STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN CROSSING AND THE LOFTS	**5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to answer a call light for a resident in pain (Resident E) for 1 of 3 residents reviewed for dignity, and failed to knock on residents' doors before entering the room (Residents 6, E, and 125) for 3 of 3 residents reviewed for dignity. Findings include: 1. On 3/4/2020, during a continuous observation, and interview, from 2:45 p.m., until 3:35 p.m., Resident E was observed waiting on a call light. At 2:45 p.m., she was observed laying in her bed, in a hospital gown. She indicated her left hand and arm were hurting pretty bad, and wanted her arm repositioned on the pillow next to her. She was unable to lift her left arm by herself, and could not reach her right arm across her body to reposition the left. Her call light was observed far out of reach, behind the mattress and looped around the top of the bed frame. Resident E was uncomfortable, and groaned in pain as she waited. The call light was pushed for the resident at this time. At 2:53 p.m., and unidentified Housekeeper was observed vacuuming the floors outside of Resident E's room, directly under the room's illuminated call light. At 3:09 p.m., Certified Nursing Assistant (CNA) 24 entered the room without knocking, and assisted Resident E's roommate to the bathroom. At 3:23 p.m., CNA 24 entered the room without knocking, and assisted Resident E's roommate back into bed. At 3:30 p.m., CNA 24 entered the room without knocking, and asked Resident E what she would like for dinner. Resident E indicated to CNA 24 that her hand was hurting really bad, and she wanted it propped back up on the pillow. When CNA 24 lifted Resident E's arm, she cried out in pain, and her whole body tensed up and her eyes squinted shut. CNA 24 stopped moving the resident's arm, until she was ready, then slowly repositioned her arm onto a pillow. CNA 24 indicated her hand was really swollen and probably stiff from sitting in that same position for a long time. CNA 24 indicated she would let the nurse know about the pain and swelling. When the CNA left the room, Resident E asked how long she waited, it was 45 minutes. On 3/5/2020 at 11:32 a.m., Resident E was observed laying in her bed. She indicated she was ready to get her bed bath, and pressed her call light. On 3/5/2020 at 11:34 a.m., CNA 23 entered Resident E's room without knocking, turned off the call light but left the resident's room. CNA 23 stopped at the door frame and spoke to an unidentified housekeeper. The CNA was informed that Resident E had her call light on because she was ready for her bed bath. CNA 23 replied to the visitor, well she'll have to hold on I can't be in two places at once. During an interview on 3/4/2020 at 3:40 p.m., the Administrator indicated, his expectation would be for a resident to wait no longer than 15 minutes for a call light to be answered. On 3/4/2020 at 3:00 p.m., Resident E's medical record was reviewed: Resident E had [DIAGNOSES REDACTED]. A nursing progress note, late dated for 3/4/2020, was entered on 3/5/2020 at 9:53 a.m. The progress note indicated, .patient has left sided weakness 2. During an interview with Resident 125, on 3/2/2020 at 9:35 a.m., CNA 14 knocked on the resident's door, and without waiting for permission came into the room. She was carrying bed sheets. 3. During an interview with Resident D, on 3/4/2020 at 11:05 a.m., Certified Nursing Aide (CNA) 28 knocked on the resident's door, and without waiting for permission, came into the room. She removed the breakfast tray, and closed the door as she left. During an interview, on 3/4/2020 at 12:16 p.m., the Regional Consultant indicated staff should have knocked on doors and waited for permission to enter before going into a resident's room. On 3/6/2020 at 4:00 p.m., the DON provided a copy of current facility policy, titled, Resident Rights, dated, 8/11/2017. The policy indicated, . when providing care, staff will, i. Knock before entering resident room if door is closed- wait for answer. 1. If no answer, knock second time before entering and announce your entrance. ii. Staff will speak respectfully to residents . c. to have a method to communicate needs to staff: i. Call light or bell access will be within reach of the resident as one method to communicate needs to staff. 1. Staff will answer call needs promptly 2. Any staff within the vicinity will answer a call light a. Notify the appropriate personnel for care needs
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure privacy was provided during an injection for a resident (Resident 37), failed to ensure medications were not given in the main dining room for a resident (Resident 59), and failed to ensure medications were not given in the activity room for a resident (Resident 27) for 3 of 11 medication administration observations. Findings include: 1. On 3/5/2020 at 11:07 a.m., Licensed Practical Nurse (LPN) 13 was observed as she gave Resident 37, a scheduled [MEDICATION NAME] 70/30 (insulin) injection, in the public hall. Privacy was not provided, as another unidentified resident was observed in the hall near the medication cart, where LPN 13 lifted Resident 37's hooded sweatshirt and tee shirt, she exposed his abdomen, and she did not wipe his skin with an alcohol wipe, but injected his abdominal skin. 2. On 3/5/2020 at 11:36 a.m., Registered Nurse (RN) 26 was observed as she gave 2 medications to Resident 59 while the resident was in the main dining room. Eight other residents were present in the main dining room, 2 unidentified residents watched the resident take her medication. 3. On 3/5/2020 at 11:42 a.m., RN 26 was observed as she gave one narcotic medication to Resident 27 while he was in the activity room. The resident was sitting next to the large glass floor-to-ceiling wall exposing him to, other residents, visitors and staff, who entering the building or walked down the main hallway. During an interview, on 3/6/2020 at 8:55 a.m., the Regional Consultant indicated LPN 13 was re-educated about providing privacy during resident medication administration. During an interview, on 3/6/2020 at 9:03 a.m., the Regional Consultant indicated medications should not be given in the dining room or the activity room. A current policy, titled, Medication Administration, dated 5/29/19, was provided by the Regional Consultant on 3/5/2020 at 12:11 p.m. A review of the policy indicated, .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident .provide for privacy/dignity . 3.1-3(p)(2)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported within 2 hours, for 1 of 1 residents reviewed for abuse, (Resident 18). Findings include: On 3/4/2020 at 9:15 a.m., Resident 18 was observed in her room, the head of her bed was elevated so that she was sitting upright. She indicated she was not doing well, because she was upset about what happened the night before. She indicated she had been abused by Certified Nursing Assistant (CNA) 21. Resident 18 indicated, last night, around 10:00 p.m., CNA 21 was supposed to be taking care of her, but he was very rude to her, and made threats at her, which made her very angry and were embarrassing. She indicated, she had been on the bedpan, and CNA 21 was supposed to come help her get off. She knew she was a large woman

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

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) and it was hard for her to turn and because she was already in pain, she was moving slow. Too slow for CNA 21, because he rushed her, and reached across her, grabbed her left shoulder and jerked her to the side, so he could get the bedpan. She yelled at him and told him to stop, that he was being too rough with her and it hurt, but he did not believe her and whispered treats, someone ought to give you a spanking, and I thought you went to the hospital, I can't believe they let you back. Then when he finally got her off the bedpan and cleaned up, Resident 18 indicated, CNA 21 indicated, you should just be glad I did get you off the bedpan, I could have left you. Resident 18 indicated she told CNA 21, he could not leave her on the bedpan, because he would get in trouble, but CNA 21 said he would not get in trouble, he would just tell his nurse, and he had other things to do. Resident 18 indicated, everything he said to her, was whispered, in a real low voice, because he did not want anyone to hear. Resident 18 indicated, she got angry and frustrated with CNA 21 because he was rough with her, so she fussed at him, and he just kept fussing back at her. When she tried to put her oxygen nasal cannula back on, CNA 21 kept trying to swat her hands away, and told her, to let him do it. She was mad, and jerked it way, and said she would do it, which made him smack her hands harder and jerked the oxygen away from her again. Resident 18 indicated, she thought he was in the room, harassing her, for about 10-15 minutes, and she yelled for help several times, but the nurse must have been passing medications because no one came. Resident 18 became tearful, and indicated she was not afraid of CNA 21, but he did hurt her shoulder, he was mean, and it made her very angry. Resident 18 indicated when CNA 21 finally left the room, she called the nurse, (LPN 20), and told her what happened. The nurse listened, but did not believe her, and then brought CNA 21 back into her room, to confront Resident 18 about her accusations. Resident 18 indicated, the CNA denied it all, and she told the nurse, she was going to report it. Resident 18 indicated she told the Administrator what happened, and