10:44 a.m. Resident D's diagnoses included, but not limited to, diabetes type II, chronic pain, and myocardial infarction (heart attack).<br><br>A review of Resident D's current physician orders for January 2024 was performed on 1/19/24. It indicated, she had current orders for the following medications: Nitroglycerin tablet 0.4 mg (milligram), one tablet sublingually every 5 minutes as needed for chest pain; oxycodone-acetaminophen 7.5-325 mg, one tablet three times daily for chronic pain; and Levemir flex pen (insulin), 34 units subcutaneously at bedtime, may take pen to resident, resident to dial up and administer. | R 0216 | 1. Immediate actions taken for those residents identified<br>Resident self-administration assessment and Care Plan updated. Updated orders received from provider for resident to keep medications at bedside.<br><br>2. How the facility identified other residents<br>Any resident residing in the facility had the potential to be affected.<br><br>3. Measures put into place/system changes<br>Director of Nursing will audit self-administer assessment and Care Plan for accuracy.<br><br>Director of Nursing will audit resident self-administer assessment monthly for 4 months then quarterly thereafter.<br><br>4. How the corrective actions will be monitored<br>The DON/designee will be responsible for compliance. Any issues identified will be immediately addressed. Director of Nursing will audit resident self-administer assessment | 03/11/2024 |

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| | A diabetic self administer medication list was provided by the facility on 1/18/23. It indicated 2 of 48 residents were able to self medicate their diabetic medications without assistance by staff and Resident D was on that list.<br><br>Resident D's clinical record did not contain a self-administration assessment for the Nitroglycerin, oxycodone-acetaminophen, nor the Levemir nor did it contain a physician's order for self-administration for Nitroglycerin or oxycodone-acetaminophen.<br><br>A review of Resident D's December 2023 and January 2024 MAR (medication administration record) indicated, the administrations of the oxycodone-acetaminophen were documented as "U-SA" which stood for "unknown-self administer" per DON (Director of Nursing) on 1/19/24 at 1:46 p.m.<br><br>Resident D's care plan dated 7/8/23 indicated, a focus on medications with an intervention dated 11/10/23 which indicated, "Res [sic, resident] prefers medication to be administered by Associate. However, Res [sic] prefers to have pain medication, Insulin[sic], and OTC[sic, over the counter] at bedside...Res[sic] provided with narcotic sheet for pain medication administration.<br><br>A Self-Administration of Medication assessment form was reviewed on 1/19/24. It indicated, "The resident who desires to self-administer medication(s), with or without staff supervision, will have a physician's order to do so in his/her Resident Record. Place a checkmark in the appropriate box below for each of the items listed. The resident must be able to demonstrate basic competency ("able with assist" or "fully capable") in each applicable step prior to receiving initial or | | monthly for 4 months then quarterly thereafter. | |

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| | continuing approval for self-administration of any medication. The Nurse will be responsible for approving self-administration of medications, or staff supervised self-administration of medications, using this review as a guide. An evaluation should be completed initially, quarterly or per state regulations, and with a change of condition."<br><br>410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and<br>(D) preference;<br>of the resident.<br>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.<br>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.<br>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.<br>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of | | | |
| R 0217<br><br>Bldg. 00 | | | | |

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| | the services to be provided.<br>Based on interview and record review, the facility failed to ensure a resident's service plan was signed and dated by the resident for 1 of 3 records reviewed for signed service plans. (Resident D)<br><br>Findings include:<br><br>The clinical record for Resident D was reviewed on 1/19/24 at 10:44 a.m. Resident D's diagnoses included, but not limited to, diabetes type II, chronic pain, and myocardial infarction (heart attack). The clinical record contained a service plan dated 11/9/23. The 11/9/23 service plan was not signed by Resident D.<br><br>An interview with DON (Director of Nursing) conducted on 1/19/24 at 3:37 p.m. indicated, she was unable to locate a copy of Resident D's service plan from 11/9/23 that Resident D had signed. | R 0217 | 1. Immediate actions taken for those residents **identified.**<br><br>**DON immediately updated (Resident D) service plan. Care Plan meeting completed and signed.**<br><br>2. How the facility identified other residents<br>Any resident residing in the facility had the potential to be affected.<br><br>3. Measures put into place/system changes<br>DON will review and sign each residents service plan on a schedule until all residents are in compliance. Each resident service plan will be reviewed and signed quarterly.<br><br>4. How the corrective actions will be monitored<br>The DON/designee will be responsible for compliance. Any issues identified will be immediately addressed. | 03/11/2024 |
| R 0240<br><br>Bldg. 00 | 410 IAC 16.2-5-4(d)<br>Health Services - Deficiency<br>(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.<br>Based on interview and record review, the facility failed to ensure a resident's medication was administered as ordered by their physician for 1 of 5 resident records reviewed, and an insulin flex | R 0240 | DON will in-service insulin certified staff on proper insulin for weekly for 4 weeks monthly for months and quarterly thereafter | 03/11/2024 |

