DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: June 11, 12, 13, 14, and 15, 2023. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 39 SNF: 6 Residential: 16 Total: 61 Census Payor Type: Medicare: 6 Medicaid: 27 Other: 12 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 23, 2023.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	07/07/2023

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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	resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview, and record review, the facility failed to provide assistance for safe smoking, or an alternative aid for smoking cessation, to a resident who desired to smoke for 1 of 2 residents reviewed for smoking. (Resident 244).	F 0550	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A smoking safety risk assessment was done on Resident 244 and care plan was	07/10/2023

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	Findings include: During an observation, on 6/13/23 at 9:28 a.m., a group of four residents were outside, smoking. Resident 244 was not present. During an observation, on 6/14/23 at 9:30 a.m., a group of residents were outside, smoking. Resident 244 was not present. At the time of the observation, the Activities Volunteer indicated there were no protective coverings for residents who may drop ashes or were at risk for burning themselves. During an interview, on 6/14/23 at 10:17 a.m., Resident 244 indicated he had not been out to smoke because staff told him people were starting fires. He was experiencing nicotine withdrawal, and he had not been offered or provided a nicotine substitute. His hands were observed to be shaking. Resident 244's clinical record was reviewed on 6/12/23 at 10:43 a.m. Diagnoses include, but were not limited to, diabetes mellitus type II, anxiety, and depression. A baseline care plan, dated 6/9/23, indicated he was a smoker. Interventions included the following: the resident was instructed about the facility policy on smoking, locations, times, and safety concerns, and observe clothing and skin for signs of cigarette burns. The resident listed smoking and spending time with his family member as activities he enjoyed. A current care plan, dated 6/12/23, indicated he had a history of smoking cigarettes and was an unsafe smoker. Current interventions, dated 6/12/23, included the following: He would not		updated. Nurse practitioner counseled Resident 244 on alternative aids for smoking. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All present and past smokers will be offered smoking cessation aids. Current smokers and all new admit smokers will have an updated smoking safety risk assessment done and then again with any change of condition that may affect their safety while smoking. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were educated on Resident Rights, including preferences and processes of reporting potential violations. Residents' preference to smoke will be identified during admission assessments and updated during care plan meetings and upon request. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will interview 5 smoking residents weekly for 4	

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	smoke in the facility and would not smoke on facility grounds, medications per physician order, nicotine patches, observe for signs and symptoms of withdrawal from tobacco, redirection to smoking due to being unsafe, resident and/or family would be educated on facility smoking procedure, the resident would keep smoking materials in a secured location, he would not keep smoking materials at the facility, and would participate in smoking assessments as needed. A current care plan, dated 6/12/23 indicated he had a physical and psychological addiction to nicotine/smoking and smoking routine. Significant extended disruptions in smoking routine may cause physical and psychosocial/ behavioral disturbance. Current physician orders, dated 6/8/2023, included may smoke as indicated with appropriate social distancing, masking and hand hygiene for psychosocial & physical/medical necessity related to nicotine addiction. The clinical record lacked an order for a smoking cessation aid. A "Smoking Safety Risk Assessment," dated 6/12/23, indicated he was unsafe to smoke, allowed cigarette to burn down to fingers, dropped ashes on clothes, and placed burning cigarettes on his lap. The Interdisciplinary Team Care Plan Recommendations were the resident was unable to smoke due to safety. During an interview, on 6/15/23 at 8:51 a.m., the Administrator indicated nursing staff performed a smoking assessment upon admission, as well as with any significant changes. The facility provided a smoking blanket to accommodate		weeks, then 3 smoking residents weekly for 4 weeks and then 5 smoking residents monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	residents who drop ashes or had a potential of burning themselves or others with cigarettes, and a smoking blanket would be used for such a situation. If it was determined that a resident is unable to safely smoke a cigarette, a nicotine patch would be provided. A supervisor should be with the residents but in actuality, they did not go out with the residents during smoking times. The supervisor responsibilities were "followed as much as they can be followed." If the Administrator was made aware of any unsafe smoking habits, she would give a verbal warning or sometimes put the resident on "dependent" smoking. The resident should be evaluated for withdrawal symptoms, but was unaware if this had been done or where documentation would be found. She was unaware of where the offer of a nicotine patch or a smoking blanket would be documented. Review of a current, undated, facility policy titled "Smoking Policy Acknowledgement Aperion Care Marion," provided by the Activities Director on 6/13/23 at 2:00 p.m., indicated the following: "...Staff will remain in the designated area, during the entire scheduled smoking time with the residents on dependent or supervised smoking...First reported smoking violation after signing the Smoking Contract: Verbal warning given to Resident, policy reviewed, unannounced room sweeps, loss of ability to self-store smoking material and Resident informed of next step in rule violation. Second reported smoking violation: Smoking policy reviewed, unannounced room sweeps continue, resident will be removed from independent and placed on dependent/supervised smoking for 30 days, and Resident informed of next step in rule violation. Third reported smoking violation: Review smoking policy, unannounced room sweeps, smoking privileges revoked for 30			