filed a police report. During the entrance conference on 3/2/2020 at 9:28 a.m., the Director of Nursing, (DON) indicated, he was on call and available to staff 24 hours a day, 7 days a week. During an interview on 3/6/2020 at 2:15 p.m., the DON and Administrator (ADM) they did not become aware of the incident until the next morning. The nurse had attempted to contact them, but they were sleeping, and woke up to missed call and text messages, so the incident was reported the next morning by 7:00 a.m. The Administrator indicated he remembered something about reporting within a 2 hour limit, but that it was more of a guideline. During the entrance conference on 3/2/2020 at 9:28 a.m., the Administrator provided a copy of current facility policy titled, Indiana Abuse & Neglect & Misappropriation of Property, dated, 9/1/2017. The policy indicated, .definitions: abuse/battery: Indiana defines abuse/battery as a person who knowingly or intentionally touches another person in a rude, insolent or angry manner . mental abuse in Indiana, verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotional suffering .examples: humiliation, harassment, threats of punishment or deprivation, bullying . It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents . In the event an allegation is make, the facility will take measured to protect residents from harm during the investigation. Accurate and timely reporting of incidents . VII. Reporting of Incidents and Facility Response. 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made . a. if the events that cause the allegations involve abuse and/or serious bodily injury the self-report must me made immediately, but not later than two (2) hours after the allegation is made 3.1-28(c)
F 0641 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were correctly coded for 4 of 19 residents reviewed for MDS assessments (Residents 15, 70, 73, and 39). Findings include: 1. On 3/4/2020 at 11:12 a.m., the medical record was reviewed for Resident 15. Resident 15's [DIAGNOSES REDACTED]. A Care Plan, dated 2/1/2020, indicated Resident 15 was . a Level II due to her [DIAGNOSES REDACTED]. On 3/3/2020 at 3:50 p.m., the Regional Consultant provided a copy of Resident 15's Pre-Admission Screening and Resident Review (PASRR) Levels I and II. The Level I, dated 9/7/2019, indicated Resident 15 required a PASRR Level II. The level II, was dated 9/16/19. The PASRR assessments indicated Resident 15 required a Level II evaluation, because she was mentally ill, and had a developmental disability. A review of Resident 15's comprehensive admission Minimum Data Set assessment (MDS), dated [DATE], and quarterly assessments, dated 9/24/2019, and 1/9/2020, indicated Resident 15 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. On 3/4/2020 at 12:20 p.m., during an interview, the MDS Coordinator indicated, the MDS assessment was wrongly coded for Resident 15's PASRR Level II. It would require a correction to be entered. The Resident Assessment Instrument (RAI) was followed to code the MDS. 2. On 3/4/2020 at 10:49 a.m., the medical record was reviewed for Resident 70. Resident 70's [DIAGNOSES REDACTED]. A Care Plan, dated 2/2/2020, indicated Resident 70 was . a Level II due to his [DIAGNOSES REDACTED]. The Level I, dated 7/25/2019, indicated Resident 70 required a PASRR Level II. The level II, was dated 8/8/2019. The PASRR assessments indicated Resident 70 required a Level II evaluation, because he was mentally ill, with [DIAGNOSES REDACTED]. A review of Resident 70's comprehensive admission Minimum Data Set assessment (MDS), dated [DATE], indicated Resident 70 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. On 3/4/2020 at 12:20 p.m., during an interview, the MDS Coordinator indicated, the MDS assessment was wrongly coded for Resident 15's PASRR Level II. It would require a correction to be entered. The Resident Assessment Instrument (RAI) was followed to code the MDS. 3. On 3/5/2020 at 10:00 a.m., the medical record was reviewed for Resident 73. Resident 73's [DIAGNOSES REDACTED]. A current physician's orders [REDACTED].#16 with 10 milliliter (balloon) to continuous drain. [DIAGNOSES REDACTED]. Provide privacy bag. A Care Plan, with a start date of 2/10/2020, indicated Resident 73 had . an Indwelling Catheter related to [MEDICAL CONDITION]. A review of Resident 73's comprehensive admission Minimum Data Set assessment (MDS), dated [DATE], indicated Resident 73 did have an indwelling urinary catheter. The most recent quarterly MDS assessment, dated 11/17/2019, indicated Resident 73 did not have an indwelling catheter, or intermittent catheterization. On 3/4/2020 at 12:32 p.m., during an interview, the MDS Coordinator indicated, the MDS was coded wrong for Resident 73's catheter. The resident's indwelling catheter was discontinued at one time, and they were doing intermittent catheterizations. Then, they had replaced the indwelling catheter, due to skin breakdown. The MDS should have indicated the resident had an indwelling catheter. The Resident Assessment Instrument (RAI) was followed to code the MDS. 4. On 3/4/2020 at 12:29 p.m., Resident 39's medical record was reviewed. The most recent comprehensive assessment, was a quarterly Minimum Data Set (MDS) assessment dated [DATE]. The MDS indicated resident 39 had an active [DIAGNOSES REDACTED]. Resident 39 did not have a current or discontinued physician order [REDACTED]. On 3/5/2020 at 1:28 p.m., the Reginal Consultant provided a current policy, dated 11/15/19, titled, MDS Responsibilities. This policy indicated, .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents .The interdisciplinary assessment shall be completed for all residents utilizing the Resident Assessment Instrument (RAI)-Minimum Data Set 3.0 (MDS) based upon oral or written communication, resident, family, interview and assessments provided by the IDT (Interdisciplinary) team members
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to create a baseline care plan, for 1 of 3 residents reviewed for baseline care plans (Resident 52). Findings include: On 3/5/2020 at 9:54 a.m., the medical record was reviewed for Resident 52. The [DIAGNOSES REDACTED]. The resident record contained no baseline care plans. On 3/5/2020 at 11:30 a.m., the Administrator provided a copy of Resident 52's blank baseline care plan document. On 3/5/2020 at 11:31 a.m., during an interview, the Director of Nursing indicated Resident 52's baseline care plans were blank, they were never completed, and she did not have comprehensive care plans entered during the 48 hour period, after admission. She should have had care plans completed in the first 48 hours, from the admission date of [DATE]. The first comprehensive care plans in the system were dated 2/2/2020. That was out of the required time range. On 3/5/2020 at 1:28 p.m., the Regional Consultant provided a current policy, dated 12/11/2017, titled, Baseline Care Plan/48 Hour Care Plan. This policy indicated, .A 48 hour care plan is the initial care plan that is created upon admission to the facility to address specific immediate needs with a focus on safety .the care plan must be completed within 48 hours of admission 3.1-30(a)

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to initiate or implement comprehensive care plans for 4 of 23 residents reviewed for care plans (Resident 13, 20, E, and 70), Findings include: 1. On 3/5/2020 at 10:11 a.m., Resident 13's record was reviewed. His [DIAGNOSES REDACTED]. His current physician's orders [REDACTED]. levetiracetam (a medication used to treat [MEDICAL CONDITION]) tablet 750 mg (milligrams), give 1 tablet by mouth two times a day for cerebral infarction related to [MEDICAL CONDITION]. b. [MEDICATION NAME] (a medication used to treat [MEDICAL CONDITION] and migraine headaches) tablet 100 mg, give 1 tablet by mouth two times a day for [MEDICAL CONDITION] disorder. c. carvedilol (a medication used to treat high blood pressure) tablet 25 mg, give 1 tablet by mouth two time a day for hypertension. d. atorvastatin calcium (a medication used to treat high cholesterol) tablet 49 mg, give 40 mg by mouth at bedtime for [MEDICAL CONDITION] (condition in which there are high levels of fat particles (lipids) in the blood). During an interview, on 3/6/2020 at 4:11 p.m., the Director of Nursing (DON) indicated the resident did not have care plans for [MEDICAL CONDITION], hypertension, or [MEDICAL CONDITION]. His expectation was when a resident was admitted or as medications were added with diagnoses, then care plans would have been added. 