STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON AT EAGLE VALLEY, THE	3060 VALLEY FARMS ROAD INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00425481, IN00427257, IN00427192, IN00429027, IN00429399, and IN00430124. Complaint IN00425481 - No deficiencies related to the allegations are cited. Complaint IN00427257- No deficiencies related to the allegations are cited. Complaint IN00427192- No deficiencies related to the allegations are cited. Complaint IN00429027- No deficiencies related to the allegations are cited. Complaint IN00429399- No deficiencies related to the allegations are cited. Complaint IN00430124- No deficiencies related to the allegations are cited. Survey dates: March 7, 8, and 11, 2024 Facility number: 014045 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 21, 2024.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of The Harrison as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	
R 0095	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy	Yantiss	04/05/2024

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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Bldg. 00	-Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and observation, the facility failed to complete the Alzheimer's/Dementia Special Care Unit form for the dementia unit, Magnolia Trails, which had the potential to affect 14 of 14 residents residing on the unit. Findings include: On 3/7/24 at 12:30 p.m., a tour of the locked dementia unit was completed. The unit was called Magnolia Trails.	R 0095	R 095 1 The form was reviewed and completed by the Regional Nurse. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Executive Director has been in-serviced by the Regional Nurse on the requirement to	05/01/2024

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	On 3/7/24 at 10:00 a.m., the Alzheimer's/Dementia Special Care Unit form was requested from the ED (Executive Director). She indicated she was unaware of the form. The form was provided to her. On 3/8/24 at 11:00 a.m., the form was completed and returned. On 3/11/24 at 4:30 p.m., the Regional Nurse indicated she would ensure the form got completed yearly. The form number was provided to her. No policy was provided regarding the Alzheimer's/Dementia Disclosure form.		complete the form. 4 The Executive Director or designee will add to the calendar for January 2nd each year to complete and submit the form. 5 Systemic changes completed: 3/8/2024	
R 0096 Bldg. 00	410 IAC 16.2-5-1.3(m)(1-2)(A-B)(i-iii) Administration and Management - Deficiency (m) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards. Based on interview and record review, the facility failed to ensure the Memory Care Director (MCD) had the correct amount of educational hours to meet the needs of the Memory Care (MC) residents during her first 3 months of hire, and subsequent annual educational hours to provide the current standard of care. This deficiency had	R 0096	R 096 1 The Magnolia Trails Director will complete all required training. A copy of the Magnolia Trails Director's degree was provided to the survey team post exit. The Magnolia Trails Director's degree	05/01/2024

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	the potential to effect 14 of 14 memory care (MC) residents residing in the MC unit. Findings include: On 3/11/24 at 10:30 a.m., the Memory Care Director's (MCD) employee file was reviewed. She was hired on 9/26/22. In the first 3 months of hire, she did not have any Alzheimer's or dementia care educational hours. She did not receive her 2023 annual hours until 3/28/23, by completing an 8 hour of online certification, called, "Certified Dementia Practitioner." She did not have a nursing degree or health care related license. On 4/27/23, she only received 1 hour of Resident Rights education, titled, "Resident Rights in AL," (Assisted Living) and no abuse education hours were observed for her since her date of hire. A job description, titled, "Magnolia Trails Director," dated 3/1/22, was provided by the Operations Specialist (OS), on 3/11/24 at 3:56 p.m. A review of the job description indicated, " ...Ensure compliance with all rules and regulations related to Resident care ...State Regulation ...Education and Experience ...Maintain CPR/First Aid Certification ...Meet continuing education requirements on job classification and position ...." On 3/11/24, the OS indicated Magnolia Trails was the MC unit. On 3/11/24 at 12:54 p.m., the OS indicated all employees needed education.		is a Bachelors of Arts in Health and Wellness. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Executive Director or designee will review all department head files quarterly for four quarters to ensure that compliance with dementia training meets state regulations. 4 Memory Care Director or designee will monitor new staff dementia training monthly for three months and quarterly thereafter to ensure compliance. The Executive Director or designee will audit two employee files weekly for four weeks and monthly for three months then quarterly thereafter for two quarters to ensure all required new hire and annual training is completed. 5 Systemic changes completed: May 1, 2024	

