STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155674	A. BUILDING 00 B. WING	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST CHARLES HEALTH CAMPUS	3150 ST CHARLES ST JASPER, IN 47546

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00399595. This visit included a State Residential Licensure Survey. Complaint IN00399595 - Federal/State deficiencies related to the allegations are cited at F921. Survey dates: February 27, 28, March 1, 2, 3, 6, 7, 2023 Facility number: 002628 Provider number: 155674 AIM number: 200299110 Census Bed Type: SNF/NF: 37 SNF: 18 Residential: 39 Total: 94 Census Payor Type: Medicare: 16 Medicaid: 28 Other: 11 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 16, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by St. Charles Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of St. Charles Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jon Howard	Executive Director	03/29/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			

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	§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure care plan interventions and physician orders were followed for 2 of 4 residents reviewed for accidents, and 1 of 2 residents reviewed for nutrition. Interventions for resident's plan of care, including wearing non-skid socks, not sitting in the wheelchair in resident's room, having a "Call, don't fall" sign in resident's room, and use of a pummel cushion on resident's wheelchair, were not followed. (Resident 34, Resident 26, Resident 38) Findings include: 1. On 2/27/23 at 10:45 A.M., Resident 34 was observed sitting in a wheelchair in the common area during an activity. Resident 34 was wearing socks that were not non-skid. On 2/28/23 at 9:49 A.M., Resident 34 was observed sitting in a wheelchair in the common area. Resident 34 was wearing socks that were not non-skid. On 2/27/23 at 1:56 P.M., Resident 34's clinical record was reviewed. The most recent quarterly MDS (minimum data set) Assessment, dated 1/4/23, indicated resident's cognition status could not be assessed, and Resident 34 required extensive assistance of 2 (two) staff with dressing. A risk for falls care plan, dated 4/8/22, included, but was not limited to, the following intervention: Provide non-skid footwear, dated 4/8/22.	F 0656	Deficiency ID: F656 Completion Date: 3/31/23 Plan of Correction Text: 1. Resident 34 was affected. Resident 34 plan of care updated to remove non-skid socks due to requires assist with transfers. No adverse effects noted. Resident 26 was affected. Call light was immediately placed within reach, “Call Don’t Fall” sign was immediately placed in room, and staff was immediately educated not to leave resident in w/c while in room. No adverse effects noted. Resident 38 was affected. Staff were immediately educated on ensuring floor was free of clutter, debris, foreign objects. Flat cushion was immediately removed, and pommel cushion placed in w/c. No adverse effects noted. 2. All residents have the potential to be affected. Staff educated on proper call light placement and following plan of care interventions ie. Non-skid socks, keeping floor free of clutter, debris, call don’t fall sign placement, not leaving resident in w/c in room, proper cushion in w/c. Clinical staff educated on the	03/31/2023

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	On 3/3/23 at 8:11 A.M., Resident 34 was observed sitting in a wheelchair in the common area. Resident 34 was wearing socks that were not non-skid. At that time, CNA (Certified Nurse Aide) 9 indicated she had assisted Resident 34 getting dressed that morning, and was not offered any other choices for clothing, that what he was currently wearing was the only thing that was offered to him to wear. During an interview on 3/3/23 at 10:35 A.M., the DON (Director of Nursing) indicated she was unaware that providing non-skid footwear was an intervention in Resident 34's risk for falls care plan. 2. On 3/2/23 at 10:39 A.M., Resident 26 was observed sitting in their wheelchair, in their room, without staff present. At that time, no signs were observed in resident's room to alert resident and the call light was on their left recliner armrest not in reach of the resident. On 2/28/23 at 3:10 P.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, muscle weakness (generalized), unsteadiness on feet, difficulty in walking, and long term use of anticoagulants. The most recent annual MDS Assessment, dated 1/21/23, indicated Resident 26's was severely cognitively impaired, was an extensive assist of 1 (one) staff for bed mobility and transferring, and an extensive assist of 2 (two) staff for toileting. Current physician's orders included, but were not limited to: Check for placement of "Call, don't fall" sign in room three times a day, started 12/22/22 Do not leave sitting up in w/c (wheelchair) in room - transfer to recliner or bed, started 12/22/22		care plan policy and placement of call light in reach. 3. As a measure of ongoing compliance, the DHS or designee will monitor 5 residents for fall interventions in place weekly x4 weeks, then every other week for 2 months, then monthly for 3 months. The DHS or designee will round 5 resident rooms to ensure call lights are within reach weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	A current risk for falls care plan, dated 3/26/21, included, but was not limited to, the following interventions: "Call, don't fall" visual cues placed in room, initiated 8/31/21 Resident to only be in w/c for transfers/transports. While in room, encourage resident to sit in recliner or lie in bed, initiated 4/1/21 A current care plan, dated 3/31/22, included, but was not limited to the following intervention: Do not leave resident in w/c in room, transfer to bed or recliner, started 3/31/22. During an interview on 3/2/23 at 10:48 A.M., RN (Registered Nurse) 24 indicated Resident 26 should not be left sitting in their wheelchair in their room. During an interview on 3/3/23 at 10:57 A.M., CNA (Certified Nurse Aide) 32 observed there was not a "Call, don't fall" sign in Resident 26's room to alert the resident. At that time, they indicated they were unsure if that was an intervention that should be in place for the resident. 3. On 2/28/23 at 8:46 A.M., during interview with Resident 38, the room was observed to have debris such as used Kleenex and snack wrappers on the floor between the resident's bed and the bathroom. In the shared bathroom, the wastebasket was overflowing with paper towels and other waste onto the floor. On 3/3/23 at 1:15 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, Dementia in other diseases classified elsewhere, Type 2			