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	days, subsequent violations will incur additional days and may result in up to involuntary discharge from the facility. If no further violations, smoking privileges may be reinstated. If reinstated, any further violation will result in permanent loss of smoking privileges...." 3.1-45 (a)(2)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident			

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	or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on observation, interview, and record review, the facility failed to resolve Resident Council grievances regarding long waits for meals for 5 of 6 residents who responded to questions during a group interview. Findings include: An undated facility document titled, "Meal Times", provided following the entrance conference 6/11/23, indicated meal service times as follows: breakfast at 7:45 a.m., lunch at 12:30 p.m., and dinner at 5:45 p.m. During observations on 6/11/23 at 11:05 a.m., 6/12/23 at 10:45 a.m., 6/13/23 at 10:30 a.m., 6/14/23 at 11:00 a.m., and 6/15/23 at 9:00 a.m., no meal times were observed posted in the dining room or adjoining areas. During a group interview with residents who participated in the Resident Council, on 3/14/23 at 10:00 a.m., the following concerns regarding lengthy meal waits were made: a. There was no posted meal time schedule. b. The residents believed breakfast was scheduled to be served at 7:30 a.m. (15 minutes earlier than the facility's indicated time.) Breakfast	F 0565	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Signs are posted in all dining rooms and at nurses' station with meal times. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Meal times will be placed in the acrylic frame inside every resident room. Meal times have been added to the Resident Council agenda, during the discussion of the monthly Resident choice meal and welcome books will be updated as needed in each resident room. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff will be educated on meal service times.	07/10/2023

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	was usually not started until at least 8:30 a.m. to 8:45 a.m. (45 minutes to an hour after the facility's indicated time.) Sometimes they didn't start serving until 9:00 a.m. c. Four of of six residents indicated breakfast was served late three times a week or more. d. The residents believed lunch was scheduled to be served at 12:15 p.m. (15 minutes earlier than the facility's indicated time.) The facility often times did not start passing lunch until 12:45 p.m. to 1:00 p.m. (15 to 30 minutes after the facility's indicated time). e. Five of six residents indicated lunch was served late three times a week or more. f. The residents believed supper was scheduled to be served at 5:15 p.m. (30 minutes before the facility's indicated time). They often times did not begin serving supper until 6:00 p.m. (15 minutes after the facility's indicated time). g. Five of six residents indicated supper was served late three (3) times a week or more. h. Late meals have been talked about regularly in Resident Council meetings. i. The facility had yet to totally resolve the concern. The council would say an issue is improving, and then it would slip right back to a concern again. It was never really fixed. During an interview on 6/14/23 at 10:50 a.m., the Activity Director, who facilitated Resident Council meetings, indicated the residents had regularly expressed concerns with dietary services, including timeliness of meals. The resident's		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Dietary supervisor/designee will monitor signs in dining rooms and nurses' station weekly and will replace any missing/damaged signs as needed. Dietary supervisor/designee will monitor start times of meal service, daily (Monday-Friday), for all 3 meals, for 4 weeks, then 3 days a week, all 3 meals, for 4 weeks and then 2 times a week, all 3 meals monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	would say the issues were improving but not resolved. During a confidential interview on 6/12/23 at 10:58 a.m., a family member indicated hall cart meal trays were served late, and often not served until 2:00 p.m. to 2:30 p.m. During an interview on 6/15/23 at 9:19 a.m., the Dietary Manager indicated he had no idea where or if the meal times were posted anywhere in the facility. At one time, there had been a posting, but he was unsure if it was still there. During an observation and interview on 6/15/23 at 9:27 a.m., the Administrator indicated she was unable to find a meal time schedule posted anywhere in the facility. The lack of posted meal times could be one of the reasons residents believed meals were served late. A current, 9/25/17, facility policy, titled "Grievances", which was provided by the Administrator on 6/15/23 at 11:11 a.m., indicated the following: "Every effort shall be made to resolve grievances in a timely manner, usually within 5 business days (excludes weekends and holidays)." 3.1-3(l)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to accurately code weight and weight gain on the Minimum Data Set (MDS) assessment for 1 of 19 residents sampled (Resident 21).	F 0641	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	07/10/2023