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	A current policy, titled, "Record Maintenance/Equipment Use," with no date, was provided by the Regional Nurse Consultant (RNC), on 3/11/24 at 4:09 p.m. A review of the policy indicated, " ...Personnel records must be properly assembled and maintained ...Employment record related to job positions ...Orientation and training records related to in-service requirements ...A separate personnel file for each Employee Partner should be kept which includes the following ...References from previous employer/s ...Medical records ...Records of any criminal investigation ...."			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure an employee references were checked for 1 of 5 employee files reviewed. Findings include: On 3/11/24 at 10:30 a.m., five employee files were reviewed. Dietary Aide (DA) 14 was hired on 10/5/23. His reference page, was hand written in print, and lacked documentation that his references were reviewed or the companies called for references. On 3/11/24 at 12:54 p.m., the Operations Specialist	R 0116	R 116 1 All employee files to be audited to ensure compliance with reference checks. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Community will complete reference checks for all future employees. The Executive Director or designee will review all new hire employee files to ensure that all required documentation is present in the file.	05/01/2024

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	(OS) observed and agreed it was DA 14's handwriting on the reference page. She indicated the Business Manager should have followed up on his references. On 3/11/24 at 3:19 p.m., the OS indicated all employee records should have been correct upon hiring. The whole process needed to be corrected. A current policy titled, "Record Maintenance/Equipment Use," with no date, was provided by the Regional Nurse Consultant (RNC), on 3/11/24 at 4:09 p.m. A review of the policy indicated, " ...Personnel records must be properly assembled and maintained ...Employment record related to job positions ...A separate personnel file for each Employee Partner should be kept which includes the following ...References from previous employer/s ...."		4 The Executive Director or designee will select 5 random employee files weekly for four weeks, then monthly for three months, then quarterly thereafter for two quarters to ensure compliance with reference checks. 5 Systemic changes completed: May 1, 2024	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies;			

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	(C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure general and/or specific orientation was provided to employees upon hire for 3 of 5 employees' records reviewed. Findings include: On 3/11/24 at 10:30 a.m., employee files were reviewed. The Memory Care Director (MCD) started on 9/26/22. She did not have a general orientation or specific orientation upon hire. Certified Nursing Aide (CNA) 12 started on 10/21/22. She did not have a specific orientation upon hire. Dietary Aide (DA) 14 started on 10/5/23. He did not have a specific orientation upon hire. On 3/11/24 at 3:19 p.m., the Operations Specialist (OS) indicated all employee records should have been correct upon hiring. The whole process	R 0119	R 119 1 All employee files will be audited to ensure compliance with orientation paperwork. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Community will complete job specific orientation checklists and general orientation checklists and include them in all employee files. The Executive Director or designee will audit all new hire employee files to ensure that all required documentation is present in the file. 4 The Executive Director or designee will select five random employee files weekly for four weeks, then monthly for three months, then quarterly thereafter for two quarters to ensure	05/01/2024

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	needed to be corrected. A current policy titled, "Record Maintenance/Equipment Use," with no date, was provided by the Regional Nurse Consultant (RNC), on 3/11/24 at 4:09 p.m. A review of the policy indicated, " ...Personnel records must be properly assembled and maintained ...Employment record related to job positions ...Orientation and training records related to in-service requirements ...."		compliance with orientation checklists. 5 Systemic changes completed: May 1, 2024	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the			

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	current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure employee initial education was completed during the hiring process and subsequent educational requirements were completed for 4 of 5 employee records reviewed. This deficiency had the potential to effect 72 of 72 residents residing in assisting living (AL) and the AL memory care (MC) units. Findings include: On 3/11/24 at 10:30 a.m., employee files were reviewed. 1. Certified Nursing Aide (CNA) 12 was hired on 10/21/22. By 4/21/23, within 6 months of her hire, she did not have any dementia care training. Her subsequent dementia care training, as of 3/8/24, was only 2.25 hours of dementia education. CNA 12's resident right training was not completed until 7/27/23 and only included 1 hours of resident rights education. She did not have any abuse training prior to working with residents and no subsequent abuse training. 2. Non-licensed care giver (NLCG) 13 started on	R 0120	R 120 1 All employee files will be audited to ensure compliance orientation paperwork. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Community compiled a scheduled in-service schedule for all new hires. In addition, the Community has begun and will continue to hold documented, monthly all staff meetings. All staff training to include, but not limited to, topics such as resident rights, abuse, and dementia. In addition, the Executive Director or designee will audit all new hire employee files to ensure that all required documentation is present in the employee file. 4 The Executive Director or designee will select five random employee files weekly four weeks, then monthly for three months, then quarterly thereafter for two quarters to ensure compliance	05/01/2024