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	diabetes mellitus with diabetic polyneuropathy, depression, anxiety, and Unspecified sequelae of cerebral infarction. The most recent quarterly MDS Assessment, dated 1/27/23, indicated resident was cognitively intact and required extensive assistance of 1 (one) staff for bed mobility, transfers, toileting, and eating, and required physical assistance with bathing. A current fall risk care plan, dated 7/11/22, included, but was not limited to, the following interventions: Pommel cushion placed in chair, dated 9/8/22 Ensure the floor is free of liquids and foreign objects, dated 7/11/22 On 3/1/23 at 8:32 A.M., Resident's room was observed to still have debris on the floor. On 3/1/23 at 9:24 A.M., Resident 38 was observed sitting on her bed. The area between the resident's bed and the bathroom was still cluttered with used Kleenex and other debris. On 3/3/23 at 10:03 A.M., Observed Resident 38 in bed. The wheelchair by her bed had a flat cushion rather than a pommel cushion on it. There was also clutter on the floor, such as used Kleenex, snack wrappers, and a lipstick tube. On 3/6/23 at 8:53 A.M., Observed Resident 38 up in wheelchair moving herself down the hall towards her room. Cushion in wheelchair was a flat cushion. A pummel cushion was not observed. Observed resident's room with used towels on the floor, as well as used Kleenex, and other debris. On 3/7/23 at 9:45 A.M., Resident 38 was out of			

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	room. The shared bathroom (shared by 2 residents) still had paper towels and debris on the floor. The wastebasket nearest the door in the room was overflowing with trash to the floor. On 3/3/23 at 1:58 P.M., a current Comprehensive Care Plan Guideline policy, dated 5/22/18, was provided and indicated the purpose of the policy was "To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines ... Comprehensive care plan need to remain accurate and current". At that time, the DON indicated staff should follow the resident's plan of care. 3.1-35(a) 3.1-35(g)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care, were provided such care, consistent with professional standards of practice in 2 of 4 residents reviewed for respiratory care. The oxygen concentrator filter was visibly soiled, oxygen tubing and humidifier	F 0695	Deficiency ID: F695 Completion Date: 3/31/23 Plan of Correction Text: 1. Residents 42 and 9 were affected by the alleged deficient practice. No adverse effects noted. Resident 42's oxygen	03/31/2023

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	bottles were not dated, and the incorrect oxygen flow rate was set on the concentrator. (Resident 42, Resident 9) Findings include: 1. During the initial interview with Resident 42 on 2/27/23 at 11:05 A.M., the resident indicated she used her oxygen as needed. Tubing on the concentrator was observed to have a date of 1/7 (no year indicated) and the filter had grayish lint all around the edges and dust flew off the filter when it was removed and put back. On 3/6/2023 at 10:25 A.M., Resident 42's records were reviewed. Diagnoses included, but were not limited to, chronic kidney disease, unspecified dementia with behavioral disturbance, emphysema, shortness of breath, and difficulty walking. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 1/30/23, indicated resident was severely cognitively impaired and required extensive assistance of 2 (two) staff for bed mobility, transfers, and toileting. Current physician orders included, but were not limited to, Change oxygen tubing monthly, dated 4/14/22 Clean external concentrator filter every two weeks on Sundays, dated 4/14/22 A current Potential for Shortness of Breath Care plan included, but was not limited to: Administer oxygen per MD order and as needed, dated 1/1/22 On 2/28/23 at 1:08 P.M., Resident 42 was observed at rest in her reclining wheelchair in her room.		concentrator filter was cleaned immediately, and oxygen tubing was changed and dated appropriately. Resident 9's tubing was changed and dated appropriately, humidifier bottle was changed and dated appropriately, portable oxygen tubing was changed and dated appropriately, and the flow rate was verified to be set at 4 LPM per order. Licensed nursing staff were immediately educated on dating of all oxygen tubing, cleaning the filter of the concentrator, verifying the humidifier bottle is not empty and is dated appropriately, and verifying the flow rate is set per order. 2. All residents have the potential to be affected. Licensed staff educated on cleaning of filter, dating all oxygen tubing, verifying the humidifier bottle is not empty and is dated, and verifying the oxygen flow rate is set per MD order. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 residents for clean oxygen concentrator filter, dating of oxygen tubing, dating and volume of humidifier bottle, and flow rate set per MD order weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at	