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| | pen was primed prior to administering the insulin dose for 1 of 5 residents observed during medication administration. (Resident D and Resident 37)<br><br>Findings include:<br><br>1. The clinical record for Resident D was reviewed on 1/19/24 at 10:44 a.m. Resident D's diagnoses included, but not limited to, diabetes type II, chronic pain, and myocardial infarction (heart attack).<br><br>A review of Resident D's current physician orders for January 2024 was performed on 1/19/24. It indicated, she had a current physician order for cyanocobalamin injection (vitamin B12), inject 1 ml (milliliter) intramuscularly one time a day every month starting on the 13th for 28 days.<br><br>Resident D's December 2023 and January 2024 MAR (medication administration record) received on 1/19/24 from DON (Director of Nursing) at 1:46 p.m. indicated the following on the MARs:<br>In December 2023:<br>12/2, 12/11, and 12/12- were left blank; and 12/6, 12/7, 12/13, 12/14, 12/16, 12/17, 12/21, 12/29, 12/30 and 12/31- were coded as "09", which indicated to "Other/See Nurse Notes".<br>In January 2024:<br>1/1, 1/2, 1/3, 1/4, 1/8, 1/13, 1/14, 1/15, and 1/17 - were coded as "09", which indicated to "Other/See Nurse Notes".<br><br>Resident D's nursing notes from 12/13/23 and 1/13/24 did not indicate if the cyanocobalamin had been administered.<br><br>An interview with DON conducted on 1/19/24 at 3:37 p.m. indicated, she was unable clarify | | | |

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| | Resident D's cyanocobalamin order prior to the exit conference. DON was unsure if Resident D's cyanocobalamin order was to administer that medication daily for 28 days starting on the 13th or if the medication was to be administered once a month on the 13th of each month.<br><br>A Medications & Treatments: Understand Medication and Treatment Labels for Medication Administration policy received on 1/19/24 at 3:30 p.m. from BOM (Business Office Manager) indicated, "If any discrepancies are noted, appropriate follow-up and resolution should be completed with physician, pharmacy, or responsible party prior to administration of medication."2. The clinical record for Resident 37 was reviewed on 1/18/24 at 11:40 a.m. The Resident's diagnoses included, but was not limited to, type 2 diabetes mellitus.<br><br>A physician order date 11/30/23 indicated Resident 37 was to receive 15 units of humalog insulin 3 times a day.<br><br>An observation was made of blood glucose and insulin administration with Qualified Medication Aide (QMA)1 for Resident 37 on 1/18/37 at 11:47 a.m. QMA 1 was observed dialing up with the dose indicator 15 units of insulin. She then administered the insulin to the resident in his right arm. QMA 1 was not observed priming the flex pen prior to administering the 15 units of insulin.<br><br>An interview was conducted with the Director of Nursing (DON) on 1/19/24 at 10:04 a.m. She indicated education would need to be provided to the staff regarding infection control and administration of insulin.<br><br>A humalog insulin manufacture instructions was | | | |