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	Findings include: Resident 21's clinical record was reviewed on 6/12/23 at 2:02 p.m. Her diagnoses included diabetes mellitus, chronic right heart failure, and acute respiratory failure with hypoxia. A 4/13/23 quarterly MDS assessment indicated the resident weighed 185 pounds and had not had a significant weight gain or loss. The resident's last two documented weights prior to the 4/13/23 assessment were 207.6 pounds on 2/3/23 and 205.2 pounds on 3/6/23. The resident's weight six months prior to the 4/13/23 assessment was 183 pounds, on 10/4/22. (The resident gained 24.6 pounds with a significant weight gain of 13% since the prior assessment period.) A 5/22/23 quarterly MDS assessment indicated the resident weighed 218 pounds and had not had a significant weight gain or loss. The resident's weight six months prior to the 5/22/23 assessment was 187.6 pounds, on 11/3/22. (The resident gained 30. 4 pounds, with a significant weight gain of 16%, since the prior assessment period.) During an interview, on 6/15/23 at 8:43 a.m., the MDS coordinator indicated the weight of 185 pounds for the 4/13/23 quarterly MDS was an error. Since the weight was entered incorrectly, the weight gain would not have been triggered. On the 5/22/23 quarterly MDS, the weight gain would usually have caused the MDS software to pre-populate the significant weight gain. The MDS coordinator was responsible to check the answers to ensure accuracy. An interview with the DON, on 6/15/23 at 1:30		Resident 21 has been added to daily weights per nephrologist. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents weights will be audited for any weight increase or decrease of 5 pounds and re-weights will be done for accuracy. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff were educated on the weights policy and reporting to DON and MD for any abnormal findings. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will review weights in daily clinical meeting 9Monday-Friday) for 4 weeks, then 3 times a week for 4 weeks and then 1 time monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA	

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	p.m., indicated the facility followed the RAI (Resident Assessment Instrument) manual for the MDS policy. The current RAI manual, dated 6/7/23, indicated the following: " ...Weight Gain ...Steps for Assessment: This item compares the resident's weight in the current observation period ...At a point closest to the 180-days preceding the current weight ...For Subsequent Assessments ...3. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago. 4. If the current weight is more than the weight in the observation period 180 days ago, calculate the percentage of weight gain ...Coding Instructions ...Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of ...10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician ...Coding Tips ...Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status ...."		Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, interview, and record review, the facility failed to provide supervision	F 0689	I. What corrective action(s) will be accomplished for those	07/10/2023

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	and assistive devices to reduce the risk of accidents for four residents who smoked. Findings include: During an observation, on 6/13/23 at 9:28 a.m., the Activities Volunteer assigned to supervise smoke breaks remained indoors, while four residents went outside to smoke on the patio. The residents remained without supervision for the duration of the smoking break. During an observation, on 6/14/23 at 9:30 a.m., the Activities Volunteer remained inside while residents went outside to smoke. The chair in which the Activities Volunteer was sitting did not provide a direct line of sight for observing residents smoking. At the time of the observation, the Activites Volunteer indicated there were no protective coverings for residents who may drop ashes or were at risk for burning themselves. During an interview, on 6/15/23 at 8:51 a.m., the Administrator indicated a supervisor should be with the residents who were smoking, but in actuality, they did not go out with the residents. The supervisor responsibilities were "followed as much as they can be followed." If the Administrator was made aware of any unsafe smoking habits, she would give a verbal warning or sometimes put the resident on "dependent" smoking. Review of a current, undated, facility policy titled "Smoking Policy Acknowledgement Aperion Care Marion," provided by the Activities Director on 6/13/23 at 2:00 p.m., indicated the following: "...Staff will remain in the designated area, during the entire scheduled smoking time with the		residents found to have been affected by the deficient practice; Staff or volunteer supervision for smokers will be outside with the smokers, during smoking posted times, and remain until the last smoker has returned inside of the building. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Supervision for all resident smokers and any safety smoking devises will be available for resident use during smoking times. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were educated on smoking procedures. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Business office manager/designee will monitor smoking to ensure that supervision is taking place outside with the resident smokers 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then 1 time weekly. The results of these audits will be	

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	residents on dependent or supervised smoking...First reported smoking violation after signing the Smoking Contract: Verbal warning given to Resident, policy reviewed, unannounced room sweeps, loss of ability to self-store smoking material and Resident informed of next step in rule violation. Second reported smoking violation: Smoking policy reviewed, unannounced room sweeps continue, resident will be removed from independent and placed on dependent/supervised smoking for 30 days, and Resident informed of next step in rule violation. Third reported smoking violation: Review smoking policy, unannounced room sweeps, smoking privileges revoked for 30 days, subsequent violations will incur additional days and may result in up to involuntary discharge from the facility. If no further violations, smoking privileges may be reinstated. If reinstated, any further violation will result in permanent loss of smoking privileges...." 3.1-45 (a)(2)		reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review, and interview, the facility failed to ensure physician prescribed diets were followed for 2 of 5 residents reviewed for nutrition (Residents 22 and 194). Findings include: 1. Resident 22's clinical record was reviewed on 6/12/23 at 2:03 p.m. Diagnoses included acute kidney failure, hypertensive chronic kidney disease, dependence on renal dialysis, congestive heart failure, supraventricular tachycardia, and atrial fibrillation. Current physician orders included general diet with regular texture, thin consistency, no tomatoes, bananas, potatoes, or orange juice (4/30/22). The resident was to have dialysis on Tuesday, Thursday, and Saturday (11/6/21). A 4/30/23 quarterly MDS (Minimum Data Set) assessment indicated the resident was severely cognitively impaired. A potassium level on 12/2/22 was high - 5.6 mEq/L (milliequivalents per liter) with 3.4 to 5.2 mEq/L being within normal limits. A potassium level on 5/23/23 was high - 5.4 mEq/L. A care plan for nutrition related to dependence on hemodialysis initiated on 9/26/21 and revised on 12/30/21 had an intervention to provide diet as ordered initiated on 9/26/21 and revised on	F 0692	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 22 and 194 diets were reviewed by RD and care plans were updated as needed. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; RD reviewed and updated as needed, all residents with diets per their diagnosis and food allergies. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff were in-serviced on different types of diets and allergies to food and how to follow diets that are on the meal cards. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Dietary supervisor/designee will audit 15 random resident meals	07/10/2023