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	Oxygen concentrator filter was still soiled with dust. On 3/1/23 at 9:14 A.M., Resident 42 was observed in room in reclining wheelchair, oxygen concentrator filter was still soiled with dust. During an interview on 2/28/23 at 1:10 P.M., RN (Registered Nurse) 25 indicated Resident 42's respiratory status stayed fairly stable.2. On 2/27/23 at 11:23 A.M., Resident 9 was observed laying in bed with oxygen being administered with nasal cannula. The tubing was dated 2/2 (year was not indicated), the humidifier bottle was empty and undated, and the flow rate was set at 4 LPM (liters per minute). On 3/1/23 at 10:41 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and polyosteoarthritis, unspecified. The most recent quarterly MDS Assessment, dated 2/4/23, indicated Resident 9 was moderately cognitively impaired, on oxygen, and they were an extensive assist of 2 (two) staff for bed mobility and transfers. Current physician's orders included, but were not limited to, the following: Oxygen at 2 LPM per nasal cannula continuous, started 10/20/2022 and discontinued 2/27/2023 at 12:04 P.M. Oxygen at 4 LPM per nasal cannula continuous, started 2/27/23 at 12:04 P.M. Change oxygen tubing monthly on the 1st day of the month, started 10/20/2022 A current potential for complications related to		least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	COPD care plan, revised 2/17/23, included, but was not limited to, the following intervention: Administer oxygen as ordered, initiated 10/21/22 On 2/28/23 at 9:36 A.M., Resident 9 was observed laying in bed with their nasal cannula on and oxygen flow rate at 4 LPM, but the machine was not turned on. At that time, the humidifier bottle was empty and not dated. The tubing was dated 2/2 (no year indicated). On 3/1/23 at 8:47 A.M., the oxygen tubing for Resident 9 was observed to be dated 2/27 (no year indicated) and the humidifier bottle was full but not dated. On 3/1/23 at 9:05 A.M., Resident 9 was observed sitting in her room, in her wheelchair, wearing oxygen per n/c (nasal cannula) from portable concentrator with tubing that was not dated. On 3/1/23 at 12:31 P.M., Resident 9 was observed laying in bed wearing her nasal cannula with the oxygen flow rate set on 3.5 LPM and the tubing and humidifier bottle undated. On 3/2/23 at 8:31 A.M., Resident 9 was observed in the dining room eating breakfast, sitting in wheelchair with n/c and portable oxygen concentrator. The tubing was not dated. On 3/2/23 at 10:44 A.M., Resident 9 was observed laying in bed wearing n/c and oxygen flow rate set on 3.5 LPM. The tubing and humidifier bottle were not dated. During an interview on 3/2/23 at 11:04 A.M., RN 24 indicated that the resident would not adjust the oxygen flow rate on the machine and the oxygen flow rate and machine should be checked by			

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	nursing every shift. At that time, they also indicated that the tubing is changed weekly on night shift and should be dated. If the humidifier bottle was low, it should be changed and dated. During an interview on 3/2/23 at 11:08 A.M., RN 24 observed that there was no date on Resident 9's oxygen tubing or humidifier bottle. At that time, RN 24 observed the oxygen flow rate was "a little under 4 LPM, like 3.5-3.75 LPM", and then adjusted oxygen flow rate to 4 LPM. On the way out of the resident's room, they observed the portable oxygen concentrator hanging on the resident's wheelchair and indicated the tubing was not dated and should be. During an interview on 3/5/23 at 9:35 A.M., the DON (Director of Nursing) indicated the nurses should check the oxygen concentrator, humidifier bottle, and flow rate every shift. On 3/6/23 at 10:30 A.M., a current Administration of Oxygen policy, revised 5/2018, was provided by the DON and indicated "1. Verify physician's order ... 14. Date the tubing for the date it was initiated. a. tubing should be changed monthly and PRN (as needed) ... 17. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is administered ... A humidifier should be used for resident receiving oxygen at 4 LPM or above ... 21. Observe the resident upon setup and periodically thereafter ... " 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
F 0758 SS=D	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN			