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|---|---|---|---|---|
| | provided by the DON on 1/9/24 at 10:04 a.m. It indicated "...Preparing your Pen...Always use a new needle for each injection to help prevent infections and blocked needles...Priming your pen. Prime before each injection. Priming your pen means removing the air 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. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top..." | | | |
| R 0268<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(a)<br>Food and Nutritional Services - Deficiency<br>(a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements.<br>Based on observation, record review, and interview, the facility failed to ensure the monthly dietary menu posted at the facility matched the three meals per day which were being served and provided a balanced distribution of the daily nutritional requirements for 48 of 48 residents who eat meals at the facility.<br><br>Findings include:<br><br>On 1/18/24 at 12:04 p.m., the lunch meal provided was observed. The lunch meal consisted of roasted turkey, soup, mashed potatoes, gravy, mixed vegetables, and a grilled ham/cheese sandwich.<br><br>On 1/19/24 at 12:23 p.m., the lunch meal provided was observed to consist of tuna sandwich, soup, | R 0268 | Registered Dietician was established on 01/22/24 by Dietary Solutions<br>DM will provide a weekly menu that will match the three meal per day which will be served and provide a balance distribution of the daily nutrients for 52 residents who eat meals at the community<br>ED will audit each meal for 7 days 4 weeks to make sure each meal coincides with the menu posted outside the dining room.<br>Dietary staff will provide a daily menu displaying all three meals to residents and staff members.<br>All three meals will follow all nutritional guidelines that the | 03/11/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 01/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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|---|---|---|---|---|
| | fresh cut fruit, spaghetti with meat sauce, and side salad.<br><br>The monthly menu posted outside of the dining room was observed on 1/19/24. The posted menu indicated, on 1/18/24 the lunch menu should have been: citrus glazed chicken, bread stuffing, California vegetables, choice of roll, and chocolate chip cookie; and the dinner meal should have been: chunky vegetable soup, ham salad sandwiches with french fries and red grapes. The posted lunch menu for 1/19/24 indicated the lunch menu should have been: Salisbury steak, onion roasted potatoes, whole baby carrots, wheat bread and brownie crinkle; the dinner menu was to be baked ziti, cauliflower, garlic toast, and apple slices.<br><br>An interview with DM (Dietary Manager) was conducted immediately following the posted menu observation. DM indicated, the monthly meal menus are generated by GFS (Gordon Food Service) and the residents at the facility prefer to have hot sandwiches for the lunch menu and a larger meal for the dinner meal so she had flipped the posted menu's lunch with dinner and visa versa and made any cold sandwich into a hot sandwich per resident preferences. When asked why the posted menu and the served meals were not the same, she indicated, she was unable to make changes to the GFS generated menu and instead posted a "Today's Specials" menu inside the dining room. DM indicated, the cooks make up the "specials" menu each morning for that day. When asked if the substitutions in the menus have been approved by a registered Dietician, DM indicated, the facility does not currently have a Dietician and the GFS generated menus were not approved by a registered dietician. | | facility requires. the Dietary staff will ensure all residents are fed an adequate meal three times a day as directed.<br>The Registered Dietician/ designee will follow up to make sure every resident has the proper diet displayed in their charts and that they are received.<br>The Registered Dietician/designee will also follow up with the monthly menu to ensure that the menu is approved and meets the facilities nutritional guidelines.<br>ED will will in- service DM to make sure all menus are signed by the RD before submitting to community. | |

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|---|---|---|---|---|
| R 0269<br><br>Bldg. 00 | This tag relates to complaint IN00425193.<br><br>410 IAC 16.2-5-5.1(b)<br>Food and Nutritional Services - Noncompliance<br>(b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician.<br>Based on observation and interview, the facility failed to ensure the menu and/or its substitutions were approved by a registered dietician for 48 of 48 residents residing at the facility.<br><br>Findings include:<br><br>A kitchen tour was conducted on 1/18/24 at 10:40 a.m. with DM (Dietary Manager). During the kitchen tour, DM indicated, the facility does not have a registered dietician on staff nor do they have a consultant dietician. DM indicated, their facility's menus are generated by GFS (Gordon Food Service) and don't indicate they had been approved by a dietician.<br><br>A copy of the GFS monthly menu for the facility was provided on 1/19/23. The menu's did not contain a signature of a registered dietician.<br><br>Cross reference R268.<br><br>This tag relates to complaint IN00425193. | R 0269 | ED has initiated service with registered dietitian (Racheal Rank) which was established 01/22/24. Pending her visit<br>Upon hiring a new Registered Dietician/ designee daily and monthly menus will be approved moving forward for all residents that reside at the facility.<br>Designee will ensure all meals follow proper nutritional guidelines and proper portions are provided to each resident.<br>Designee will ensure all residents are receiving their proper diet in accordance to their chart and orders.<br>Monthly menus will require signature of Registered Dietician to ensure that all guidelines are being followed.<br>ED will audit all menus for 7 days 4 weeks until 100 percent compliance with policy and regulations to make sure residents is receiving nutritional and proper portions meals based off guidelines.<br><br>ED will audit all menu for RD signature for 100 compliance with policy and regulations | 03/11/2024 |