2. On 3/3/2020 at 9:40 a.m., Resident 20 was observed wearing a nasal cannula (NC), she indicated her oxygen (O2) level was 4 liters per minute. There was no container of water on the oxygen concentrator to humidify the oxygen. On 3/5/2020 at 2:54 p.m., Resident 20's medical record was reviewed. Her [DIAGNOSES REDACTED]. Her current physician's orders [REDACTED]. She had a comprehensive care plan, dated 9/30/2019, for oxygen therapy, with instructions to use, humidified, oxygen. During an interview, on 3/5/2020 at 2:58 p.m., the Regional Consultant indicated Resident 20's care plan was incorrect, the O2 does not need to be humidified. Her care plan was a template and not resident specific. A current care plan, titled, Plan of Care Overview, dated 5/30/2019, was provided by the Regional Consultant on 3/5/2020 at 1:54 p.m. A review of the policy indicated, .Care Plan is the written treatment provided for a resident that is resident-focused and provided for optimal personalized care 3. On 3/4/2020, during a continuous observation from 2:45 p.m., until 3:35 p.m., Resident E was observed laying in her bed. She was wearing a hospital gown, and her left hand was partially propped up on a pillow. Resident E indicated she did not mind wearing the hospital gown in bed, but she would like to be dressed when she got up. Except she was not able to get up out of bed because something was wrong with her wheelchair, and it took two staff members to get her out of bed due to her size and weight. Her feet were cold, and she did not have socks on. Resident E had not been talked to about her daily routine preferences, food likes/dislikes, and no one had talked with her about the pain and swelling in her left hand. She did not have any pressure sores that she was aware of, and did not know if staff were supposed to help turn and reposition her in bed, because she was unable to do so for herself. On 3/4/2020 at 3:00 p.m., Resident E's medical record was reviewed. Resident E had [DIAGNOSES REDACTED]. for care, or nursing care needs, in the following areas which included but were not limited to: a. positioning b. her left sided weakness, pain/swelling in her hand c. Activities of Daily Living self-performance deficit: transfers, bed mobility, toileting, personal hygiene . d. her risk of developing pressure/diabetic ulcers e. how to care for and treat her [DIAGNOSES REDACTED]. f. activity and daily routine preferences, i.e. wearing socks, wearing a hospital gown, getting up by a certain time of day . During an interview on 3/6/2020 at 10:40 a.m., the Regional Nurse Consult indicated, comprehensive care plans are completed within 14 days. At this time she provided a copy of current facility policy, titled, Plan of Care Overview, revised 7/26/2018. The policy indicated, .Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care . the facility will: .iii. Review care plans quarterly and/or with significant changes in care 4. On 3/3/2020 at 10:07 a.m., during an observation, and interview, Resident 70 was seated in a wheel chair in the entry area of the facility. He indicated he had had 4 [MEDICAL CONDITION] in one day. His left arm rested on a flat platform affixed to the wheelchair arm. His left arm appeared immobile, his fist was clinched, and contracted. He moved, and repositioned his left arm with his right hand, but was unable to extend his fingers. He was no longer receiving any therapy, or assistance with range of motion (ROM) exercises. On 3/4/2020 at 10:49 a.m., the medical record for Resident 70 was reviewed. The [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A current care plan, dated 2/5/2020, indicated Resident 70 had [MEDICAL CONDITION]/[MEDICAL CONDITION] related to a stroke. The goal indicated Resident 70 would maintain optimal status, and quality of life, within limitations imposed by L-side [MEDICAL CONDITION]/[MEDICAL CONDITION], through review date 5/5/2020. The interventions included: Give medications as ordered. Monitor/document for side effects and effectiveness. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Pain management as needed. See MD orders. Provide alternative comfort measures PRN (as needed). PT, OT (occupational therapy), ST (speech therapy) evaluate and treat as ordered. There was no care plan related to ROM exercises, or a splint for Resident 70, to maintain mobility or prevent a decrease in ROM. There were no care plans that indicated Resident 70 refused ROM, a splint, or any care. Resident 70's quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident 70 had a functional limitation in range of motion, with impairment of his upper and lower extremity, of one side. The section for restorative ROM indicated 0 for passive and active ROM. Splint or brace was coded as 0. On 3/5/2020 at 11:02 a.m., during an interview, Physical Therapist 29 indicated Resident 70 was no longer receiving therapy services. He had been given a splint but he was not compliant with putting it on, and wearing it. The resident was taught to put on his own splint, and do passive ROM on his left wrist, using his right hand. It was his own responsibility, he was non-compliant, and refused to do it. There was no documentation for monitoring the splint or ROM. Nursing did not have to monitor it because it was not a nursing order, it was the resident's responsibility. He should do it himself. On 3/5/2020 at 11:19 a.m., during an interview the Director of Nursing indicated, Resident 70's care plan had been updated today. It should have been put in prior to today. On 3/5/2020 at 1:28 p.m., the Regional Consult provided a current policy, dated 11/15/19, titled MDS responsibilities. This policy indicated interdisciplinary assessment shall be completed for all residents utilizing the Resident Assessment Instrument .the comprehensive care plan must be completed by day 21 after admission or 7 days after the MDS is completed 3.1-35(a)(1) 3.1-35(b)(1) 3.1-35(b)(2)

F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with a diabetic ulcer (open sore or wound) of the left heel and midfoot was assessed when developing altered mental status [MEDICAL CONDITION] (a systemic infection) (Resident B) and the facility failed to ensure the development of a wound care plan, weekly wound assessments and daily dressing changes were completed (Residents E) for 2 of 4 residents reviewed for wounds. The facility failed to assess a resident with new onset pain and swelling of the arm for 1 of 1 resident randomly observed with pain (Resident C). Findings include: 1. On 3/5/20 at 2:00 p.m., a review of Resident B's medical record indicated the resident was admitted to the facility, from the (Name of Hospital) on 1/24/20 with the diagnoses, included but not limited to, non-pressure chronic ulcer of the left heel and midfoot. Resident B did not have a [DIAGNOSES REDACTED]. An Admission Minimum Data Set (MDS) assessment, dated 1/31/20, indicated Resident B was cognitively intact, was an extensive assist of two staff with bed mobility, transfers, toilet use and personal hygiene. The resident was always incontinent of urine and frequently incontinent of bowel, reported occasional pain, described at 4 of 10, and received scheduled routine pain medication. The resident did not have, but was at risk for developing pressure ulcers. The resident did have diabetic ulcers on his feet, but did not have an infection. A care plan, dated 1/28/20 and revised on 2/4/20, indicated Resident B had three diabetic ulcers on his left heel/ankle, right ankle, and left foot. Interventions included, but were not limited to, monitor/document wound: size, depth, margins, including periwound (surrounding) skin, sinuses, undermining, exudates (drainage), [MEDICAL CONDITION], granulation, infection, necrosis, eschar, or gangrene. Document progress in wound healing on an ongoing basis. Monitor, document, and report to doctor any signs or symptoms of infection: green drainage, foul odor, redness, and swelling. Treat wound as per facility protocol. physician's orders [REDACTED]. A physician's orders

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) [REDACTED]. A physician's orders [REDACTED]. Resident B's February Treatment Administration Record (TAR) was reviewed, and indicated the scheduled daily treatments for the wounds had been completed daily, as ordered, no concerns noted on the TAR for the resident's wounds. Initial Non-pressure Skin Grids, dated 1/24/20, indicated Resident B was admitted to the facility with wounds, a left heel wound, which was documented as unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) without exudate (drainage) and with no additional documented wound measurements noted and a left foot dorsal wound, which measured length 2.5 centimeters (cm) x (by) width 2 cm x depth 0.2 cm without exudate. Non-pressure Skin Grids, dated 1/29/20, indicated Resident B's left heel wound, measured 7 cm x 7 cm x 0.1 cm, with partial thickness skin loss and a small amount of foul purulent exudate noted and a left dorsal foot wound which measured 0.3 cm x 1.6 cm x 0.1 cm without exudate, with a note on both skin grids which indicated, new patient to facility, areas assessed by the NP (nurse practitioner), wounds classified as diabetic with secondary [MEDICAL CONDITION] (localized swelling of the body caused by an abnormal accumulation of lymph). Non-pressure Skin Grids, dated 2/5/20, indicated Resident B's left heel wound, measured 6.1 cm x 7 cm x 0.1 cm with an odor and a medium amount of blood tinged exudate and left dorsal foot wound, which measured 1.8 cm x 1.2 cm x 0.1 cm without exudate, with an Nurse Practitioner (NP) summary of care and treatment note, which stated wounds were stable and the resident had been refusing medications and not eating or drinking well, with education provided on importance of nutrition and hydration to improve wounds. A skilled documentation assessment, dated 2/8/20, indicated Resident B had an alert mental status with no identified concerns noted. A skilled documentation assessments, dated 2/9/20 and 2/10/20, indicated Resident B was mentally alert and within normal limits for the resident with no issues or concerns with skin or wounds noted. A progress note, dated 2/10/20 at 11:00 p.m., indicated Resident B's sister walked up to writer and indicated Resident B looked declined. Writer assessed resident but resident did not show any sign of distress. Resident's sister called ambulance and Resident B was taken to the hospital. Resident B's hospital record, dated 2/11/20 at 3:19 a.m., indicated family was visiting Resident B at the facility and found the resident to be very confused with poor intake for the last few days. Resident B was brought to the hospital at the family's