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Bldg. 00	Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's			

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	medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 3 of 7 residents reviewed for unnecessary medications. Resident's had PRN (as needed) anti-anxiety medications that were ordered for greater than 14 days without a rationale included in their clinical record. (Resident 50, Resident 25, Resident 30) Findings include: 1. On 3/1/23 at 9:46 A.M., Resident 50's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and depression. Resident 50 was admitted 11/16/22. The most recent admission MDS (Minimum Data Set) Assessment, dated 11/22/22, indicated Resident 50 was moderately cognitively impaired, they received an anti-anxiety medication 0 of 7 days, and had no behaviors during the assessment look back period. Current physician orders included, but were not limited to: alprazolam (an anti-anxiety medication) tablet 0.25 mg (milligram) orally for anxiety three times a day PRN, started 11/16/22 with no indicated stop date. The current MAR (medication administration record) from 2/1/23 through 3/1/23 was reviewed and indicated Resident 50 was assessed 3 (three) times daily for behaviors of excessive worry,	F 0758	Deficiency ID: F758 Completion Date: 3/31/23 Plan of Correction Text: 1. Residents 50, 25, and 30 were affected by the alleged deficiency. No adverse effects noted. Resident 50 order for PRN alprazolam reviewed with physician or designee for stop date and rationale to continue after the 14 days evaluation. Resident 25 order for PRN lorazepam reviewed with physician or designee for stop date and rationale to continue after the 14 days evaluation and reasoning for second PRN anti-anxiety medication. Resident 30 order for PRN lorazepam reviewed with physician or designee for stop date and rationale to continue after the 14 days evaluation. Physician or designee has placed a rationale note in medical record for continuation and stop dates have been added to the PRN antianxiety orders. 2. All residents have the potential to be affected. Clinical leadership team educated on PRN antianxiety medications require a stop date and rationale note from	03/31/2023

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	restlessness, and agitation. There were no behaviors documented. It also indicated Resident 50 was administered the ordered PRN alprazolam on the following dates: 2/3/23 at 12:01 A.M. 2/8/23 at 9:16 A.M. 2/11/23 at 8:58 A.M. 2/28/23 at 3:35 P.M. 3/1/23 at 6:40 P.M. Resident 50's clinical record lacked any physician notes with a rationale to continue alprazolam PRN after the 14 day evaluations. 2. On 2/28/23 at 10:06 A.M., Resident 25's clinical record was reviewed. Diagnoses included, but were not limited to, seizures and anxiety. The most recent admission MDS Assessment, dated 1/23/23, indicated Resident 25 was cognitively intact, and received antianxiety medications 7 of 7 days during the look back period. Current orders included, but were not limited to: lorazepam (an anti-anxiety medication) solution 2 mg/mL (milligrams per milliliter) injection, IM (intramuscular) for seizures every 2 (two) hours PRN, ordered 1/17/23 with no indicated stop date. The MAR (medication administration record) from January 2023 through March 2023 indicated Resident 25 received lorazepam 2 mg/mL IM on 1/18/23. Progress notes included, but were not limited to the following: 1/17/23 at 2:01 P.M. "Spoke with [doctor's name] of orders received from hospital ... ordered Lorazepam 2 mg IM every 2hrs PRN seizure activity ..." 1/31/23 at 4:21 P.M. "... Lorazepam 2 mg Q2hrs		physician or designee after the 14-day evaluation. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 residents for duplicate PRN antianxiety meds and rationale with new PRN orders weekly x4 weeks, then every other week x2 months, then monthly x3 months 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	[every 2 hours] for seizures ..." The clinical record lacked other documentation of a rationale as to why Resident 25 was taking a PRN anti-anxiety medication beyond 14 days or the need for a second anti-anxiety medication. During an interview on 3/2/23 at 8:12 A.M., LPN (Licensed Practical Nurse) 5 indicated if Resident 25 were to have seizure activity, she would administer lorazepam 2mg IM injection, as there was a current order for every 2 hours as needed. 3. On 2/28/23 at 2:03 P.M., Resident 30's clinical record was reviewed. Resident 30 was admitted on 7/19/22. Diagnoses included, but were not limited to, metabolic encephalopathy, personal history of traumatic brain injury, altered mental status, unspecified dementia, unspecified severity, with other behavioral disturbance, and major depressive disorder, recurrent, moderate. The most recent quarterly MDS Assessment, dated 2/2/23, indicated Resident 30 was moderately cognitively impaired and an anti-anxiety medication was administered for 7 of 7 days during the look back period. Current physician orders included, but were not limited to the following: Ativan (lorazepam) 0.5 mg twice a day for anxiety, dated 9/14/22-2/9/23 Ativan (lorazepam) 0.5 mg tablet every 6 hours PRN for agitation, dated 11/29/2022 with no end date Re-evaluate PRN Ativan every two weeks, dated 9/29/22 Anti-Anxiety Medication Use-Observe resident closely for significant side effects: sedation, drowsiness, ataxia(drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash, dated 9/14/22			