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|---|---|---|---|
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|---|---|---|---|---|
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(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.<br>Based on observation, record review, and interview, the facility failed to ensure food preparation and serving areas were maintained in accordance with state and local sanitation and safe food handling standards for: non intact walls; lids on refuse containers when not in use; ensuring detergent agent was dispensing during warewashing; having scoops for bulk items and protecting scoops from splashes, spills, and/or dust; ensuring lids/containers of bulk items were clean and free of debris/dust; staff in kitchen wearing appropriate hair restraints; labeling/dating of opened items; ensurance of no expired items; food items not stored on the floor in freezer; and maintenance of a clean and sanitary kitchen for 48 of 48 residents who eat meals at the facility.<br><br>Findings include:<br><br>A kitchen tour was performed on 1/18/24 at 10:40 a.m. with DM (Dietary Manager) and Cook. During the kitchen tour the following was observed:<br>General kitchen:<br>- the wall underneath the warewashing machine appeared to be falling apart and missing chunks.<br>- 3 garbage cans were observed to not have lids in place when not currently in use.<br>- the warewashing machine's detergent bucket was found to be empty and it was unsure how long it had been empty.<br>- automatic soap dispenser by service sink was | R 0273 | maintenance repaired the missing tile under warewash.<br>ED in-serviced MD to make sure all equipment in the kitchen is in working condition and to do weekly checks preventative maintenance quarterly on all equipment.<br><br>three trash cans were replaced with cans with lids.<br>ED in-service DM to make sure all trash cans has a lid and trash bag in them at all times.<br><br>DM will in-service staff to monitor liquids and when they get low or empty to inform DM or replace it.<br><br>maintenance has replaced automatic soap dispensers with liquid bottle soap and hand sanitizer.<br>ED in-service with DM and MD to make sure staff inform Management when any liquid or chemical are running low.<br><br>DM in-service staff to do regular cleaning throughout the shift also make sure to place open dates on all food when opened. | 03/11/2024 |