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	11/30/21. During an observation, on 6/14/23 at 1:24 p.m., the resident's tray contained meatloaf, half a baked potato, and carrots. The resident had consumed approximately two-thirds of the potato. During an interview, on 6/14/23 at 1:25 p.m., CNA 8 and CNA 9 indicated they were unaware the resident was not to receive potatoes, tomatoes, orange juice, or bananas. If the resident was not to received something, it would be on his ticket. They did not remember seeing anything listed on his ticket. Review of the resident's meal ticket, for 6/15/23, provided by the HR (Human Resources) Director on 6/15/23 at 10:15 a.m., indicated no tomatoes, bananas, orange juice, or potatoes for the resident. According to the Mayo Clinic website page, "End-stage renal disease," accessed on 6/19/23 at 12:31 p.m., as part of the treatment for kidney disease, a physician may recommend a special diet be followed to support the kidneys. Lower potassium foods should be chosen. High-potassium foods include bananas, oranges, potatoes, spinach, and tomatoes. According to the National Kidney Foundation website page, "High Potassium," accessed on 6/19/23 at 12:49 p.m., high levels of potassium in the blood can cause serious heart problems and sudden death. 2. During an interview, on 6/13/23 at 9:27 a.m., Resident 194 indicated he was allergic to tomatoes, but often received tomatoes or tomato products on his food tray.		daily (Monday-Friday) for 4 weeks, the 10 resident meals daily for 4 weeks and then 10 weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	During an interview, on 6/13/23 at 2:30 p.m., LPN 10 indicated resident 194 had an allergy to tomatoes. He usually ate in the dining room. He did occasionally receive tomatoes or tomato products on his tray, but he let the staff know right away if that happened. The resident's clinical record was reviewed 6/14/23 at 9:15 a.m. Allergies included tomato products. A 4/30/23 significant change MDS assessment indicated the resident was moderately cognitively impaired. During an interview, on 6/14/23 at 12:37 p.m., Cook 5 indicated they did not use the meal tickets in the main dining room because it was a routine, and they knew the residents. Review of the resident's meal ticket, for 6/15/23, provided by the HR (Human Resources) Director on 6/15/23 at 10:15 a.m., indicated the resident was allergic to tomatoes. A current facility policy, dated 2020, provided by the Dietary Manager on 6/15/23 at 11:52 a.m., indicated " ...The precaution statements are generally used to guide meal selections for residents that require additional modifications in intake to aid control of a problematic health condition ..." 3.1-46(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and			

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	emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on interview and record review, the facility failed to provide ordered medications for 1 of 5 residents reviewed for medications (Resident 21). Findings include: Resident 21's clinical record was reviewed on 6/12/23 at 2:02 p.m. Diagnoses included chronic right heart failure, acute respiratory failure with	F 0755	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 21 was assessed by nurse and MD was notified. II. How other residents having the potential to be affected by the	07/10/2023