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	Resident 30's clinical records indicated pharmacy reviews were done monthly from 9/27/22 through 2/10/23. A GDR (gradual dose reduction) completed on 2/10/23 indicated the pharmacist recommended assessing the psychotropic PRN medication, lorazepam 0.5 mg po (by mouth) every six hours PRN for agitation which had been active since 11/29/22. The physician's evaluation lacked a rationale to continue the medication. Resident 30's clinical records lacked any physician notes with a rationale to continue lorazepam PRN after the 14 day evaluations. During an interview on 3/2/23 at 9:55 A.M., LPN 5 indicated Resident 30 hadn't needed the PRN Ativan for a long time. Once he was put on Haldol, he has been very pleasant. She has not had any reports of any behaviors in the last two weeks. During an interview on 3/2/23 at 11:15 A.M., the DON (Director of Nursing) indicated the PRN anti-anxiety medications were reviewed every two weeks by the prescriber to see if they need to continue as PRN or become a routine medication. If they need to stay PRN, the prescriber will put the reason within their physician note in the resident's clinical record. On 3/3/23 at 1:58 P.M., a current Psychotropic Medication Usage policy, revised 10/9/17, was provided by the DON and indicated " ... 1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process ...			

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	8. PRN order for psychotropic drugs are limited to 14 days. Except as provided if the attending physician or prescriber believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration of the PRN order ... " 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable, and sanitary environment was maintained in 3 of 3 resident halls, 1 of 1 laundry rooms, and 1 of 1 common shower rooms. Resident room floors were sticky and debris was on the floor, resident items were uncovered and unlabeled in shared bathrooms, there was a strong urine odor in the bathroom, and vent covers were soiled in the shower room and laundry room. (100 Hall, 200 Hall, 300 Hall, Hall 200 Shower Room, Laundry room) Findings include: 1. During an interview on 2/27/23 at 11:29 A.M., Room 205's family indicated the roommate was urinating on the bathroom floor and toilet seat. The family member also indicated that staff was asked to clean the bathroom floor and spray the room because "it smelled like a litter box". This was a shared room with two residents.	F 0921	Deficiency Tag # F0921 Completion Date 3/31/23 1.No residents were affected by the alleged deficient practice. All effected rooms noted in 2567, shower and laundry rooms on Health Center were immediately Inspected and cleaned and any maintenance concerns addressed. 2.All residents have the potential to be affected. ED/Designee educated staff on proper cleaning procedure and the maintenance of the campus. 3.As a measure of ongoing compliance: ED/Designee will monitor 5 random rooms, shower room, laundry room weekly x 4, then monthly x 3, and quarterly thereafter, with results being forwarded on to the IDT (inter	03/31/2023

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	On 2/28/23 at 3:43 P.M., the (shared) bathroom in Room 205 was observed with dark yellow urine and toilet paper in the toilet. The non-slip strips in front of the toilet were covered with black lines. On 3/3/23 at 8:54 A.M., Room 205 was observed with dark yellow urine in the toilet and there was a clear liquid on the floor in front of the toilet. The bathroom had a strong urine odor. Room 205 had a strong odor of urine. 2. On 2/28/23 at 8:48 A.M., Room 308 (private room) was observed with paint chip debris on the floor just outside of the bathroom door by the doorframe. The call light that was wrapped around the resident's bed did not work, and the bathroom was observed with 2 (two) uncovered graduated cylinders sitting on the back of the toilet with a yellow film in the bottom of them, a washbasin and bedpan on the floor under the sink uncovered, the floor was sticky, and the sink was slow to drain (40 seconds to drain the sink when it was 1/3 full). On 3/2/23 at 8:30 A.M., Room 308 was observed with paint chip debris still on the floor, the call light was still not working, but was coiled and sitting on the recliner, the 2 uncovered graduated cylinders were still on the back of the toilet, and the sink was still slow to drain. 3. On 2/28/23 at 2:13 P.M., Room 301 (private room) was observed with a broken outlet cover with exposed jagged edges by the bed, white debris between the bed and the wall, the floor was covered with food crumb debris, the bathroom floor was sticky, a glove was in the sink, 2 (two) spoons were behind the faucet on the sink, a wipes pack was sitting on the back of the toilet uncovered with a wipe exposed, a used wash		disciplinary team) for review. 4.As a quality measure, the ED/Designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted	