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|---|---|---|---|
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|---|---|---|---|---|
| | not operating.<br>- the doors in kitchen area to the chemical closet and back door had black marks above and below the door handles from dirty hands/fingers.<br>- air vent above service sink appeared rusty with fuzz on vent slats<br>- a wire shelved rack holding clean pots had caked on dust adhered to the shelves and the plastic netting hanging down the side of the rack were discolored with splashed/spilled substances.<br>- the stove had black, burnt on grime near burners, spilled substance down front of stove, the back splash guard contained a large dark brown, dried on, splash mark with drip marks coming down from the splash mark.<br>- the wall behind the stove contained dark brown, dried on splash marks with drip marks.<br>- the spice rack contained 3 spice bottles left open to air and none of the three left open spices had opened dates<br>- above the steam table, the ceiling tiles and tiles support racking contained a black, fuzzy substance growing on them.<br>- shelving under prep tables contained dust and old food debris; one shelf contained clean dishes stored with the dishes facing upwards allowing dust/debris to settle on eating surfaces.<br>- the food service temperature log did not contain food temps since 10/23.<br>- staff member 42 was observed in the kitchen without a beard restraint on during the tour<br><br>Dry good area:<br>- in the dry foods area located across from the back door, was a plastic bowl with flour remnants inside the bowl, was sitting on top of several cans of cranberry sauce and left open to air/debris.<br>- the lids for bulk containers of flour, sugar, bread crumbs were littered with crumbs and/or dust debris and containers had dark drips marks on | | maintenance will conduct preventative maintenance on all equipment in kitchen quarterly.<br><br>DM will in-service staff nothing should be on the floor.<br>DM will in-service staff all food should be covered and dated.<br>ED will audit all food in kitchen is labeled and dated 7 days for 4 weeks until 100 percent compliance.<br><br>Soap Dispensers have been changed and updated.<br><br>Staff have been in-service on hygiene and proper dietary attire and to make sure it is worn at all times.<br><br>Open containers of food has been labeled and dated.<br><br>Scoops have been provided for all bulk items and are properly stored when not in use.<br><br>Maintenance has repaired all improper findings in the kitchen and staff have been in-service on proper cleaning and cooking techniques.<br><br>Following all facility guidelines Meals will be served in a safe sufficient manner. | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
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|---|---|---|---|---|
| | them.<br>- a previously opened package of mini marshmallows had no opened date.<br>- underneath the shelving racks in the dry storage area were crumbs, black debris and dirt on the floor.<br>- on shelves in the dry goods area was an opened bottle of sweet n' sour sauce without an opened date and an opened bag containing noodles without an opened date.<br>- the rack containing canned goods, had dried spill marks and dust.<br><br>Inside the walk in refrigerator was:<br>- a tray of pre-poured ketchup cups covered by unsecured plastic wrap and no prep date/time<br>- half of an onion wrapped in plastic wrap without a prep date/time<br>- 3 quarts of unopened heavy cream with expiration dates of 12/9/23<br>- A large tea dispenser with a dispensing spigot was sitting on a tray with spilled tea covering the bottom of the tray and no prep date/time.<br>- a bottle of opened apple juice without an opened date<br>- two full trays of slices of pecan pie without prep dates/times; one tray had an opened container of tomatoes on top of the pie slices.<br>- walls in fridge had black drip marks<br><br>The reach-in cooler:<br>- outside temperature gauge was not working; two inside temperature gauges read 54 degrees Fahrenheit<br>- a container of pesto sauce had an expiration date of 12/6/23; and no opened date<br>- a container of cottage cheese had an expiration date of 1/9/24; and no opened date<br>- a container of chicken base had no opened date<br>- a tub of mozzarella cheese had an expiration date | | Maintenance will do monthly checks to ensure that the dishwasher and all kitchen equipment is properly working and up to the facilities policy.<br><br>Dietary manager/ designee will ensure all staff are properly dressed and ready to sanitize and serve food safely. | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| | of 11/5/23 and no opened date<br>- a plastic container with a green lid contained a yellow, solid substance with no label or prep date<br>- an opened quart of heavy cream with an expiration date of 12/9/23 had no opened date<br>- three slices of pecan pie had no prep date<br>- a large gallon container of ranch dressing did no have an opened date nor was the expiration date noted.<br>- the rubber door seal on the reach-in cooler was caked with a black substance<br><br>In the walk-in freezer:<br>- a box of chocolate sheet cakes; a box of frozen broccoli, and a box containing boxed donuts were stored on the floor in the freezer.<br><br>An interview with DM conducted immediately following the taking of lunch meal temperatures on 1/18/24 at 12:04 p.m. indicated, the food temperature log had not been kept up to date since the change in ownership of the facility which occurred in 11/23.<br><br>A Dietary Dress Code policy was received on 1/19/24 from ADM at 1:21 p.m. It indicated, "Hair net, chef wear for food preparation, black scrub pants and black scrub top for all dietary staff, dish washers and servers, aprons, rubber sole or other non-skid shoes. No skirts of dresses or any type of flowing loose garment...If long sleeves are required, a long sleeve back scrub jacket may be worn.<br><br>The Indiana Retail Food Establishment Sanitation Effective November 13, 2004, indicated, "Effectiveness of hair restraint Sec. 138. (a) Except as provided in subsection (b), food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing | | | |

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|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 01/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| FORT HARRISON ALF OPERATIONS | 8025 DOUBLEDAY DRIVE<br>INDIANAPOLIS, IN 46216 |