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	hypoxia, chronic obstructive pulmonary disease, and diabetes mellitus. Current physician's orders included bumetanide (diuretic) 1 mg give three times a day for fluid retention (5/6/23). A care plan for altered cardiovascular status related to heart failure initiated on 5/3/19 and revised on 3/28/22 had a goal to be free from complications of cardiac problems through the next review (revised 2/2/23). The interventions included medications as ordered (initiated 5/3/19). A Physician-Prescriber Progress Note, dated 4/7/23 at 2:26 p.m., indicated the resident had asked to lie down as she felt poorly and was increasingly short of breath. The chest X-ray done on 4/7/23 was reviewed and indicated venous congestion (accumulation of fluid in the lungs) and blunting of the costophrenic angles (usually caused by pleural effusion which is the build-up of excess fluid between the layers of the membranes that line the lungs). The assessment/plan was acute respiratory failure due to acute on chronic congestive heart failure. Metolazone (diuretic) then furosemide (diuretic) was ordered. A Nurses Note, date 4/10/23 at 12:40 p.m., indicated the one-time dose of metolazone was not delivered from pharmacy. The NP (Nurse Practitioner) was notified and did not want the medication administered at that time. A Physician-Prescriber Progress Note, dated 4/10/23 at 11:59 p.m., indicated the resident felt significantly better since she had a furosemide (diuretic) injection. The assessment/plan indicated acute respiratory failure due to acute on chronic		same deficient practice will be identified and what corrective action(s) will be taken; All new orders given to residents for the last 30 days were audited for any medication administration errors. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses and qualified medication aids were in serviced on medication administration policy. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will audit new medication orders daily (Monday-Frida) during clinical meeting for errors for 4 weeks, then 3 times weekly for 4 weeks and then 1 time weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	congestive heart failure. The resident had crackles to her left lung base. The plan was to give furosemide (diuretic) injection now and continue bumetanide. During an interview, on 6/14/23 at 3:13 p.m., the ADON indicated the 4/7/23 ordered metolazone was ordered to be given on 4/8/23. The medication did not arrive from the pharmacy. The medication was not given. The NP was notified on 4/10/23 (three days later) by the ADON. During an interview, on 6/15/22 at 9:22 a.m., LPN 13 indicated when a medication was not available, she would call the pharmacy. If the pharmacy could not provide it quickly then would call the physician to see if wanted the medication was to be held or if an alternative medication would need to be given. Notifications would be placed in the nurses notes. During an interview, on 6/15/23 at 9:25 a.m., LPN 2 indicated he would check the emergency drug kit if a medication was not available. He would call the pharmacy and notify the physician. Documentation of the notifications would be placed in the progress notes. A current, undated policy, left on the conference room table on 6/15/23 at 1:30 p.m., indicated "medications are administered as prescribed." 3.1-25(a)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to store, prepare, and distribute foods under safe sanitary conditions regarding dating and labeling foods, disposing of outdated food items, cleaning equipment, and hand washing. This deficient practice had the potential to impact 43 of 43 facility residents, who received meals from the kitchen. Findings include: During an interview on 6/15/23 at 10:02 a.m., the DON indicated there were 45 health care residents residing in the facility on 6/11/23. Of the 45 residents, 43 consumed food orally. During a kitchen tour on 6/11/23 at 9:40 a.m., the following concerns were observed: a. The walk-in refrigerator had undated and unlabeled foods as follows: a loaf of deli meat,	F 0812	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All food items not dated, labeled or expired were disposed of immediately. Kitchen equipment was inspected and cleaned as needed. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Hand free trash cans are placed by all kitchen hand washing stations. Cleaning list updated to catch any missed equipment. All open food items will be checked daily for proper labeling.	07/10/2023

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	identified as ham, a loaf of deli meat identified as turkey, a bowl of yellowish sauce identified as salad dressing, chopped leafy greens identified as lettuce, and a tub of grated powdery substance identified as parmesan cheese. The foods were identified by Cook 5. b. The walk-in refrigerator had left-over food items, which were over 3 days old, as follows: chicken Alfredo, dated 6/7/23 (4 days old) and chicken salad dated 6/7/23, (4 days old). Cook 5 indicated left over foods could be held for 3 days. c. The walk- in refrigerator had a block of sliced cheese, which was not totally wrapped in cellophane, leaving the cheese open to air. d. The can opener base and blade were covered with a sticky residue. e. The exhaust hood over the stove had a thick layer of black sticky residue. f. Two of the three drip pans, located under the burners on the stove, were covered in a brown/black burnt on food residue. The third drip pan was stuck in the oven and could not be pulled out for inspection or cleaning. During a lunch observation, on 6/14/23 from 12:14 p.m., the following was observed: a. Dietary Aide 6 washed her hands and touched the lid of the trash can when throwing away the paper towel after washing. b. Dietary Aide 7 washed her hands and touched the trash can lid of trash can when throwing away the paper towel after washing her hands. She then touched cups, and pitchers. Following this,		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff has been educated on proper labeling of open items, with date of open and expiration date on item. All dietary staff educated on cleaning list and proper way to clean items if needed and on hand washing. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Dietary supervisor/designee will audit open items for proper labeling daily for 4 weeks, then 4 times a week for 4 weeks and then 2 times weekly. Dietary supervisor/designee will audit cleaning of equipment list daily for 4 weeks, then 3 times a week for 4 weeks and then weekly. Dietary supervisor/designee will randomly observe dietary staff washing hands and disposing of paper towel,4 times weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make	