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	cloth was observed on the floor behind the toilet wadded up, and the base of the toilet was observed with discolored caulk that was broken up and coming up from the floor. On 3/2/23 at 8:25 A.M., the same was observed in Room 301. 4. On 2/27/23 at 2:21 P.M., Room 305 (private room) was observed with a tissue under the AC (air condition) unit, food crumb debris on the floor, and the call light did not work. An uncovered washbasin was observed on the bathroom floor under the sink, debris in all corners of the bathroom, the toilet tank was leaning back resting on the wall, and the vent in the bathroom ceiling did not have a cover. On 3/2/23 at 9:50 A.M., Room 305 was observed with food crumb debris on the floor, debris in the corners of the bathroom, the toilet tank was still tilted and resting on the wall, and the vent was still not covered in the bathroom ceiling. 5. On 2/27/23 at 10:45 A.M., Resident 40 was observed sitting in a wheelchair in the common area during an activity. The front left corner of the chair cushion was ripped open with the foam inside of it exposed. On 3/2/23 at 9:55 A.M., Resident 40 was observed sitting in a wheelchair in the common area. The front left corner of the chair cushion was still ripped open with exposed foam. At that time, Hospice CNA (Certified Nurse Aide) 15 indicated Resident 40's cushion was most likely provided by hospice, and that typically the hospice staff would change them as needed. Hospice CNA 15 indicated she had visited Resident 40 that morning, but did not notice the ripped cushion.			

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	6. On 2/27/23 at 1:36 P.M., an empty denture cup and an uncovered toothbrush were observed laying on the sink, unlabeled in the shared bathroom of room 110 with 2 (two) residents. On 3/3/23 at 8:40 A.M., the denture cup was still on the sink unlabeled. 7. On 2/27/23 at 11:28 A.M., a tube of toothpaste and an uncovered toothbrush, were observed unlabeled and laying on the sink in the shared bathroom of room 112 with 2 (two) residents. 8. On 2/27/23 at 10:59 A.M., in the shared bathroom of room 114 with 2 (two) residents, 1 (one) empty, pink denture cup, a razor, and a tube of toothpaste, without the lid closing it, were observed unlabeled on the sink. An uncovered incontinence pad and an unlabeled tube of denture adhesive were observed laying on the back of the toilet . There were 3 (three) open bags of resident incontinence pads observed on the bathroom floor, with 2 (two) loose incontinent pads laying on top of a bag. Another unlabeled, empty, pink denture cup was observed sitting on top of the paper towel holder. 4 (four) uncovered, pink wash basins were observed on the floor under the sink. An uncovered toothbrush, 1 (one) purple denture cup, 1 (one) yellow denture cup, and a tube of toothpaste were observed laying on the storage container against the wall unlabeled. On 3/3/23 at 8:38 A.M., the same was observed. 9. On 2/28/23 at 9:54 A.M., in the shared bathroom of room 202 with 2 (two) residents, an open bag of resident incontinence pads was observed on the floor. A brown substance was observed smeared on front of the toilet bowl, on the toilet seat, and 2 (two) brown smears the size of a quarter on the			