request. In the emergency department, Resident B was lethargic but arousable, with a noticed significant foul-smelling drainage from his left heel, where the plain imaging (x-ray) showed some gas of the soft tissue and found to have osteo[DIAGNOSES REDACTED]. The resident was admitted to the hospital with [REDACTED]. The hospital podiatry department did not believe resident was a candidate for limb salvage and an amputation of the resident's left lower leg and foot was completed on 2/12/20. A hospital record, social worker note, dated 2/11/20 at 12:12 p.m., indicated social worker had received referral from the emergency room bedside registered nurse for concerns of abuse/neglect, the EMT (emergency medical transport) reported Resident B was covered in urine, with wounds not dressed, the left foot had toes green, and the resident presented to the hospital, with altered mental status, lethargy, and chronic wounds. Facility reported to the EMTs, prior to transport to the hospital, the resident was at his normal baseline. A facility progress note, incident note for Resident B, dated 2/14/20 at 2:11 p.m., indicated record reviewed due to concerns reported to facility by the admitting hospital about resident in urine, in poor condition, and with wounds having foul smell with investigation initiated due to alleged neglect and quality of care. On 3/6/20 at 11:30 a.m., the Director of Nursing (DON) provided the facility's investigation documentation and an undated document, which indicated, the wound NP and DON had assessed Resident B's wounds on the morning before the resident went to the hospital. Resident B was extensively educated by the NP and DON. On 3/6/20 at 3:58 p.m., the DON indicated Resident was assessed at the time of discharge to the hospital and also daily on 2/8/20, 2/9/20 and 2/10/20. Resident B was alert, cognitively intact, able to speak and answer questions appropriately, with no changes in his baseline status. The resident refused fluids and foods at times. The weekly wound assessment, completed on 2/5/20, indicated the resident's wounds were stable and there were no green toes at the time of the assessment. 2. On 3/5/2020 at 1:20 p.m., Resident C was observed sitting in her wheelchair near the 100-hall nurses' station. When she crossed her right leg, over her left leg, the bottom of her pants leg lifted, and a bandage was visible. The edges of the bandage were soiled and discolored a brown/red. The date on the bandage was 3/3/2020. On 3/5/2020 at 3:05 p.m., after Resident C was assisted to bed, the Wound Nurse observed her bandage. The wound nurse indicated the date on the bandage was 3/3/2020, and the brown/red discoloration around the edges of the bandage was blood from the wound draining. The area was not a pressure ulcer, but had started out as a small scabbed area. On 3/5/2020 at 3:10 p.m., at a computer on the 100-hall nurses' station, the Wound Nurse confirmed Resident C's physician order [REDACTED]. The Wound Nurse indicated the bandage should have been changed the day before, then again today by 3:00 p.m., which was missed, and any time in between, if it was bleeding through like it was. The Wound Nurse indicated the area was found on 2/11/2020 for which there was a corresponding Skin-Grid, (wound assessment) to assess and measure the new area, a second Skin-Grid on 2/18/2020, but the one for 2/25/2020 had not been completed, and the one for 3/2/2020, was opened but had not been completed at this time. On 3/5/2020 at 8:57 a.m., Resident C's medical record was reviewed. The most recent comprehensive assessment was a quarterly Minimum Data Set (MDS) assessment, dated, 1/11/2020. The MDS indicated Resident C was severely cognitively impaired, required extensive assistance for her Activities of Daily Living (ADLs) and skin tears were present. Resident C had a current physician order [REDACTED].apply [MEDICATION NAME] to LLE wound and cover with foam dressing daily, and PRN. As needed for wound Resident C's Medication Administration Record [REDACTED]. There was no comprehensive care plan, updated, or initiated, to outline approaches or interventions on how to care for the Resident, and the new wound area. An initial Non-Pressure Skin Grid, dated, 2/11/2020 indicated Resident C had a new area on her left lower leg, .has a scabbed area located on LLE. (Resident) self propels in wheelchair and it appears she has hit her leg on her wheelchair . The area measured 2 cm (centimeters) long, by 1 cm wide, and 0.1 cm deep. Orders for the area were to apply [MEDICATION NAME] to lower leg, cover with foam daily and PRN. A second Non-Pressure Skin Grid, dated 2/18/2020 indicated, the wound measured 1.8 cm long, by 0.9 cm wide, by 0 cm deep, and was improving. The third Non-Pressure Skin Grid was not found. The fourth Non-Pressure Skin Grid was dated 3/2/2020, but closed on 3/5/2020. The assessment indicated the wound was not improving and now measured, 3.2 cm long, by 2.1 cm wide, by 0.1 cm deep, and a referral was made to have Resident C seen by the wound Nurse Practitioner (NP). During an interview on 3/9/2020 at 9:59 a.m., the Wound Nurse indicated, she changed the Resident's bandage already that morning, and it was bleeding less, and indicated it was very important to follow the daily treatments as ordered to promote wound healing. Also, Resident C was picked up for weekly wound rounds, to help ensure the healing process. On 3/9/2020 at 11:30 a.m., the Director of Nursing provided a copy of current facility policy titled, Skin Care & Wound Management Overview dated, 7/1/2016. The policy indicated, .the facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds. The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues . Skin care and wound management program includes, but is not limited to: .application of treatment protocols based on clinical best practice standards for promoting wound healing . Treatment: 6. monitor and document progress On 3/9/2020 at 12:30 p.m., the Director of Nursing provided a copy of current facility policy titled, Standards of Nursing Practice, dated 1/12/2017. The policy indicated, .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents . issues may include but are not limited to monitoring hydration, output, fever, vital signs and other care area that the nurse may initiate During an interview on 3/6/2020 at 10:40 a.m., the Regional Nurse Consult indicated, comprehensive care plans are completed within 14 days. At this time she provided a copy of current facility policy, titled, Plan of Care Overview, revised 7/26/2018. The policy indicated, .Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care .the facility will .iii. Review care plans quarterly and/or with significant changes in care 3. On 3/4/2020, during a continuous observation from 2:45 p.m., until 3:35 p.m., Resident E was observed waiting on a call light, in pain. At 2:45 p.m., she was observed laying in her bed, in a hospital gown. She indicated her left hand and arm were hurting pretty bad, and wanted her arm repositioned on the pillow next to her. She was unable to lift her left arm by herself, and could not reach her right arm across her body to reposition the left. Her call light was observed far out of reach, behind the mattress and looped around the top of the bed frame. Resident E was uncomfortable, and groaned in pain. The call light was pushed for the resident at this time. At 3:30 p.m., CNA 24 entered the room without knocking, and asked Resident E what she would like for dinner. Resident E indicated to CNA 24 that her hand was hurting really bad, and she wanted it propped back up on the pillow. When CNA 24 lifted Resident E's arm, she cried out in pain, and her whole body tensed up and her eyes squinted shut. CNA 24 stopped moving the resident's arm, until she was ready, then slowly repositioned her arm onto a pillow, and indicated her hand was really swollen and probably stiff from sitting in that same

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	155826	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN CROSSING AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) position for a long time. CNA 24 indicated she would let the nurse know about the pain and swelling. At 3:35 p.m., CNA 24 was observed at the nurses' cart, and indicated to Licensed Practical Nurse (LPN) 20, that Resident E's hand was swollen and she complained of pain in her arm. On 3/4/2020 at 3:00 p.m., Resident E's medical record was reviewed. Resident E had [DIAGNOSES REDACTED]. A nursing progress note, late dated for 3/4/2020, was entered on 3/5/2020 at 9:53 a.m. The progress note indicated, .patient has left sided weakness On 3/6/2020 at 9:13 a.m., Resident E was observed sitting up in her bed, as she finished her breakfast. Her left hand was observed, and the swelling continued. Resident E indicated it was still hurting, and she did not know what caused the swelling, no one had seen her or followed up with her. During an interview on 3/6/2020 at 9:45 a.m., the Administrator indicated, it would be his expectation that when a resident complained of pain and had new or worsening swelling, the nurse would complete and document and assessment of the potential change in condition to see if it was something new, and if they needed to call the Doctor. On 3/6/2020 at 9:51 a.m., Resident E's medical record was briefly reviewed a second time with LPN 30 and LPN 31. They indicated, there was a progress note, dated on the 5th, as a late entry for the 4th, but it did not relate to any pain or swelling. There was no new skin assessment, or change of condition assessment. LPN 30 and 31 indicated, when a resident has a new complaint of pain or swelling, then staff should go down and assess the arm to see if it was new and problematic swelling, try to help reposition the area for immediate intervention and comfort, then talk to the Nurse Practitioner who is almost always in the building, or call the on call Doctor for any new orders that may want to try. On 3/9/2020 at 12:30 p.m., the Director of Nursing provided a copy of current facility policy titled, Standards of Nursing Practice, dated 1/12/2017. The policy indicated, .