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	she used her hands to unhook the chain that separated the dining room from the food service area. With the same soiled hands, she touched the paper napkins and served the napkins to 10 residents in the main dining room. With the same soiled bare hands, she provided the residents silverware, during which she periodically touched the food contact surface of the spoons and forks with the same soiled hands. c. At 12:20 p.m., Dietary Aide 7 placed clean gloves in her pants pockets. On 6/14/23 at 12:32 p.m., Dietary Aide 7 cleansed her hand with hand gel and then took the gloves out of her pocket and donned them. d. At 12:34 p.m., Dietary Aide 7 took off her gloves and threw them away. While doing so, she touched the lid of the trashed can. She touched other kitchen items and surfaces following touching the trash can lid. A current, undated, facility document titled "Weekly Cleaning Schedule", provided by the HR Director on 6/15/23 at 10:15 a.m., indicated the following: "...Task...Clean Range Hood... Clean Ovens...." A current, undated, facility document titled "Daily Cleaning Schedule", provided by the HR Director on 6/15/23, 10:15 a.m., indicated the following: "...Task...Wash & Sanitize Can Opener...." A current, 2020, facility policy titled "Proper Hand Washing and Glove Use", provided by the Dietary Manager on 6/15/23 at 11:25 a.m., indicated the following: "...All employees will use proper hand washing procedures and glove usage in accordance with State and Federal sanitation guidelines...All employees will wash hands upon		recommendations to revise the plan of correction as indicated.	

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	entering the kitchen from any location, after all breaks...and between all tasks... Employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair, and before and after working with an individual resident...." A current, 2020, facility policy titled "Cleaning Rotation", provided by the Administrator on 6/15/23 at 11:11 a.m., indicated the following: "...Items cleaned and sanitized after each use: Can opener... Items cleaned weekly: Hoods...." A current, 2020, facility policy titled, "Labeling and Dating Foods (Date Marking)", which was provided by the Administrator on 6/15/23 at 11:11 a.m., indicated the following: "...Date marking of refrigerated storage food items:...Once opened, all ready to eat, potentially hazardous food will be redated with a use by date according to current safe food storage guidelines or by the manufacturers expiration date... Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines... Prepared foods or open items should be discarded when:...The food item is left over for more that 72 hours...." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a			

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	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to ensure staff completed hand hygiene during medication administration for 1 of 4 staff observed during medication administration. (LPN 11). Findings include: During a medication administration observation, on 6/15/23 at 6:37 a.m., LPN 11 obtained a blood pressure for a resident, prepared the morning dose of medications, and attempted to administer medications to the resident. The resident declined medications. No hand hygiene had been performed after obtaining the blood pressure. Immediately following the observation, LPN 11 obtained a blood pressure from another resident,	F 0880	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Nurse was educated on hand washing and infection control. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All staff was observed while preforming proper hand washing. III. What measures will be put into place and what systemic changes will be made to ensure that the	07/10/2023

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	prepared the morning dose of medications, and administered the medications. No hand hygiene had been preformed before she returned to the medication cart to gather the next resident's medications. During an interview, on 6/15/23 at 6:47 a.m., LPN 11 indicated she performed hand hygiene when she thought about it, but was aware she should perform hand hygiene after every resident. Review of a current, undated, facility policy, titled "Medication Administration General Guidelines," left on the table on 6/15/23 at 1:30 p.m., and indicated the following: "...2. Hand washing and Hand Sanitation: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly: a) before beginning a medication pass, b) prior to handling any medication, c) after coming into direct contact with a resident...." 3.1-18(l)		deficient practice does not recur; All staff was educated on proper techniques of hand washing and infection control. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will randomly quiz staff on how and when to wash hands, 12 staff from different departments will be quizzed daily (Monday-Friday) for 4 weeks, then 8 staff daily for 4 weeks and then 12 staff weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: June 11, 12, 13, 14, and 15, 2023. Facility number: 012809 Residential Census: 16	R 0000		

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 23, 2023.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on interview and record review, the facility failed to ensure at least one staff member was certified in First Aid for 11 of 21 shifts reviewed. Findings include: Review of a seven day staffing schedule was	R 0117	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; List of all staff members who have a certification in first aid was compiled.	07/10/2023

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	completed on 6/15/23 at 2:00 p.m. Of a total of 21 shifts reviewed, 11 of 21 shifts did not include a staff member that was certified in First Aid. During an interview, on 6/15/23 at 2:18 p.m., the ADON indicated no one who was certified in First Aid worked the shifts in question, but there should have been a staff member certified in First Aide for each shift. The facility did not have a policy related to First Aid certifications. No further information was received prior to exit.		II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Facility will ensure at least 1 staff member in the building, 24 hours a day, has first aid certification. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Human resource manager has a binder with all first aid certifications. Those certifications will be shared with the nursing scheduler to ensure staffing is correct each shift. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Human resource manager/designee will audit first aid binder weekly to notify all staff with certification as to when their rei-certification is due. This on-going audit will be done weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to ensure service plans were signed by the resident for 3 of 5 residents reviewed for signed	R 0217	I. What corrective action(s) will be accomplished for those residents found to have been	07/10/2023