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|---|---|---|---|---|
| | that covers body hair, that are designed and worn to effectively keep their hair from contacting:<br>(1) exposed food;<br>(2) clean equipment, utensils, and linens; and<br>(3) unwrapped single-service and single-use articles...<br>Food storage Sec. 177. (a) Except as specified in subsections (b) and (c), food shall be protected from contamination by storing the food as follows:<br>(1) In a clean, dry location.<br>(2) Where it is not exposed to splash, dust, or other contamination.<br>(3) At least six (6) inches above the floor.<br>(4) In a manner to prevent overcrowding.<br>(5) In packages, covered containers, or wrappings.<br>(b) Food in packages and working containers may be stored less than six (6) inches above the floor on case lot handling equipment...<br>Ready-to-eat, potentially hazardous food; date marking<br>Sec. 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day one (1):<br>(1) Forty-one (41) degrees Fahrenheit or less for a maximum of seven (7) days.<br>(2) Forty-five (45) degrees Fahrenheit or between forty-one (41) degrees Fahrenheit and forty-five (45)<br>degrees Fahrenheit for a maximum of four (4) days in existing refrigeration equipment that is not capable of maintaining the food at forty-one (41) degrees Fahrenheit or less if: | | | |

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|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 01/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| FORT HARRISON ALF OPERATIONS | 8025 DOUBLEDAY DRIVE<br>INDIANAPOLIS, IN 46216 |

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|---|---|---|---|---|
| | (A) the equipment is in place and in use in the food establishment, and<br>(B) the equipment is upgraded or replaced to maintain food at a temperature of forty-one (41) degrees<br>Fahrenheit or less as specified in section 187(a)(2)(B)(ii) of this rule.<br>(b) Except as specified in (d) and (e) of this section, refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a retail food establishment and if the food is held for more than twenty-four (24) hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in subsection (a) and:<br>(1) the day the original container is opened in the retail food establishment shall be counted as day one<br>(1); and<br>(2) the day or date marked by the retail food establishment may not exceed a manufacturer's use-by date<br>if the manufacturer determined the use-by date based on food safety.<br>(c) A refrigerated, ready-to-eat potentially hazardous food that is frequently rewrapped, such as lunchmeat<br>or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine, may be marked as specified in subsection (a) or (b) of this section, or by an alternative method such as:<br>(1) a logging system that tracks the batch or lot;<br>(2) tagging the batch or lot in a manner that effectively identifies the food to be monitored; or<br>(3) any other method that identifies the date by which the food must be consumed or discarded. | | | |

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|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 01/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| FORT HARRISON ALF OPERATIONS | 8025 DOUBLEDAY DRIVE<br>INDIANAPOLIS, IN 46216 |

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|---|---|---|---|---|
| | (d) Subsections (a) and (b) do not apply to individual meal portions served or repackaged for sale..."<br><br>This tag relates to complaint IN00425193. | | | |
| R 0354<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(g)(1-7)<br>Clinical Records - Noncompliance<br>(g) A transfer form shall include the following:<br>(1) Identification data.<br>(2) Name of the transferring institution.<br>(3) Name of the receiving institution and date of transfer.<br>(4) Resident ' s personal property when transferred to an acute care facility.<br>(5) Nurses ' notes relating to the resident ' s:<br>(A) functional abilities and physical limitations;<br>(B) nursing care;<br>(C) medications;<br>(D) treatment; and<br>(E) current diet and condition on transfer.<br>(6) Diagnosis.<br>(7) Date of chest x-ray and skin test for tuberculosis. | | | |
| | Based on interview and record review, the facility failed to ensure a resident transferred to another facility was provided the relevant information that included: behaviors, ambulation, bladder and bowel function, feeding and location where the resident was discharged for 2 of 2 resident discharged. (Residents' E and F)<br><br>Findings include:<br><br>1. The clinical record for Resident F was reviewed on 1/18/24 at 2:00 p.m. The Resident's diagnoses included, but was not limited to, anxiety disorder.<br><br>A transfer and discharge report for Resident F | R 0354 | 1. Immediate actions taken for those residents identified<br><br>Director of Nursing in-serviced staff on resident transfer/discharge.<br><br>2. How the facility identified other residents<br>Any resident residing in the facility had the potential to be affected.<br><br>3. Measures put into place/system changes<br>Director of Nursing will audit each resident transfer/discharge records | 03/11/2024 |

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|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 01/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| FORT HARRISON ALF OPERATIONS | 8025 DOUBLEDAY DRIVE<br>INDIANAPOLIS, IN 46216 |