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents . issues may include but are not limited to monitoring hydration, output, fever, vital signs and other care area that the nurse may initiate During an interview on 3/6/2020 at 10:40 a.m., the Regional Nurse Consult indicated, comprehensive care plans are completed within 14 days. At this time she provided a copy of current facility policy, titled, Plan of Care Overview, revised 7/26/2018. The policy indicated, .Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care . the facility will: .iii. Review care plans quarterly and/or with significant changes in care This Federal tag relates to Complaint IN 609. 3.1-37(a)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were protected from potential accidents when a steam table was left on and unattended in an open dining area for 3 of 3 observations, and to ensure a resident was not left on the facility bus, without assistance to get off for 1 of 3 residents reviewed for assistance getting off the bus (Resident 32). The facility failed to ensure medications were not left at bedside for 2 of 19 sampled residents (Residents 74 and 49). Findings include: 1. On 3/2/2020 at 10:45 a.m., during the initial tour of the second floor, the Dining Room was observed. The steam table was hot and had visible steam rising from the metal lids, which covered the hot water. The steam table was located in an open dining area, which was easily accessible to residents ambulating, or in wheel chairs. There were no employees in attendance of the Dining Room. On 3/2/2020 at 11:56 a.m., the steam table was observed, in the 2nd floor Dining Room. Hot steam continued to rise from the metal lid covers. No employees were in the room, or nearby. Residents were beginning to come into the Dining Room for lunch. On 3/2/2020 at 2:42 p.m., a third observation of the steam table, still on, with hot steam coming up off the metal lid covers. On 3/2/2020 at 3:30 p.m., during an observation and interview with the Director of Nursing (DON), and Dietary Aid 15, the DON indicated, the steam table should not have been left on unattended. Dietary Aid 15 indicated the steam table had to be turned on for 2 hours before meals in order for the food to be hot, when it was served. She turned it on before meals, then she had to go back downstairs to get the meal ready. She couldn't stay and watch it because she had other things that had to be done. The DON indicated there was no policy for monitoring the steam table to prevent accidents. 2. On 3/3/2020 at 9:14 a.m., Resident 32 was observed in his room, sitting up in his bed. He indicated there had been an incident a couple weeks ago, where he was forgotten, and left on the facility bus for about 30 minutes, after it had been parked in the parking lot. He had been taken to a doctor's appointment, was the only one on the bus. When they returned to the facility that evening, the Bus Driver parked in the parking lot, and not at the front door, got off the bus, and took in a piece of equipment for another resident. Resident 32 waited, but soon realized, no one was coming back. He felt fortunate that he was able to get out of his wheelchair, climbed over the console and into the driver seat where he honked the buses horn for several minutes to try and get someone to come help him off, but one came. Eventually he thought he would either have to get off the bus and inside by himself, or he would have to spend the night on the bus. Resident 32 climbed out of the bus and walked himself into the facility. He indicated, that might not have seemed like a long walk, but by the time he made it into the lobby, he was very weak, out of breath, shaking and tired. During an interview on 3/3/2020 at 11:16 a.m., the Administrator (ADM) indicated, he was at the facility the night of the incident with Resident 32 and the bus. Apparently the Bus Driver unloaded something for another resident, but then received a phone call and left the facility campus. We did not determine if the Bus Driver told anyone he was leaving, and that Resident 32 was still on the bus, parked in the parking lot. Resident 32 was tired of waiting, and got himself off the bus. The ADM indicated he was in the lobby when Resident 32 walked in, and had someone come and asses Resident 32 for injuries, there were none, and then Resident 32 was assisted back to his room. The ADM indicated it was his preference for the Bus Driver to unload residents at the front door, and before any equipment, if possible. During a follow up interview on 3/3/2020 at 11:58 a.m., Resident 32 indicated it was fairly cold out the night he was left on the bus, but he had his coat on. He was mostly concerned about his ability to physically get out of the situation, it was more survival, and I just had to do it. Resident 32 indicated, when he got into the facility, he was really out of breath, tired and shaking, and it took a day or so to feel fully recovered. During an interview on 3/3/2020 at 12:53 p.m., the Bus Driver indicated, he had received a personal phone call on his way back to the facility with Resident 32 in the bus. When they got to the facility there were other vehicles at the front entrance, so he just found an empty spot in the parking lot. He unloaded an electric wheelchair for another resident, and took that inside. The Bus Driver indicated, when he got the phone call, he blanked out. He saw someone in the hall and only said, I have to go. He did not tell anyone Resident 32 was still on the bus, and he left the facility campus. While he was driving, he got a phone call from the ADM, and then he remembered about Resident 32, he turned around and came back to the facility. When he returned, Resident 32 was in the lobby. At this time, the Bus Driver pointed to the approximate spot where the bus was parked in the parking lot. On 3/3/2020 at 1:07 p.m., Physical Therapist, (PR) 35 measured the distance from the parking lot space, to the first chair in the facility lobby. The distance was 97 feet. PT 35 indicated, it was not a good situation for Resident 32 to have walked by himself, and it would have been better to have staff assistance or supervision. On 3/06/2020 at 10:22 a.m., Resident 32's medical record was reviewed. The most recent comprehensive assessment was a quarterly minimum data Set (MDS) assessment, dated 1/17/2020. The MDS indicated Resident 32 was cognitively intact, required the assistance of at least 1 staff member for transfers, and walking, and had active [DIAGNOSES REDACTED]. There was a comprehensive care plan, dated 1/8/2020, which indicated, Resident 32 was at risk for falls due to gait/balance problems. Interventions for this care plan included, but were not limited to: anticipate and meet (Resident 32)'s needs. On 3/3/2020 at 2:00 p.m., the ADM provided a copy of the investigation into the incident. A Concern Form dated 2/17/2020 indicated, .Resident expressed that he was upset because the Bus Driver had not come back and he had to leave the bus on his own Actions to resolve the concern: .evaluated Resident, suspended Driver pending investigation A blank piece of paper titled, Investigation Note, dated, 2/17/2020, was not signed by a staff member, indicated, .at approximately 4:30 (Resident 32) entered the facility via the main entrance. Resident stated that he had gotten himself off the bus when the bus driver did not come back. This writer was in the lobby and did a quick visual assessment of the resident and assisted resident to room per request. Resident stated that the vehicle was not locked and that he exited through the driver's side door . nursing assessment competed- no signs of injury A nursing progress note dated 2/17/2020 at 5:52 p.m., indicated, . (Resident 32) returned from appointment in good condition, A&Ox3 (alert and oriented to person, place and time). No distress noted/voiced at this time. No skin issues noted/voiced, denies pain On 3/2/2020 at 3:00 p.m., the ADM indicated there was no policy for when and how to unload the facility bus, but that it was his preference for residents not to wait for more than 10 minutes, and they should be assisted off the bus at the front door. On 3/2/2020 at