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	service plans (Residents 3, 11, and 15). Findings include: 1. Resident 11's clinical record was reviewed on 6/15/23. Current diagnoses included chronic obstructive pulmonary disease, respiratory failure, dyspnea, and acute kidney failure. The resident had a Service Plan dated 1/25/23. The Service Plan was not signed by the resident.2. Resident 3's clinical record was reviewed on 6/15/23. Current diagnoses included, schizoaffective disorder, Hypertension and diabetes mellitus. The resident was admitted to the facility on 4/22/23. The clinical record lacked a service plan signed by the resident.3. Resident 15's clinical record was reviewed on 6/15/23 at 11:27 a.m. Diagnoses included, but were not limited to, heart failure and chronic obstructive pulmonary disease. He had admitted to the assisted living facility on 11/16/22. His clinical record lacked a signed and dated service plan. During an interview, on 6/15/23 at 4:07 p.m., the Administrator indicated she did not have anything signed for resident service plans. During an interview, on 6/15/23 at 4:10 p.m., the Administrator indicated she did not have a facility policy on signed service plans. The facility's goal was to follow the regulations.		affected by the deficient practice; Residents 11, 3 and 15's service plans have been updated, reviewed and signed by each resident. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit was done on all service plans to ensure they had been updated and current and those that were not have been corrected as well. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Social Service Director was educated on all steps to the service plan. A calendar of service plan meetings has been created and a reminder for signatures is on each date. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee will audit the residential service plans as they happen, from the created calendar for the next 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90%	

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			compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (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 observation, interview, and record review, the facility failed to ensure a QMA obtained and documented authorization from a licensed nurse prior to administering a PRN (as needed) medication for 1 of 1 PRN medication administrations observed. (QMA 12) Findings include: During a medication administration observation, on 6/15/23 at 7:40 a.m., QMA 12 administered a PRN Immodium (antidiarrheal) medication. QMA 12 did not obtain authorization from a licensed nurse prior to administering the PRN medication. During an interview on 6/15/23 at 3:35 p.m., QMA 12 indicated when giving a PRN medication she would document pain level (for example), give the PRN medication to the resident, and then notify	R 0246	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; PRN medicine was reviewed by nurse. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residential charts have been audited for the last 30 days for following appropriate PRN administration. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	07/10/2023

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	the nurse so he/she could follow-up. It was not necessary to notify the nurse prior to administration of a PRN medication. Review of a current job description, titled "Qualified Medication Aide (QMA)," dated 3/23/17 and provided by DON on 6/15/23 at 3:55 p.m., indicated "...Compliance - Participates in all in-service programs to expand and develop abilities. Maintains compliance to all personnel policies, established community policies and procedures, and Federal and State regulations and standards...."		All nurses and qualified medication aides were educated on PRN medication administration. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will audit PRN medication use in clinical meeting (Monday-Friday) daily for 4 weeks, then 3 times a week for 4 weeks and then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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, prepare, and distribute foods under safe sanitary conditions regarding, dating and labeling foods, exposing of outdated items, cleaning equipment, and hand washing. This deficient practice had the potential	R 0273	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All food items not dated, labeled or expired were disposed of	07/10/2023

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	to impact 16 of 16 facility residential residents. Findings include: During an interview on 6/15/23 at 10:02 a.m., the DON indicated there were 16 residential care residents were residing in the facility at the beginning of survey on 6/11/23. All 16 consumed food orally. During a kitchen tour on 6/11/23 at 9:40 a.m., the following concerns were observed: a. The walk-in refrigerator had undated and unlabeled foods as follow: A loaf deli meat, identified as ham, a loaf of deli meat identified as turkey, a bowl of yellowish sauce identified as salad dressing, chopped leafy greens identified as lettuce, and a tub of grated powdery substance identified as parmesan cheese. The foods were identified by Cook 5. b. The walk-in refrigerator had left-over food items which were over three days old as follows: chicken Alfredo, dated 6/7/23 (4 days old) and chicken salad dated 6/7/23, (4 days old). Cook 5 indicated left over foods could be held for three days. c. The walk- in refrigerator had a block of sliced cheese, which was not totally wrapped in cellophane leaving the cheese open to air. d. The can opener base and blade were covered with a sticky residue. e. The exhaust hood over the stove had a thick layer of black sticky residue. f. Two of the three drip pans, located under the		immediately. Kitchen equipment was inspected and cleaned as needed. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Hand free trash cans are placed by all kitchen hand washing stations. Cleaning list updated to catch any missed equipment. All open food items will be checked daily for proper labeling. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff has been educated on proper labeling of open items, with date of open and expiration date on item. All dietary staff educated on cleaning list and proper way to clean items if needed and on hand washing. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Dietary supervisor/designee will audit open items for proper labeling daily for 4 weeks, then 4 times a week for 4 weeks and then 2 times weekly. Dietary supervisor/designee will audit cleaning of equipment list daily for	