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	3/11/23. Within 6 months of hire she did not have the required 6 hours of dementia training, only 1.75 hours of dementia education on 6/9/23 and 9/6/23. Her subsequent dementia training, as of 3/8/24, was only 0.5 hours on 10/24/23. Her resident rights training was not completed until 4/7/23 and only indicated 1 hours of resident rights education. She did not have any abuse training prior to working with residents and no subsequent abuse training. 3. Qualified Medication Aide (QMA) 5 only had 1 hour of resident rights training and no abuse training prior to working with residents. 4. Dietary Aide (DA) 14 did not have any dementia or abuse training. He had 1 hour of resident rights training on 3/8/24, the survey entry date. On 3/11/24 at 12:54 p.m., the Operations Specialist (OS) indicated all employees needed education. On 3/11/24 at 3:19 p.m., the OS indication all employee records should have been correct upon hiring and annually. The whole process needs to be corrected. A current policy titled, "Record Maintenance/Equipment Use," with no date, was provided by the Regional Nurse Consultant (RNC), on 3/11/24 at 4:09 p.m. A review of the policy indicated, " ...Personnel records must be properly assembled and maintained		with required in-servicing. 5 Systemic changes completed: May 1, 2024	

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	...Employment record related to job positions ...Orientation and training records related to in-service requirements ...."			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.			

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	(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure health screenings and at least one baseline tuberculous (TB) screening were completed before hire, with subsequent TB screenings to complete a baseline 2 step TB process for 4 of 5 employees reviewed. These deficiencies had the potential to effect 72 of 72 assisted living resident and assisted living memory care (MC) residents residing in the facility. Findings include: Employee files were reviewed on 3/11/24 at 10:30 a.m. 1. The MC Director (MCD) started on 9/26/22. She had her first TB screening by injection on 9/26/24 and her 2nd TB screening by injection on 10/18/22. The second injection was 22 days after the first injection for TB screening. The requirement for time between injections was 7 to 21 days. On 3/11/24 at 3:10 p.m., the Operations Specialist (OS) indicated she did have a second TB screening by injection, but it was one day late. She did not have a TB assessment in 2023 or so far in 2024 until the survey team entered the facility for an annual survey on 3/8/24. 2. Certified Nursing Aide (CNA) 12's employee file was reviewed. She started on 10/21/22.	R 0121	R 121 1 The Community will review all employee records for deficient practices. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Executive Director or designee will audit all new hire employee files to ensure that required tuberculin skin test documentation is present in the employee file. 4 The Executive Director or designee will audit all new hire employee records within the first 21 days of hire to ensure TB compliance. The Wellness Director or designee will audit five random employee files weekly four weeks, then monthly thereafter for five months. 5 Systemic changes completed: May 1, 2024	05/01/2024

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HARRISON AT EAGLE VALLEY, THE	3060 VALLEY FARMS ROAD INDIANAPOLIS, IN 46214

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	She did not have a health screening prior to working with the residents. CNA 12 had her first baseline TB screening by injection on 2/24/23, several months after she started working with residents. She did not have a second TB screening. 3. Non-licensed care giver (NLCG) 13's employee file was reviewed. She started on 3/11/23. She did not have a health screening prior to working with the residents. She did not have any baseline, TB screenings by injection prior to working with residents. She had no chest x-ray and TB assessments after hire. 4. Dietary Aide (DA) 14's employee file was reviewed. He started on 10/5/23. She did not have any baseline, TB screenings by injection prior to working with residents. He had no chest x-ray and TB assessments after hire. On 3/11/24 at 3:19 p.m., the Operations Specialist (OS) indication all employee records should have been correct upon hiring and annually. The whole process needed to be corrected. The facility had been short in nursing in regards to staff getting tuberculous (TB) screenings. A current policy, titled, "Record Maintenance/Equipment Use," with no date, was provided by the Regional Nurse Consultant (RNC), on 3/11/24 at 4:09 p.m. A review of the policy indicated, " ...Personnel records must be properly assembled and maintained ...Employment record related to job positions ...A			