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) 3:15 p.m., the Regional Clinical Consultant provided a copy of the Bus Driver's Job description, dated, 3/15/2003. The Job description indicated, . The position of Van/Shuttle Driver is responsible for ensuring safe transport for the staff (and residents). The position must function as both a team member, team leader, and supervisor to ensure that work is accomplished and quality care is delivered . job expectations . keep your team members informed- communicate all information necessary to get the job done right . 3. On 3/5/2020 at 2:57 p.m., Resident C was assisted into her room by the Administrator and Certified Nursing Assistant (CNA) 23. The Administrator left the room, and CNA 23 indicated she would go ahead and transfer Resident E into bed. She placed a gait belt around the resident's waist, then put her arms under the resident's arms and around her back, in a bear-hug style. CNA 23 lifted Resident C out of her wheelchair, and even though Resident C's feet were on the ground, she did not bear any weight. CNA 23 indicated the Resident could not bear any weight, but she was light enough to lift. Once the resident was sat on the bed, CNA 23 assisted her to lay down. On 3/5/2020 at 8:57 a.m., Resident C's medical record was reviewed. The most recent comprehensive assessment was a quarterly Minimum Data Set (MDS) assessment, dated, 1/11/2020. The MDS indicated Resident C was severely cognitively impaired, required extensive assistance of at least two staff members for transfers, and had three recent falls, 1 with injury. Resident C had a comprehensive care plan initiated 8/13/2015, and last revised on 1/10/2018. The care plan indicated, (Resident C) was at risk for an ADL (activity of daily living) Self Care Performance Deficit (related to) Dementia, weakness. Interventions for this care plan included but were not limited to: .Transfer: 1 staff participation with transfers . This intervention was last revised 3/7/2017. Resident C had a comprehensive care plan initiated 8/13/2015, which indicated, . (Resident C) is at risk for falls (related to) weakness, potential (medication) side effect, and [DIAGNOSES REDACTED].assist of 1 staff for ADLs and mobility as needed . This intervention was last revised 11/15/2018. During an interview on 3/6/2020 at 11:33 a.m., the MDS Coordinator indicated according to Resident C's most recent MDS she was a two person assist for transfers, and her interventions had not been revised. On 3/6/2020 at 4:00 p.m., the DON provided a copy of current facility policy titled, Resident Rights, dated, 8/11/2017. The policy indicated, .Safety of residents, visitors, and employees is a top priority of care . On 3/9/2020 at 12:30 p.m., the Director of Nursing provided a copy of current facility policy titled, Standards of Nursing Practice, dated 1/12/2017. The policy indicated, .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents 4. On 3/2/2020 at 11:39 a.m., Resident 49 was observed reclined in her bed. She indicated she had just woke up, and the Certified Nursing Assistant (CNA) was coming to help her get up for the day. A cup of pills was observed on her bedside table, next to her bed and she indicated the nurse just bought them and left them for her, she could take them when she got up. She did not know what the pills were. During an interview on 3/2/2020 at 11:44 a.m., Registered Nurse, (RN) 26 indicated Resident 49 had been sleeping, so he left her 8:00 a.m. medications for her to take when she woke up. RN 26 indicated Resident 49 did not have an order or assessment to self-administer her mediations. On 3/2/2020 at 12:00 p.m., Resident 49's medical record was briefly reviewed. There was no physician order for [REDACTED]. There was no assessment or evaluation for the resident to self-administer her medications. During an interview on 3/2/2020 at 3:15 p.m., the DON indicated medications should never be left in a resident room. The resident may not see them, and forget to take them, or other residents, or visitors could take the medications. 5. On 3/2/2020 at 3:02 p.m., a cup of applesauce with three pills dropped on top, was observed on Resident 74's dresser. Resident 74 was not in his room. On 3/2/2020 at 3:09 p.m., Licensed Practical Nurse (LPN) 25 observed the pills left in the resident's room, and indicated she had a phone call she had to run and take and left the pills there, but she should have taken them back up to the nurses' station. During an interview on 3/2/2020 at 3:15 p.m., the DON indicated medications should never be left in a resident room. The resident may not see them, and forget to take them, or other residents, or visitors could take the medications. On 3/2/2020 at 3:55 p.m., the DON provided a copy of current facility policy titled, Medication Administration, dated, 8/2/2010. The policy indicated, . do not leave medications unattended . do not leave resident until medication is swallowed . do not leave medication at bedside 3.1-45(a)
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure pharmacy recommendations were followed for 1 of 5 residents reviewed for unnecessary medications (Resident 52). Findings include: On 3/5/2020 at 9:54 a.m., the medical record was reviewed for Resident 52. The [DIAGNOSES REDACTED]. A pharmacy medication regimen review (MRR), dated 2/4/2020, indicated, Please update record with appropriate information to support the use of [MEDICATION NAME]. A hand written word [MEDICAL CONDITION], was written on the review document and was signed on 2/5/2020, by the physician. The current physician order [REDACTED]. On 3/5/2020 at 11:31 a.m., during an interview, the Director of Nursing indicated, Resident 52's diagnosis/indication for [MEDICATION NAME] should have been changed with the pharmacy recommendation. On 3/5/2020 at 1:28 a.m., the Regional Consultant provided a current policy, dated 9/23/19, titled Medication Regimen Review. This policy indicated, .The Consultant Pharmacist shall conduct a monthly medication regimen review for each resident in the facility .Any medication irregularities noted by the consultant Pharmacist during the monthly review shall be documented on a separate, written report .The report shall be sent to the resident's attending physician .The Director of Nursing or designee will be responsible for addressing all medication irregularity reports with the attending physicians in a manner that meets the needs of the resident 3.1-25(i)
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to monitor and assess a resident for behaviors, and or side effects of anti-anxiety, anti-coagulant, anti-depressant, and hypnotic (sleep) medications, for 1 of 5 residents reviewed for unnecessary medications (Resident 52). Findings include: On 3/5/2020 at 9:54 a.m., the medical record was reviewed for Resident 52. The [DIAGNOSES REDACTED]. The physician orders [REDACTED].An active order, dated 1/29/2020, indicated [MEDICATION NAME] HCl tablet 100 mg (milligrams), give 1 tablet by mouth at bedtime for /antidepression (sic). b. An active order, dated 1/29/2020, indicated, apixaban (blood thinner) tablet 5 mg, give 5 mg by mouth two times a day for anticoagulation, hold this medication until 2/7/2020 do not restart this medication until then. c. An active order, dated 1/29/2020, indicated, [MEDICATION NAME] (controlled drug, anti-anxiety) tablet 5 mg, give 1 tablet by mouth every 8 hours as needed for Muscle Spasms. d. An active order, dated 1/29/2020, indicated [MEDICATION NAME] (anti-depressant) HCL ER capsule (extended release 24 hour) 75 mg, give 1 capsule by mouth at bedtime for depression. There were no orders to monitor for behaviors, and or side effects of anti-anxiety, anti-coagulant, anti-depressant, and hypnotic (sleep) medications. There were no entries in the medical record indicating medications were being monitored, or the resident was assessed for any negative outcomes related to adverse effects of the medications. On 3/5/2020 at 11:31 a.m., during an interview the Director of Nursing (DON) indicated, medication monitoring orders should have been put into Resident 52's Medication Administration Record, [REDACTED]. On 3/5/2020 at 1:28 a.m., the Regional Consultant provided a current policy, dated 9/23/19, titled Medication Regimen Review. This policy indicated, .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents 3.1-48(a)(3)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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	155826	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN CROSSING AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored in the medication rooms for 2 of 2 medication storage observations, failed to ensure expired medications were not stored in emergency carts for 2 of 3 random emergency cart observations, and failed to ensure a medication cart was kept locked, when out of line of sight of the nurse, for 1 of 3 medication pass observations. Findings include: 1a. On 3/06/2020 at 2:31 p.m., during a medication storage observation, on Heritage Hall, and interview with Registered Nurse (RN) 12, the medication room refrigerator contained an open bottle of [MEDICATION NAME] serum, in a box. The box or bottle contained no open date, or initial. RN 12 indicated the medication vial should have been dated and initialed, when it was opened. 