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| | was provided by the Director of Nursing on 1/19/24 at 11:00 a.m. It indicated Resident F was transferred/discharged from the facility on 12/19/23 at 8:38 a.m. It did not include the location of the receiving party, the reason for the transfer, or the relevant information that included behaviors, ambulation, bowel and bladder function, type of feeding and Resident F's "usual level of functioning."<br><br>An interview was conducted with the Director of Nursing on 1/19/24 at 3:15 p.m. She indicted the transfer/discharge report and the medication list was sent to the receiving party when a resident discharges. The level of functioning information was provided if the receiving facility request.2.The clinical record for Resident E was reviewed on 1/18/24 at 3:39 p.m. Resident E's diagnoses included, but not limited to, hypertension, depression, and congestive heart failure. Resident E transferred from the facility to another facility on 12/18/23.<br><br>A progress note dated 11/30/2023 at 9:08 a.m. indicated, the demographics and physician paperwork was sent to the new facility.<br><br>A nursing note dated 12/18/2023 at 2:27 p.m. indicated, "Resident transferred to [sic, name of new facility] facility via personal vehicle accompanied by family. Transfer paperwork sent with resident."<br><br>An interview with DON (Director of Nursing) conducted on 1/19/24 at 9:59 a.m. indicated, a Transfer/Discharge form and a list of medications was what was sent to the new facility.<br><br>A copy of Resident E's Transfer/Discharge form was provided by DON on 1/19/24 at 9:59 a.m. The | | for proper documentation, demographics, location, functional abilities and physical limitations, condition on transfer, and disposition of medications.<br><br>4. How the corrective actions will be monitored.<br>The Director of Nursing/designee will be responsible for compliance. Any issues identified will be immediately addressed. Director of Nursing will audit transfer/discharge records weekly for 4 weeks and thereafter. | |

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| | | A. BUILDING 00<br>B. WING | 01/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| FORT HARRISON ALF OPERATIONS | 8025 DOUBLEDAY DRIVE<br>INDIANAPOLIS, IN 46216 |

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| | form did not contain: the name of the receiving institution; date of transfer; nurse's notes relating to the resident's functional abilities and physical limitations; nursing care; treatments; condition on transfer; or skin test for tuberculosis.<br>Additionally, Resident E's clinical record did not contain a disposition of her medications upon transfer.<br><br>A Medications & Treatments: Understand Medication and Treatment Labels for Medication Administration policy was received from BOM (Business Office Manager) was received on 1/19/24 at 3:30 p.m. The policy indicated, "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:<br>a. The name of the resident.<br>b. The name and strength of the drug.<br>c. The prescription number.<br>d. The reason for disposal.<br>e. The amount disposed of.<br>f. The method of disposition.<br>g. The date of disposal.<br>h. The signature of the person conducting the disposal of the drug.<br>i. The signature of a witness, if any, to the disposal of the drug."<br><br>A Discharge and Transfer Policy was received on 1/19/24 at 3:30 p.m. from BOM. It indicated, "It is the policy of the community to discharge or permanently transfer a resident if, and when the need should arise." | | | |
| R 0407 | 410 IAC 16.2-5-12(b)(1-4)<br>Infection Control - Noncompliance | | | |

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| Bldg. 00 | (b) The facility must establish an infection control program that includes the following:<br>(1) A system that enables the facility to analyze patterns of known infectious symptoms.<br>(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.<br>(3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.<br>(4) Reporting communicable disease to public health authorities.<br>Based on observation, interview, and record review, the facility failed to ensure infection control was maintained while administrating insulin for 1 of 5 residents' observed during medication administration. (Resident 37)<br><br>Findings include:<br><br>The clinical record for Resident 37 was reviewed on 1/18/24 at 11:40 a.m. The Resident's diagnoses included, but was not limited to, type 2 diabetes mellitus.<br><br>A physician order date 11/30/23 indicated Resident 37 was to receive 15 units of humalog insulin 3 times a day.<br><br>An observation was made of blood glucose and insulin administration with Qualified Medication Aide (QMA)1 for Resident 37 on 1/18/37 at 11:47 a.m. During the insulin administration, QMA 1 was observed wiping a small area of the resident's arm with an alcohol pad. She then inserted the needle that was attached to the flex pen into the resident's arm and pushed the dose knob to administer the insulin. Prior to completion of the dose, QMA 1 was observed removing the needle | R 0407 | 1. Immediate actions taken for those residents identified<br><br>Director of Nursing in-serviced staff on infection control and insulin administration.<br><br>2. How the facility identified other residents<br>Any resident residing in the facility had the potential to be affected.<br><br>3. Measures put into place/system changes<br>Director of Nursing will audit insulin administration for 4 weeks, then monthly for 3 months and thereafter. Additional infection control and insulin administration education will be provided monthly for clinical staff.<br><br>4. How the corrective actions will be monitored.<br>The Director of Nursing/designee will be responsible for compliance. Any issues identified | 02/26/2024 |