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	separate personnel file for each Employee Partner should be kept which includes the following ...Medical records ...." 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (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: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			
R 0216 Bldg. 00	Based on interview and observation, the facility failed to complete a medication self-administration assessment for a resident who had a medication at bedside for 1 of 8 residents observed for medications at bedside (Resident N). Findings include: During an observation on 3/8/24 at 1:45 p.m., Resident N was observed sitting in his chair in his apartment. He had oxygen per nasal cannula at 4 liters per minute. Next to him on his table was an inhaler, albuterol. He indicated he used the medication for shortness of breath. On 3/8/24 at 3:00 p.m., a record review was completed for Resident N. He had the following diagnoses which included, but were not limited to,	R 0216	R 216 1 The Community reviewed all residents who self-medicate to ensure each record contained a self-medication assessment. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Community will conduct an in-service on resident self-medication administration for all medication staff. 4 The Wellness Director or designee will audit each resident's record that self-medicates to ensure that an assessment is in the record weekly for four weeks,	05/01/2024

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	CHF (congestive heart failure), OSA (obstructive sleep apnea), A-Fib (atrial fibrillation), HLD (hyperlipidemia), HTN (hypertension), and DM (diabetes mellitus). A medication-self administration assessment was not provided. A policy for medications at bedside for residents who do not self-administer medications was requested and was not provided at the end of the survey.		then monthly for six months. 5 Systemic changes completed: May 1, 2024	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure medications were not crushed without an order, and failed to ensure medications were not crushed that were listed on the do-not-crush list, for 1 of 5 resident reviewed for medication pass (Resident BB). Findings include: During observation on 3/8/24 at 12:36 p.m., Qualified Medication Aide (QMA) 6 prepared a medication to be administered to Resident BB. She indicated that the resident received all her meds crushed and given in applesauce. She could not find an order to crush resident BB's medications in the electronic medical record (EMR). LPN 7 could not locate an order to crush medications in the	R 0241	R 241 1 The Community reviewed all resident medications to ensure that the delivery method matched the physician order. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Community will conduct an in-service on medication administration, including crushing medications, for all medication staff. 4 The Community received a list of do not crush medications	05/01/2024

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	paper chart, and asked if an order to crush medications was required. QMA 6 indicated the resident received all her medications crushed and mixed in applesauce and had always taken them that way. When asked if Resident BB had any medications that could not be crushed, the QMA indicated she did not know. The medication list was reviewed by the QMA who reviewed all the meds that she administered for the 8:00 a.m. medication pass and indicated that they were all given crushed and in applesauce. Medications listed included Metoprolol Succinate Extended Release (ER) and Venlafaxine 150 milligrams (mg) ER. When the QMA 6 asked LPN 7 what medications could not be crushed, LPN 7 indicated heart medications and any capsule that had beads in them. LPN 7 asked if crushing medications that were not supposed to be would decrease their effectiveness. When asked if they had a list of medications that were not able to be crushed, QMA 6 indicated that it used to hang up behind the door but was not there anymore. LPN 7 advised QMA 6 that the list should be in the narcotic logbook, they did not find one in the book. QMA 6 then crushed the medication she indicated to be dicyclomine 20 mg (used to treat a certain type of intestinal problem called irritable bowel syndrome), mixed it in applesauce, and gave it to Resident BB. QMA 6 indicated she was the one who administered all the resident's 8:00 a.m. medications that day and indicated that she gave them all to her crushed and mixed in applesauce. Resident BB's record was reviewed on 3/8/24 at 2:48 p.m. The profile indicated the resident's diagnosis included, but was not limited to, anxiety (what we feel when we are worried, tense or afraid), dementia (declining cognitive abilities of remembering, thinking, or making decisions),		that were placed on each med cart for each staff member to reference. An audit of each resident that receives crushed medications will be conducted weekly for four weeks, then monthly thereafter for five months. 5 Systemic changes completed: May 1, 2024	