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	burners on the stove, were covered in a brown/black burnt on food residue. The third drip pan was stuck in the oven and could not be pulled out for inspection or cleaning. During a lunch observation on 6/14/23 from 12:14 p.m., the following was observed: a. Dietary Aide 6 washed her hands and touched the lid of the trash can when throwing away the paper towel after washing. b. Dietary Aide 7 washed her hands and touched the trash can lid of trash can when throwing away the paper towel after washing her hands. She then touched cups, and pitchers. Following this, she used her hands to unhooked the chain that separated the dining room from the food service area. With the same soiled hands she touched the paper napkins and served the napkins to 10 residents in the main dining room. With the same soiled bare hands she provided the residents silverware. When providing the silverware, she periodically touched the food contact surface of the spoons and forks with the same soiled hands. c. At 12:20 p.m., Dietary Aide 7 placed clean gloves in her pants pockets. On 6/14/23 at 12:32 p.m., Dietary Aide 7 cleansed her hand with hand gel and then took the gloves out of her pocket and donned them. d. At 12:34 p.m., Dietary Aide 7 took off her gloves and threw them away. While doing so she touched the lid of the trashed can. She touched other kitchen items and surfaces following touching the trash can lid. During an interview on 6/14/23 at 1:05 p.m., Cook 5 indicated both residents who reside on health care		4 weeks, then 3 times a week for 4 weeks and then weekly. Dietary supervisor/designee will randomly observe dietary staff washing hands and disposing of paper towel,4 times weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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and residential eat meals prepared in the same facility kitchen and served from the same food service area.

A current, undated, facility document titled "Weekly Cleaning Schedule", provided by the HR Director on 6/15/23, 10:15 a.m., indicated the following: "Task...Clean Range Hood... Clean Ovens...."

A current, undated, facility document titled "Daily Cleaning Schedule", provided by the HR Director on 6/15/23, 10:15 a.m., indicated the following: "...Task...Wash & Sanitize Can Opener...."

A current, 2020, facility policy titled "Proper Hand Washing and Glove Use", provided by the Dietary Manager on 6/15/23 at 11:25 a.m., indicated the following:
"...All employees will use proper hand washing procedures and glove usage in accordance with State and Federal sanitation guidelines...All employees will wash hands upon entering the kitchen from any location, after all breaks...and between all tasks... Employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair, and before and after working with an individual resident...."

A current, 2020, facility policy titled "Cleaning Rotation", provided by the Administrator on 6/15/23 at 11:11 a.m., indicated the following: "...Items cleaned and sanitized after each use: Can opener... Items cleaned weekly: Hoods...."

A current, 2020, facility policy titled, "Labeling and Dating Foods (Date Marking)", provided by the Administrator on 6/15/23 at 11:11 a.m., indicated the following: "...Date marking of refrigerated storage food items:...Once opened, all

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	ready to eat, potentially hazardous food will be redated with a use by date according to current safe food storage guidelines or by the manufacturers expiration date... Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines... Prepared foods or open items should be discarded when:...The food item is left over for more that 72 hours...."			
R 9999 Bldg. 00	410 IAC 16.2-3.1-14 Personnel (j) Medication shall be administered by licensed nursing personnel or qualified medication aides. If medication aides handle or administer drugs or perform treatments requiring medications, the facility shall ensure that the persons have been properly qualified in medication administration by a state-approved course. Injectable medications shall be given only by licensed personnel. (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and	R 9999	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A list of missing education for the qualified medication aids were created by the human resource manager. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Human resource manager created a list of all missing education for all staff to be completed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Human resource manager/designee has a calendar set up on the first of every month to create a list of the staff that has training due that month.	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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	dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: 1. Based on record review and interview, the facility to ensure QMA's had completed six hours of medication related trainings for 1 of 1 QMA's reviewed for annual trainings (QMA 3). 2. Based on record review and interview, the facility failed to ensure annual resident rights, abuse, and dementia trainings were completed for 3 of 5 employee files reviewed for required annual training (QMA 3, LPN 2, and CNA 4). Findings include: Employee records, provided on 6/11/23, were reviewed on 6/15/23 at 8:30 a.m. and indicated the following: 1a. QMA 3's employee file lacked annual medication related inservice education. 2a. QMA 3's employee file lacked the completion of annual dementia training. 2b. LPN 2's employee file lacked annual dementia training and abuse training. 2c. CNA 4's employee file lacked annual resident rights and abuse training. It also lacked the completion of annual dementia training. During an interview on 6/15/23 at 9:20 a.m., the Human Resource Director indicated the facility did		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Human resource manager/designee will give department managers a list of staff and trainings that are due for the month in the weekly HR meeting. This list will be updated with trainings that have not been done the week before or become due. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	not have a policy related to annual resign rights, abuse, dementia, and QMA medication trainings.			