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| | from the resident's arm, touching the outer needle shield with her gloves and then reinserting the needle into the resident's arm three times during the administration. QMA 1 did not disinfect the resident's arm prior to reinserting the needle in the arm either time she removed and reinserted.<br><br>An interview was conducted with the Director of Nursing (DON) on 1/19/24 at 10:04 a.m. She indicated education would need to be provided to the staff regarding infection control and administration of insulin.<br><br>A humalog insulin manufacture instructions was provided by the DON on 1/9/24 at 10:04 a.m. It indicated "...Preparing your Pen...Always use a new needle for each injection to help prevent infections and blocked needles...Step 10:...Wipe your skin with an alcohol swab, and let your skin dry before you inject your dose. Step 11: Insert the needle into your skin. Push the dose knob in and slowly count to 5 before removing the needle...Trouble shooting...If the dose knob is hard to push: Pushing the dose knob more slowly will make it easier to inject. Your needle may be blocked. Put on a new needle and prime the pen..." | | will be immediately addressed. | |
| R 0414<br><br>Bldg. 00 | 410 IAC 16.2-5-12(k)<br>Infection Control - Deficiency<br>(k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br>Based on observation, interview and record review, the facility failed to ensure hand hygiene was maintained during an observation of an insulin medication administration for 1 of 5 residents' observed during medication administrations. (Resident 37) | R 0414 | All 52 residents were affected in a sense proper hand hygiene in-services have been given to all staff members on all shifts and will be closely monitored.<br><br>All QMAs have been in-service on | 03/11/2024 |

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| | Findings include:<br><br>The clinical record for Resident 37 was reviewed on 1/18/24 at 11:40 a.m. The Resident's diagnoses included, but was not limited to, type 2 diabetes mellitus.<br><br>A physician order date 11/30/23 indicated Resident 37 was to receive 15 units of humalog insulin 3 times a day.<br><br>An observation was made of blood glucose and insulin administration with Qualified Medication Aide (QMA)1 for Resident 37 on 1/18/37 at 11:47 a.m. QMA 1 was observed at a medication cart with Resident 37's glucometer and humalog insulin flex pen. She then went to the resident's door knocked and opened the door. After entrance to the room, she placed the glucometer and flex pen on the resident's bedside table. She then reached in her pocket and pulled out a pair of gloves that she donned. QMA 1 was observed obtaining the resident's blood sugar and administered 15 units of humalog insulin with the gloves. There was no observation of hand hygiene prior to donning on the gloves.<br><br>An interview was conducted with the Director of Nursing on 1/19/24 at 10:04 a.m. She indicated hand hygiene should have been performed prior to donning on the gloves.<br><br>A handwashing policy was provided by the Administrator on 1/18/24 at 2:00 p.m. It indicated "...Purpose: Handwashing is regarded as the single most important means of preventing the spread of infections. All associates should wash their hands to prevent the spread of infection and disease to other residents, other associates and visitors. Suggested Guidelines: A minimum twenty | | the proper way to give insulin to residents on all shifts.<br><br>Extra hand sanitation and gloves have been placed in supporting area of the building to ensure availability of all things needed to provide proper and safe care to residents.<br><br>In-services are also being provided semi annually and annually to ensure safe and adequate care to all 52 residents in the facility.<br><br>The Director of Nursing/ designee will follow up with staff daily to ensure proper protocol is being followed. | |

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| | (20) second hand washing should be performed in situations including but not limited to:...Before preparing or handling medications...3. The use of gloves does not replace hand washing..." | | | |