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	depression (a constant feeling of sadness and loss of interest), hypertension (high blood pressure), hypothyroidism (condition where the thyroid doesn't create and release enough thyroid hormone into the bloodstream), and insomnia (condition of not sleeping as one should). A physician's order, dated 11/17/23, Trazodone tablet (tab) 50 mg (milligrams) (an antidepressant that is sometimes prescribed as a sleep aid), take one tablet by mouth at bedtime. Venlafaxine (treats depression) cap (capsule) 150 mg ER (extended release) one cap by mouth once daily, and Metoprolol Succinate tab 100 mg ER one tab by mouth once daily. A medication administration record for the month of March 2024 indicated that QMA6 administered all Resident BB's scheduled medications for the entire day of 3/8/24. During an interview on 3/11/24 at 12:01 p.m., the Wellness Director (WD) indicated that if a resident received medications crushed, they needed to have an order for that medication and that physicians will indicate it to be crushed on their order sheet. She indicated that they had recently provided an in-service education related to do not crush medications and handed out the do not crush list of medications to them. A copy of the most recent in-service was requested but not provided. On 3/8/24 at 2:48 pm., the Executive Director (ED) provided and identified a document as a current facility policy, titled, "February 2023-Resource#390224 Meds That Should Not Be Crushed." The policy indicated, " ...Crushing extended-release meds can result in administration of a large dose all at once. Crushing			

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	delayed-release meds can alter the mechanism designed to protect the drug from gastric acids or prevent gastric mucosal irritation. Crushing sublingual or buccal tabs can alter effectiveness ...Crushing irritating or hazardous meds can be harmful to the individual crushing the meds ...Medications that should not be crushed ...Metoprolol Succinate ...Trazodone ...Venlafaxine ...."			
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to add a diagnosis (reason for being administered) to medication orders which had the potential to affect 3 of 9 residents reviewed for medication orders (Residents H, E, and T). Findings include: 1. A record review was completed on 3/11/24 at 10:10 a.m. for Resident H. She had the following diagnoses which included, but not limited to, HTN (hypertension). She had orders for medications which lacked diagnoses for use. a. Calcium +D 600/800 (a supplement) b. Diclofenac Gel 1% (used for pain) c. Exelon capsule 3mg (used for memory loss) d. Crestor 10mg (used for hyperlipidemia) e. Vitamin D3 capsule 50mcg (a supplement) 2. A record review was completed for Resident T. She had the following diagnoses which included, but not limited to, A-Fib (atrial fibrillation), CHF (congestive heart failure), and COPD (chronic	R 0299	R 299 1 The Community reviewed each resident's medication administration record (MAR) to ensure that each medication order had a diagnosis or reason for administration. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 An in-service will be conducted with all care staff, discussing the need for diagnosis added to medications on the MAR. In addition, the Community will add diagnosis to all medications listed on the MAR. 4 The Wellness Director or designee will audit the MAR for compliance with diagnosis listed on the MAR with the medication weekly for four weeks, then	05/01/2024

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	obstructive pulmonary disease). She had orders for medication which lacked a diagnosis for use. a. Alendronate 70mg (used to treat OP (osteoporosis) b. Atorvastatin 20mg (used to treat hyperlipidemia) c. Olopatadine sol. 0.2% (used to treat itchy eyes) d. Tumeric 500mg (used as an antiflammatory) e. Vitamin B-12 100mcg (a supplement) f. Xidra drops 5% (use to treat dry eyes) 3. On 3/11/24 at 10:30 a.m., a comprehensive record review was complete for Resident E. She had the following diagnoses which included but not limited to SOB (shortness of breath), HTN (hypertension), and weakness. She had orders for medications which lacked a diagnosis for use. a. Acyclovir 200mg (used to treat herpes infections) b. Albuterol Neb 0.083% (used to treat SOB) c. Amlodipine 5mg (used to treat HTN (hypertension) d. Aspirin 81mg (preventative) e. Atorvastatin 20mg (used to treat HLD) f. Azelastine Spray 0.15% (used to treat symptoms such as sneezing) g. Bethanechol 25mg (used for the bladder) h. Centrum 50+ (a supplement) i. Ciprofloxacin 250mg (used for infections) j. Doxycycline 100mg (used for infections) k. Magnesium Oxide 250mg (a supplement) l. Metoprolol Suc 100mg ER (used to HTN) m. Pot Chloride 10meg (a supplement) n. Risperidone 2mg (used to treat psychotic disorders) o. Sertraline 100mg (used to treat depression) p. Spiriva Resp 2.5mcg/act (used to treat COPD) q. Toresemide 20mg (used to treat HTN) r. Vitamin D3 25mcg (a supplement)		monthly thereafter for five months. 5 Systemic changes completed: May 1, 2024	

