STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155238	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yorktown Manor	2000 S Andrews Rd Yorktown, IN 47396

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48146 Based on record review and interview, the facility failed to ensure shift to shift narcotic reconciliation was completed for 2 of 3 carts reviewed for medication storage. (300 hall cart and 100 hall cart) Findings include: 1. During a medication storage observation of the 300 hall cart, accompanied by RN 5, on 10/4/24 at 2:00 p.m., the Controlled Drugs- Count Record was reviewed and the following dates lacked signatures for shift to shift reconciliation of controlled substances: In October 2024- 10/1 on evening and night shifts, 10/2 on night shift, 10/3 on day and night shifts, 10/4 on day shift. In September 2024- 9/4 on evening shift, 9/14 on night shift. During an interview, at the time of the observation, RN 5 indicated the narcotic count was completed at the beginning and end of each shift. 2. During a review of the 100 hall cart Controlled Drugs- Count Record, provided by Medical Records on 10/4/24 at 3:00 p.m., the following dates lacked signatures for shift to shift reconciliation of controlled medications: In October 2024- (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/1 on day and night shifts, 10/2 on evening and night shifts, 10/3 on evening and night shifts, 10/4 on day shift. In September 2024- 9/10 on evening and night shifts, 9/11 on night shift, 9/12 on evening and night shifts, 9/18 on day and night shifts, 9/20 on day shift. During an interview, on 10/4/24 at 2:52 p.m., the DON indicated the expectation was for oncoming staff and outgoing staff to complete a narcotic reconciliation before the exchange of keys for the medication cart. During an interview, on 10/8/24 at 11:57 a.m., the DON indicated the actual narcotic count number was documented on the separate narcotic sheets for each resident. The staff utilize the separate narcotic count sheets to verify the medication count. The staff sign the Controlled Drugs-Count Record after the count is verified as correct. A facility policy, revised 12/12, titled, Controlled Substances, provided by the Administrator on 10/8/24 at 10:32 a.m., indicated the following: .9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services 3.1- 25(b)(3)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 09676 Based on observation, interview, and record review, the facility failed to ensure menus were followed to ensure proper portions were served for 1 of 1 meal observed for following menus (10/7/24 Lunch). This deficient practice had the potential to impact 69 of 69 residents. Finding include: An undated facility document titled, Midwest Fall/Winter 2024-2025, provided by the facility following the entrance conference on 10/2/24, indicated lunch on October 7, 2024 was Baked Ziti with Meat sauce, Tossed Salad with Dressing, and Ice Cream. An undated facility document titled, Midwest Fall/Winter 2024-2025, Diet Spreadsheet Short Name Format, provided by the Certified Dietary Manager on 10/7/24 at 11:19 a.m., indicated the portion of baked ziti to be served to the residents was 6 ounces. During the lunch meal service observation on 10/7/24 from 10: 58 a.m. to 11:06 a.m. [NAME] 4 served a 4-ounce serving of baked pasta on 10 plates, which were placed in the meal service cart to be serve to the 200 hall. The cook indicated the trays were prepared and ready for service to the residents. The pasta was prepared in a method which allowed for both regular and mechanical soft diets to eat the some pasta. During an interview on 10/7/24 at 11:06 a.m., [NAME] 4 indicated she was using #8 scoop to serve the baked pasta entree. She did not know the portion size of the #8, gray handled scoop. During an interview on 10/7/24 at 111:07 a.m., the Certified Dietary Manager (CDM) indicated the cook had served the wrong size portion of pasta in error. The portion which had been plated was 4 ounces. The menued portion of baked pasta was 6 ounces. The facility would need to add 2 ounces additional pasta to correct the error. During an interview on 10/08/24 at 11:30 a.m., the Administrator indicated 69 of 69 residents ate food prepared in the facility kitchen. A current, 7/2023 facility policy titled, Standardized Recipes, which was left on the conference table by facility leadership on 10/8/24 at 9:05 a.m., indicated: .Standardized recipes (in appropriate portion sizes) for each set of cycle menus are provided and maintained in the facility . Cooks are expected to use and follow the recipes provided . 3.1-20(i)(l)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48384 Based on observation and interview, the facility failed to ensure hand hygiene was completed during medication administration for 3 of 5 residents observed. (Resident 12, Resident 36, and Resident 50) Findings include: During a medication administration observation on 10/7/24, at 11:24 a.m., RN 5 removed medications for Resident 12 from the 300 Hall medication cart. Prior to removing medications, the RN did not perform hand hygiene. Three oral medications, one nasal spray, and one bottle of eye drops, were removed from the cart. RN 5 handed the medications and a cup of water to the resident. She donned clean gloves to administer the eye drops to the resident. On the way out of the room, the RN removed and disposed of the gloves. No hand hygiene was performed after glove removal or as she exited the room. On 10/7/24, at 11:30 a.m., RN 5 removed medications for Resident 50, including three oral medications. No hand hygiene was performed prior to removing the medications. The nurse handed the medications and a cup of water to the resident, watched as the resident took the medications, then left the resident's room. No hand hygiene was observed upon exiting the room. On 10/7/24, at 11:36 a.m., RN 5 removed one medication for Resident 36. She did not perform hand hygiene. She handed the medication and a cup of water to the resident, watched the resident take the medications, then left the room. No hand hygiene was performed upon exiting the room. During an interview with RN 5, on 10/7/24 at 11:41 a.m., she indicated there was no hand sanitizer available on the medication cart. She usually had her own with her, but did not. She had forgotten to use the available hand sanitizer on the wall. During an interview with the DON on 10/7/24 at 2:45 p.m., she indicated RN 5 should have used hand sanitizer. A current facility policy titled Handwashing/Hand Hygiene, provided by the DON on 10/7/24 at 2:44 p.m., indicated the following: .Policy Statement - This facility considers hand hygiene the primary means to prevent the spread of infections .1) All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2) All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3) Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies .6) Use an alcohol-based hand rub alternatively .for the following situations .b) Before and after direct contact with residents; c) Before preparing or handling medications; .8) The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections 3.1-18(a)(l)