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	floor by the sink. On 3/3/23 8:41 A.M., the plastic on the right handlebar of toilet seat was cracked and the front quarter of the plastic is missing. During an interview on 3/3/23 at 10:51 A.M., CNA 32 indicated the handlebar should not be like that and Resident 21 used that bathroom. She indicated she would put in a work order for maintenance to fix it. During an interview on 3/3/23 at 11:00 A.M., Housekeeper 7 indicated they were unsure how long the handlebar looked like that. At that time, they indicated maintenance should be aware of it because it isn't safe for the resident and it shouldn't be like that. During an interview on 3/3/23 at 10:53 A.M., CNA 9 indicated that resident items in the bathroom should be labeled and covered if needed. They further indicated bags of resident incontinence pads were usually kept in the closet and there shouldn't be uncovered incontinence pads laying out. 10. During observation of the laundry area on 3/1/2023, at 10:46 A.M., the vent covers on the ceiling above the washing machines were visibly soiled, rusty, and covered with a mold-like substance. The ceiling had large tan spots which laundry staff indicated had been a water or condensation leak that maintenance had repaired but not re-painted. There was a palm-sized patch of drywall falling off the ceiling above the washer on the right. Laundry staff indicated there was a leak behind the first washing machine that squirts water out into the gutter behind the machine. The gutter behind the washing machines had a black mold-like substance growing above the gutter, in the middle of the wall. There were two hooks on			

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	the wall above the washer on the left that were holding dusty old belts and hoses hanging above the washers. Staff indicated they're so old they probably wouldn't work on the machines they have. Staff indicated that housekeeping never does a thorough cleaning in the laundry and the laundry staff just do whatever they can. The laundry staff indicated some of their equipment was in very poor condition. For example, they indicated the middle washer was down for about a year and a half and they just got it going again. The containers used to sort the clothes are frames made of plastic pipe that have metal frames inside to hold the bags of soiled laundry. The metal frames are bent out of shape and fall out of the plastic pipe onto the floor when they are full of soiled laundry. Staff have informed management about it but did not get a commitment to replace or repair them.. The laundry staff indicated the equipment with casters (laundry carts, trash containers, etc.) needs new casters. They added that some of them are so dirty you can't get them clean anymore, described them as so "gunked up" they don't roll anymore, with accumulated debris over the years, "like a bad grocery cart. It's back breaking. You have to shove them". Observed rusty wheels on three of three laundry carts, the rubber on the wheels is old and cracked. Staff sprayed cleaner on one of them and ran it across paper towels, and the wheel left black streaks on the paper. Staff also indicated a need for more space to expand the laundry. "We are crammed to the hilt in here and need space to organize". 11. On 2/27/23 at 10:00 A.M., Resident 19 complained the shower room being cold when they take showers. Resident indicated "It gets so			

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	dirty a dog wouldn't take a shower in there". On 2/27/23 at 10:07 A.M., Resident 24 complained the shower room was cold all the time and the water was lukewarm. On 3/7/23 at 9:59 A.M., the common shower room was observed to be soiled. Specifically, the trash can next to the toilet was overflowing with paper towels, there was paper debris on the floor around the toilet. In the shower anteroom, there were wet tissues, used latex gloves, and washcloths on the floor, and a trash can overflowing with used briefs and other trash. There were 3 shower stalls. Two of them had plastic bottles, used bandages, and wet wash cloths on the floor. There were used latex gloves on the floor next to the bathtub. The shower room floor was soiled and sticky to walk on. The vent on the ceiling just inside the main entry door and the area around it was covered with a black/gray mold-like substance; the wall above the door is covered with black/gray mold-like substance. The shower room felt very cool, but there was no thermostat in the room to assess the temperature. There was a small heater on the ceiling in the middle of the room. When turned on, the heater put out a very small amount of heat. During an interview on 3/3/23 at 8:47 A.M., Housekeeper 7 indicated all resident rooms and bathrooms should have been cleaned daily by housekeeping, and floors vacuumed daily as well. At that time, she indicated anything that the residents used daily should be cleaned. During an interview on 3/3/23 at 10:40 A.M., the Maintenance Supervisor indicated he has been aware of most room concerns for several days, but			

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	had not gotten around to fixing them. He indicated he would need a plumber to fix Room 305's toilet, and had not scheduled one yet. He also indicated he was made aware of the broken outlet cover in Room 301 earlier in the week. He indicated he was not aware of the handrail plastic being cracked and missing in the bathroom of room 202. He is unsure how long it had been in that condition. At that time, he indicated there was no specific policy related to maintenance, but he had a monthly schedule of possible concerns to look over in resident rooms, and at all other times, he relied on work orders to be filled out by other staff. He indicated if staff observed a maintenance concern, they needed to fill out a work order, which were reviewed daily every morning and again in the afternoon. On 3/3/23 at 1:58 P.M., a current Room Cleaning policy, revised 6/15/22, was provided and indicated "Health Center resident rooms are cleaned daily and deep cleaned monthly ... If there are any maintenance issues generate a work order in TELS [maintenance communication system]" On 3/5/23 at 9:35 A.M., the DON (Director of Nursing) indicated there was not a policy but "it was the facility's policy to label and cover resident items" This Federal tag relates to Complaint IN00399595. 3.1-19(f)(5)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (u) In addition to the required inservice hours in	F 9999	Deficiency ID: F9999 Completion Date: 3/31/23 Plan of Correction Text:	03/31/2023