1b. On 3/6/2020 at 2:45 p.m., during a medication storage observation, on Health Hall, and interview with Licensed Practical Nurse (LPN) 19, the medication room refrigerator contained 3 [MEDICATION NAME] acetate 25 mg (milligram) suppositories, and 4 [MEDICATION NAME] 10 mg (milligram) suppositories, loose on the shelf with no package or resident label. LPN 19 indicated the suppositories should have been inside a plastic bag from pharmacy with a resident identifier label. On 3/3/2020 at 10:49 a.m., the Administrator provided a current, undated policy, titled Storage of Medications. This policy indicated, .The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medication to the original container .Certain medications or package types, such as IV (intravenous) solutions, multiple dose injectable vials .once opened, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency .When the seal of the manufacturer's container or vial is initially broken, the container or vial will be dated 2. On 3/2/2020 at 12:16 p.m., the emergency cart on Heritage hall was observed unlocked, and contained the following expired items. a. There were 4 expired IV (intravenous) starter kits (to start an IV). b. There was 1 - 22 gauge needle. c. There were 2 - 110 mL (milliliters, a unit of measurement) sterile 0.9% normal saline containers, expired on 6/2018. d. There were 6 - 110 mL sterile water containers, expired on 2/2019. e. There was 1 - 1000 mL bag 0.45% sodium chloride, expired February 2020. f. There were 11 - 10 mL normal saline IV flush only syringes, expired 3/1/2020. g. There were 2 - 10 mL normal saline IV flush only syringes, expired 11/1/2019. h. There were 3 - empty 5 mL syringes, expired 1/2020. i. There was 1 - empty 10 mL syringes, expired 1/2020. On 3/2/2020 at 12:37 p.m., the emergency cart on Health hall was observed unlocked, and contained the following expired items. a. There were 20 - 2.5 mL 0.9% sodium chloride ampoules, expired 10/2019. b. There were 4 - 22 gauge needles, and 2 - 24 gauge needles. c. There were 3 - 110 mL sterile 0.9% normal saline containers, expired on 2/14/2019. d. There were 1 - 110 mL sterile water container, expired on 2/20/2019. e. There was an accu-check kit (small zipper bag with a machine and supplies to read blood sugars) and 6 lancets (small blade used to attain blood drops for blood sugar check). On 3/2/2020 at 12:51 a.m., the Director of Nursing (DON) indicated, there should not have been any needles or anything expired in the emergency carts. The accu-check kit with 6 lancets should not have been in the emergency cart. A current policy, titled, Storage of Medications, with no date, was provided by the DON on 3/2/2020 at 3:32 p.m. A review of the policy indicated, .All expired medications will be removed from the active supply and destroyed 3. During a continuous observation on 3/5/2020, from 4:20 p.m., until 4:31 p.m. Licensed Practical Nurse, (LPN) 20 was observed to leave the medication cart unlocked. At 4:21 p.m., she entered Resident 68's room. She closed the resident's door. Voices were heard in the hall near the unlocked medication cart. At 4:26 p.m., LPN 20 returned to the medication cart, removed 4 medications, and brought the glucometer (device for testing blood sugar) in the room for Resident 68. At 4:28 p.m., LPN 20 left the medication cart unlocked, and entered Resident 68's room again. She took the medication cup, and the glucometer with her. Voices were heard in the hallway again near the unlocked medication cart. She returned to the medication cart at 4:31 p.m. During an interview, on 3/5/2020 at 4:59 p.m., the DON indicated the medication cart should have been locked anytime the nurse was away from the cart. A current policy, titled, Medication Administration, dated 5/29/2019, was provided by the Regional Consultant on 3/5/2020 at 12:11 p.m. A review of the policy indicated, .Do not leave medication cart unlocked 3.1-25(j) 3.1-25(m) 3.1-25(n)
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 2 residents, with latex allergies [REDACTED]. Findings include: On 3/2/2020 at 10:45 a.m., during the initial tour of the second floor, the Dining Room was observed. An open box of powder free latex gloves was observed on the counter, beside the steam table. On 3/2/2020 at 11:46 a.m., the powder free latex gloves remained on the counter, of the 2nd floor Dining Room, beside the steam table, as residents were entering the Dining Room for lunch. During a continuous dining observation, Resident 17 was observed in the 2nd floor Dining Room for lunch. On 3/2/2020 at 12:45 p.m., Certified Nurse Aid (CNA) 16 put on latex gloves and cut cake, from a large sheet pan. She used gloved hands to place cake on individual plates. On 3/2/2020 at 12:50 p.m., Activities Assistant 17 entered the Dining Room and put on latex gloves. She prepared a Styrofoam container of food and took it down the hall. On 3/2/2020 at 1:12 p.m., Dietary Aide 15 was observed as she removed pans from the steam table, wearing latex gloves, and putting clear plastic wrap over food containers, of leftover food. On 3/2/2020 at 2:42 p.m., the box of powder free latex gloves remained on the 2nd floor Dining Room counter. On 3/2/2020 at 3:30 p.m., during an observation, and interview, with the Director of Nursing (DON), he indicated latex gloves could be a problem for residents with latex allergies [REDACTED]. He wasn't sure who had ordered them, but they should not have ordered latex. On 3/2/20 at 3:57 p.m., during an interview, the Regional Consultant indicated they will try to figure out where latex gloves came from, they typically didn't order latex gloves. On 3/2/2020 at 3:57 p.m., the DON provided a list of resident allergies [REDACTED]. On 3/2/2020 at 4:29 p.m., during an interview, the DON indicated the residents with latex allergies [REDACTED]. The latex gloves were ordered by the Dietary Dept., they said they could use them for cleaning. The DON indicated, he told her they couldn't be used for cleaning because latex gets spread onto surfaces and those with allergies [REDACTED]. This policy indicated, .The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies [REDACTED].
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to maintain the kitchen's dish area under clean and sanitary conditions for 2 of 2 observations, failed to label and date food in the dining room for 3 of 3 observations, and failed to ensure a refrigerator and freezer were clean for 2 of 2 observations. This deficient practice had the potential to 84 of 86 residents served out of the kitchen. Findings include: On 3/2/2020 from 9:10 a.m., until 9:30 a.m., an initial kitchen tour was conducted with the Culinary Supervisor, (CS). The floors were littered with crumbs, paper/plastic particles, and other debris throughout the kitchen. The CS indicated the floors needed to be swept, and should be swept after each shift. The deep fryer was observed to have a copious amount of burnt and caked on grease and, the floor surrounding the fryer was splattered with grease and debris. The CS indicated the fryer should be cleaned as needed, and on a weekly basis, and looked like it needed to be cleaned. The dish area was observed to be disorganized, as several random pots, pans, and other utensils and equipment were stacked across all surfaces. Standing water was observed in several of the pans, and the three compartment sink was observed with standing water in the base of the sinks, with copious amounts of food particles, ad congealed fats floating on the surface. Several flying insects were observed throughout the kitchen, but concentrated in the dish area. Two green, course/wire, sponges were observed on the top dish rack, covered with soggy food particles. During an interview on 3/2/2020 at 9:22 a.m., Cook 32 indicated, there was no designated staff member as the dishwasher, so after he got done cooking he had to run the dish area. He did not know what food was left over in the 3 compartment sink, or how long it was there, because he was still cleaning up from breakfast. On 3/4/2020 at 11:30 a.m., during a second kitchen visit, the dish area remained disorganized. Food particles, crumbs, and debris were observed on the floor, the trash can was uncovered, and the sink basin by the dish washer was observed full and over flowing onto the tray rack, floor, and into the dishwasher compartment to drain. The 3 compartment sink wash basin, was observed to have standing

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) water, and there was a pan, filled with water, and floating food particles and congealed grease observed sitting in the sink. Several flying insects were visible in the dish area. Two green, course/wire, sponges were observed on the top dish rack, covered with soggy food particles. During an interview on 3/4/2020 at 11:32 a.m., the Regional Culinary Director indicated there was something wrong with the valve of the water spigot, so the water would just run through the faucet and not through the sprayer, which caused the overflow, so the staff should turn the faucet off after each use to prevent overflow. On 3/4/2020 at 11:45 a.m., the CS provided a cleaning schedule for the kitchen and indicated the policy was to clean as needed and on a daily basis, after each shift. Items to be cleaned included, but were not limited to: floors, equipment, and the dish area. Assignments for staff indicated, staff should wipe down their area, make sure everything is put away and clean, and to clean out all shelving and counters by the dish machine. 2. On 3/2/2020 at 10:45 a.m., during the initial tour of the second floor, the Dining Room was observed. A small plastic container of shredded cheese, partially covered in plastic wrap was sitting on the countertop, in the serving area. The cabinet above the oven contained an unlabeled, undated, plastic storage container of brown sugar, and an open, undated, bag of potato chips. The counter top had 3 cereal dispensers containing, corn flakes, rice, and oat cereals without dates. On 3/2/2020 at 11:45 a.m., during a Dining observation the container of shredded cheese remained on the countertop. On 3/2/2020 at 2:42 p.m., Dietary Aid 15 was observed as she scraped plates into a tall thin plastic trash can, without a lid, and cleaned off tables, in the 2nd floor Dining Room. On 3/02/2020 at 03:30 p.m., during a Dining Room observation, and interview, with the Director of Nursing (DON), the shredded cheese remained on the countertop. A trash can with no lid was beside the counter, full of food scraped from plates, and trash. There was a strong odor, from the open trash. The 3 cereal dispensers, on the counter remained undated. The undated brown sugar and potato chips were observed in the cabinet. The DON indicated the brown sugar and potato chips should have been dated when they were opened. The shredded cheese should not have been left on the counter after breakfast. The cereal dispensers needed dates on them. The trash can should not have been sitting in the Dining Room uncovered. On 3/3/2020 at 10:49 a.m., the Administrator provided a current undated policy, titled Food Preparation. This policy indicated It is the center policy that all foods are prepared, in accordance with the guidelines of the USDA Food Code. 3. On 3/2/2020 at 03:00 p.m., during a random observation of the Heritage Hall nursing pantry, the freezer, on the bottom of the full sized refrigerator, contained a thick coating of sticky pink substance, which appeared to have been spilled into the freezer. On 3/2/2020 at 3:20 p.m., during an observation and interview, the Director of Nursing (DON) indicated, he did not know who was responsible for cleaning the pantry refrigerators. They probably didn't know either, and that was why it was not clean. There was no policy for cleaning the pantry refrigerator, or schedule routine of cleaning. 