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	During an interview on 3/11/24 at 3:08 p.m., a policy titled, "New Orders," was provided by the OS (Operations Specialist) and the OS indicated it was the current policy. It indicated, " ...If the order is a medication order, write the name of the medication, strength, amount, route of administration, frequency, and reason for being taken ...."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and interview, the facility failed to ensure medications were dated when opened and failed to provide a label for medications which had the potential to affect 8 of 14 residents reviewed for medication storage (Residents KK, CC, K, EE, FF, DD, GG, and HH). Findings include: 1. Resident KK had a bottle of melatonin inside the medication cart with no label directing staff how to use the medication. The label only had her last name on it. 2. Resident CC had a bottle of vitamin D inside the medication cart with no label and only her last name. 3. Resident K had a Lantus insulin pen with no date to indicate when it was opened. 4. Resident EE had a bottle of artificial tears and a bottle of refresh lacri-lube ointment with no date	R 0300	R 300 1 The Community will audit all medication carts to ensure that all open medications are appropriately labeled and dated. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 All over the counter medications will be labeled with a name, date opened, and expiration date. An in-service will be conducted with all care staff instructing them to label all OTC medications, including date opened. 4 The Wellness Director or designee will audit the medication carts weekly for four weeks, then monthly thereafter for five months. 5 Systemic changes	05/01/2024

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	to indicate when they were opened. 5. Resident FF had a bottle of Systane with no date to indicate when it was opened. 6. Resident DD had a bottle of latanoprost 0.005% and a bottle of timolol mal sol 0.5% with no date to indicate when they were opened. 7. Resident GG had a bottle of D3, acetaminophen, vitamin b, iron, aspirin and allergy relief with no label to indicate how to use the medication. 8. Resident HH had a bottle of acetaminophen and D3 with no label to indicate how to use the medication. A policy titled, "Storage of Medications" was provided by the OS (Operations Specialist) on 3/11/24 at 1:30 p.m. It indicated, " ...If a resident has his/her over the counter (OTC) medications stored in the medication cart, each OTC medication must be labeled with the resident's name, apartment number and date the medication was opened. Follow the state licensing regulation requirement for OTC labeling ...."		completed: May 1, 2024	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection			

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	transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to ensure gloves were worn during insulin administration for 1 of 1 resident observed for medication pass (Resident Y). Findings include: On 3/8/24 at 11:47 a.m., Licensed Professional Nurse (LPN) 7 was observed to inject Novolog insulin for Resident Y without wearing gloves. Resident Y's record was reviewed on 3/11/24 at 12:58 p.m. The profile indicated the resident's diagnoses included, but was not limited to, type 2 diabetes (DM2) (a disease that occurs when your blood glucose, also called blood sugar, is too high). A physician's order, dated 12/15/23, Novolog injection flexpen (pre-filled insulin medication injector) inject 10 units subcutaneously (under the skin) three times daily, before meals. A physician's order, dated 12/15/23, Novolog injection flexpen, inject subcutaneously per sliding scale three times daily. Blood Sugars between 151 and (-) 200 inject 1 unit (U), 201-250 inject 2 U, 251-300 inject 3 U, 301-350 inject 4 U, greater than 351 inject 5U. During an interview on 3/11/24 at 12:01 p.m., the Wellness Director indicated staff were required to wear gloves during insulin administration. On 3/8/24 at 2:48 p.m., the Executive Director (ED) provided and identified a document as a current	R 0407	R 407 1 Resident Y was assessed to ensure that there were no observable signs of infection at the injection site. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 An in-service will be conducted with all care staff to educate on proper infection control, such as wearing gloves during medication administration. 4 The Wellness Director or designee will randomly audit five staff members while completing an insulin administration for compliance weekly for four weeks, then monthly thereafter for five months. 5 Systemic changes completed: May 1, 2024	05/01/2024

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	facility policy, titled, "Health Related Services Ops Manual" with a date of 8/17. The policy indicated, " ...Subcutaneous injections ...3. Equipment necessary for the administration of subcutaneous insulin ...gloves ...."			