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	155674	A. BUILDING 00 B. WING	03/07/2023

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	subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure required dementia-specific training was completed for 3 of 10 employee files reviewed. (CNA 40, CNA 41, CNA 23) Findings include: 1. On 3/2/23 at 9:45 A.M., CNA (Certified Nurse Aide) 40's employee file was reviewed. Hire date was 7/11/22. The file documentation indicated they had completed 4.5 of 6 hours required for dementia-specific training. 2. On 3/2/23 at 11:00 A.M., CNA 41's employee file was reviewed. Hire date was 4/9/19. The file documentation indicated they had completed 0 of 3 hours required for dementia-specific training. 3. On 3/2/23 at 2:00 P.M., CNA 23's employee file was reviewed. Hire date was 8/1/18. The file documentation indicated they had completed 2 of 3 hours required for dementia-specific training. During an interview on 3/3/23 at 1:10 P.M., the DON (Director of Nursing) indicated the SSD (Social Services Director) completed the dementia training and she wasn't sure what the		1. No residents were affected by the alleged deficient practice. C.N.A. 40 completed the required initial 6 hours of dementia-specific training. C.N.A. 41, 23 completed the required annual 3 hours of dementia-specific training. 2. All residents have the potential to be affected. The Director of Health Services and Director of Social Services immediately educated on the required hours of dementia-specific training and the company monitoring system. The IDT (Inter disciplinary team) educated on the required hours of dementia-specific training and the company monitoring system and reports. 3. As a measure of ongoing compliance: The ED or designee will monitor 5 random staff members for completion of required dementia-specific training weekly x4 weeks, then every other week x2 months, then monthly x3 months 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	requirements were. During an interview on 3/3/23 at 1:15 P.M., the SSD indicated newly hired employees do a dementia program that accounts for 3 (three) hours dementia training and were assigned additional online dementia education to complete their hours. At that time, she also indicated other employees were assigned online dementia training annually to complete. They were unsure what the required hours were for employees. On 3/6/23 at 10:30 A.M., a current Mandatory Annual Training's policy, revised 2/5/21, was provided by the DON and indicated "Trainings are determined and assigned based on the employee's position within the organization and in accordance with State and Federal agency requirements ... 5. The campus will run a monthly report in (computer program) showing those employees that have/have not completed their assigned trainings. a. The report will be reviewed and discussed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting. b. Corrective action may be taken on those employees who do not complete the required trainings by the designated deadline ... "			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification, State Licensure Survey, and the Investigation of Complaint IN00399595. Complaint IN00399595 - State deficiency related to the allegations is cited at F921. Survey dates: February 27, 28, March 1, 2, 3, 6, 7,	R 0000	The submission of this plan of correction does not indicate an admission by St. Charles Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of St. Charles Health	

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	2023 Facility number: 002628 Residential Census: 39 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.		Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of			

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	audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure the fire department was invited to attend fire drills at least every 6 (six) months. Finding includes: On 3/6/23 at 2:06 P.M., fire drill reports were provided from January 2022 through February 2023. The drill reports lacked documentation of the fire department being invited or attending the fire drills. At that time, the Maintenance Supervisor indicated the fire department was invited to attend fire drills once a year, and were invited in November 2022, when a fireman did come to the campus, but only did smoke detector training at the Villas (independent living). On 3/7/23 at 9:30 A.M., the Corporate Nurse indicated there was not a policy specific to fire drills, but the facility had been inviting the fire department once a year. At that time, she was unaware that the fire department should have been invited every 6 months.	R 0092	Deficiency ID: F092 Completion Date: 3/31/23 Plan of Correction Text: 1. No residents were affected by the alleged deficient practice. The Director of Plant Ops and the Executive Director immediately educated on inviting the fire department to a fire drill every 6 months. The fire department has been invited to attend the fire drills 3/30/23 2. All residents have the potential to be affected. The IDT (inter disciplinary team) educated on the regulation of inviting the fire department to a fire drill every 6 months. 3. As measure of ongoing compliance: The ED or designee will monitor the fire department attendance at the facility's fire drill weekly x4 weeks, then every other week x2 months, then monthly x3 months to meet the every 6 month attendance. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance	03/31/2023

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			Improvement meetings. The plan will be reviewed and updated as warranted.	