3.1-21(i)(1) 3.1-21(i)(3) 3.1-21(i)(5)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper infection control procedures were followed for cleaning a glucometer (a medical device used to measure blood sugar levels) for 6 of 6 residents observed for glucometer use (Residents 29, 46, 68, 67, 23, and 18). This deficient practice had the potential to effect 20 of 20 residents who used a shared glucometer device. The facility failed to ensure proper handwashing was completed for 3 of 12 observations during a medication administration observation. Findings include: On 3/5/2020 at 11:07 a.m., a glucometer was observed on a paper towel on top of the 2nd floor medication cart. On 3/5/2020 at 11:17 a.m., the Sani-Cloth Plus wipes label was observed. It indicated, for cleaning glucometers, wipe off debris with first cloth, then with second cloth, allow treated surface to remain wet for two (2) minutes. Let air dry. On 3/5/2020 at 11:21 a.m., Licensed Practical Nurse (LPN) 13 was observed as she wiped off the glucometer with the first Sani-Cloth Plus wipe, for about 10 seconds and set it down on the medication cart on the same paper towel she picked it up from. On 3/5/2020 at 11:24 a.m., LPN 13 was observed as she washed her hands, she turned the water faucet off with her bare hands, then dried her hands with paper towels. On 3/5/20 at 11:25 a.m., LPN 13 was observed as she used the glucometer for the top of the medication cart for Resident 29. After she checked the resident's blood sugar, she was observed as she wiped off the glucometer with the first Sani-Cloth Plus wipe, for about 10 seconds, and set it down on the same paper towel that she picked it up from. On 3/5/20 at 4:03 p.m., LPN 20 was observed as she removed her personal cell phone from a pocket, looked at the phone screen and silenced it. Without washing her hands, she picked up a medication cup with 2 medications for Resident 46, picked up the glucometer which sat on top of the Heritage medication cart observed with no barrier under it, and pulled the vital sign machine with her into the resident's room. LPN 20 was observed as she placed the glucometer on the resident's over the bed table, and did not place a barrier under it. Without putting on gloves, she used a lancet (small blade used a get blood drops for a glucometer) on the resident's finger, wiped the first drop of blood off with an alcohol wipe, and captured the second drop of blood for the glucometer strip. She set the glucometer on the resident's over the bed table with no barrier under it, and placed the bloody alcohol wipe on the top of the glucometer. When she got back to the medication cart, she set the glucometer on top of the medication cart with no barrier under it, and did not clean the glucometer. On 3/5/2020 at 4:26 p.m., LPN 20 opened the Heritage medication cart and removed 4 medications for Resident 68. She took the medication cup and the contaminated glucometer into the resident's room. She placed the glucometer on the resident's over the bed table and did not place a barrier under it. Without washing her hands or putting on gloves, she used a lancet on the resident's finger, wiped the first drop of blood off with an alcohol wipe, and captured the second drop of blood for the glucometer strip. She set the glucometer on the resident's over the bed table with no barrier under it, and placed the bloody alcohol wipe on the glucometer. When she got back to the medication cart, she set the glucometer on top of the medication cart with no barrier under it, and did not clean the glucometer. On 3/5/2020 at 4:33 p.m., LPN 20 re-entered Resident 68's bathroom to wash her hands. She turned the water faucet off with her bare hands, and dried them with paper towels. On 3/5/2020 at 4:39 p.m., LPN 20 checked Resident 67's blood sugar. She placed the contaminated glucometer on the resident's over the bed table and did not place a barrier under it. Without washing her hands or putting on gloves, LPN 20 used a lancet on the resident's finger, wiped the first drop of blood off with an alcohol wipe, and captured the second drop of blood for the glucometer strip. She set the glucometer on the resident's over the bed table with no barrier under it, and placed the bloody alcohol wipe on the glucometer. When she got back to the medication cart, she set the glucometer on top of the medication cart with no barrier under it, and did not clean the glucometer. On 3/5/2020 at 4:43 p.m., LPN 20 checked Resident 23's blood sugar. She placed the contaminated glucometer on the resident's over the bed table and did not place a barrier under it. Without washing her hands or putting on gloves, LPN 20 used a lancet on the resident's finger, wiped the first drop of blood off with an alcohol wipe, and captured the second drop of blood for the glucometer strip. She set the glucometer on the resident's over the bed table with no barrier under it, and placed the bloody alcohol wipe on the glucometer. When she got back to the medication cart, she set the glucometer on top of the medication cart with no barrier under it. She did not clean the glucometer. She returned to the resident's bathroom, washed her hands, and turned the faucet off with her bare hands and dried her hands with paper towels. On 3/5/2020 at 4:51 p.m., LPN 20 checked Resident 18's blood sugar. She placed the contaminated glucometer on the resident's over the bed table and did not place a barrier under it. Without washing her hands and putting on gloves, LPN 20 used a lancet on the resident's finger, wiped the first drop of blood off with an alcohol wipe, and captured the second drop of blood for the glucometer strip. She set the glucometer on the resident's over the bed table with no barrier under it, and placed the bloody alcohol wipe on the glucometer. When she got back to the medication cart, she set the glucometer on top of the medication cart with no barrier under it, and did not clean the glucometer. She returned to the resident's bathroom, washed her hands, and turned the faucet off with her bare hands and dried her hands with paper towels. During an interview, on 3/5/2020 at 4:59 p.m., the Director of Nursing (DON) indicated, the glucometer should have been cleaned between residents, staff member's hands should have been washed appropriately, and the nurses should have worn gloves when she used the lancets. During an interview, on 3/6/20 at 9:53 a.m., the Regional Consultant indicated 2 residents who also received accu-checks (blood sugar measurement) using a shared glucometer, both had [DIAGNOSES REDACTED]. On 3/6/2020 at 11:11 a.m., the DON indicated there were 20 residents in the facility who had orders to receive accu-checks and shared the glucometer. On 3/6/2020 at 4:19 p.m., the Regional Consultant indicated Resident 70 had a history of [REDACTED]. On 3/6/2020 at 4:21 p.m., the Administrator indicated Resident 64 had active [MEDICAL CONDITION]. On 3/5/2020 at 4:59 p.m., the DON indicated the glucometers should have been cleaned correctly between residents, staff should have washed their hands correctly, and the nurses should have worn gloves when lancets were used. A current policy, titled, Standard Precautions, dated 5/29/2010, was provided by the Regional Consultant on 3/5/2020 at 12:11 a.m. A review of the policy indicated, .hand washing with soap and water .turned off faucet with clean, dry paper towel -

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) discard! A current policy, titled, Medication Administration, dated 5/29/2010, was provided by the Regional Consultant on 3/5/2020 at 12:11 p.m. A review of the policy indicated, .perform appropriate hand hygiene before beginning mediation (sic) administration .perform hand hygiene before and after each residents medication is administered A current policy, titled, Blood Glucose Point of Care Testing, dated 5/29/2010, was provided by the Director of Nursing on 3/5/2020 at 11:53 a.m. A review of the policy indicated, .gather supplies including clean glucometer, perform hand hygiene, done gloves, turn on machine and place on a hard surface with a clean barrier under device .use a single-use lancet to puncture finger to obtain blood sample using side of finger and not finger pad .remove gloves and perform hand hygiene .place a clean barrier under glucometer until disinfected .do not place uncleaned glucometer on top of med or treatment cart without a clean barrier under the device .perform hand hygiene prior to disinfecting, don gloves, perform disinfection procedure, remove gloves and perform hand hygiene 3.1-18(b)(1) 3.1-18(l)