STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00408033 and IN00409616. This visit included the Investigation of Residential Complaint IN00405486. Complaint IN00408033 - Federal/State deficiencies related to the allegations are cited at F677 and F692. Complaint IN00409616 - Federal/State deficiencies related to the allegations are cited at F624, F684, F686, and F842. Complaint IN00405486 - State deficiency related to the allegations is cited at R0240. Unrelated deficiency is cited. Survey dates: June 7, 8, and 9, 2023 Facility number: 000471 Provider number: 155572 AIM number: 100290390 Census Bed Type: SNF/NF: 64 SNF: 6 Residential: 8 Total: 78 Census Payor Type: Medicare: 4 Medicaid: 33 Other: 28 Total: 70 These deficiencies reflect State Findings cited in	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deana Jordan Collins	Regional Nurse Consultant	07/12/2023

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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	accordance with 410 IAC 16.2-3.1. Quality review completed on 6/19/23.			
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.			
	Based on record review and interview, the facility failed to ensure resident's discharges to home were safe and orderly, related to no description of a resident's wounds and no current vital signs upon discharge, for 2 of 3 residents reviewed for discharges. (Residents E and K) Findings include: 1. Resident E's record was reviewed on 6/7/23 at 11:37 a.m. The diagnoses included, but were not limited to, spinal cord injury of the thoracic spine, paraplegia, diabetes mellitus, hyperlipidemia, and depression. The resident was discharged from the facility to home on 5/27/23. The Wound Summary Forms, dated 5/23/23, indicated a pressure ulcers were located on the coccyx/sacral area, the left heel, the right ischial tuberosity, the left lateral mallelous (ankle), and the perineum. The skin condition on discharge was not documented (left blank) on the Discharge Instructions provided to the resident at the time of	F 0624	**F- 624 Preparation for Safe/Orderly Transfer/Discharge** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:**	07/02/2023

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	discharge. The treatments instructions were given without documentation when the treatment had been completed at the facility and when the next treatment was scheduled to be completed. During an interview on 6/8/23 at 10:46 a.m., Nurse 1 indicated she had completed the treatments right before he was discharged from the facility. She had not documented the skin condition at the time of the discharge. 2. Resident K's record was reviewed on 6/9/23 at 8:29 a.m. The diagnoses included, but were not limited to, osteomyelitis of vertebra, sacral, and sacrococcygeal region and sacral pressure ulcer. A Discharge Minimum Data Set assessment, dated 4/4/23, indicated the resident had a planned discharge to home. The Discharge Instructions, dated 4/4/23, indicated the vital signs and oxygen saturation levels were not assessed at the time of the discharge. The temperature documented was dated 3/19/23 at 1 p.m., respirations were dated 2/12/23 at 8 p.m., the oxygen saturation was dated 2/12/23 at 8:01 p.m., and the blood pressure and pulse were dated 3/30/23 at 9:15 a.m. During an interview on 6/9/23 at 9:09 a.m., the Director of Nursing indicated the vital signs were not current at the time of the discharge. This Federal tag relates to Complaint IN00409616. 3.1-12(a)(21)		**Residents E and K discharged from the facility.** **2) How the facility identified other residents:** **Any resident who is discharging from the facility have the potential to be affected by the cited practice.** **3) Measures put into place/ System changes:** **DON/Designee to educate nursing staff on the correct procedure to follow for resident's discharges to include wound description, current vital signs.** **4) How the corrective actions will be monitored:** DON/Designee to review discharge paperwork to ensure all areas have ben completed to include wound descriptions and current vitals. Audits will be completed during daily stand up meeting 5X a week X 4 weeks , 2X week times 4 weeks , then weekly .	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 7-2-2023**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure residents who required assistance with bathing, received bathing as preferred by the resident for 3 of 3 residents reviewed for bathing. (Residents D, F, and G) Findings include: 1. Resident D's record was reviewed on 6/8/23 at 9:10 a.m. The diagnoses included, but were not limited to, dementia. An Admission Minimum Data Set (MDS) assessment, dated 2/25/23, indicated a moderately impaired cognitive status, required limited	F 0677	**F – 677 ADL Care Provided for Dependent Residents** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	07/02/2023

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assistance of two staff for transfers, ambulation, hygiene, had no bathing and had no behaviors.

The Care Plan, dated 2/22/23 and revised on 6/5/23, indicated a self-care deficit related to her cognitive status. The interventions included assistance of staff with bathing and showering was needed.

The Preference Assessment, dated 2/25/23, indicated her preference for bathing was a shower twice a week.

The showers were scheduled for Monday and Thursdays on day shift.

No showers or bathing was received from February 22 through February 28, 2023.

March 2023 documentation indicated the shower was refused on 3/2/23. Bathing had not been completed until 3/13/23 and she had gone 20 days without bathing.

Bathing had not been completed from 3/31/23 to 4/6/23, from 4/10/23 to 4/24/23, from 5/19/23 to 5/25/23, and from 5/26/23 to 6/5/23.

During an interview on 6/8/23 at 12:10 p.m., the Director of Nursing indicated the resident refused showers and would wash herself up in the bathroom. She indicated there was no Care Plan for refusals or interventions for the refusals.

2. Resident F was interviewed on 6/7/23 at 8:38 a.m., and indicated she was not showered and bathed twice a week.

Resident F's record was reviewed on 6/8/23 at 12:49 p.m. The diagnoses included, but were not

deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

1)Immediate actions taken for those residents identified:

Resident D discharged from facility on 6-16-23. Resident F received a shower on 6-20-23 and resident G received a shower on 6-19-23.

2) How the facility identified other residents:

All residents have the potential to be affected by the alleged deficient practice. SS/Designee to perform a full house audit on shower preferences to ensure resident choices are being honored.

3) Measures put into place/ System changes:

DON/Designee to re-educate nursing staff on performing showers per resident preference.

4) How the corrective actions will be monitored:

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	limited to, Parkinson's disease. A Quarterly MDS assessment, dated 3/7/23, indicated a moderately impaired cognitive status, no behaviors, required extensive assistance with transfers and hygiene, and was dependent for bathing. A Care Plan, dated 3/6/23, indicated refusals of showers. The interventions included to negotiate a time for showers so she can participate in the decisions. If she refused, leave and return 5-10 minutes later and attempt again. A Preference Assessment, dated 3/2/23, indicated her bathing preference was a shower and twice a week was acceptable. The shower was scheduled for Tuesday and Saturday days. The 4/2023 shower forms indicated no bathing had been completed from 4/5/23 to 4/11/23, 4/12/23 to 4/18/23, 4/19/23 to 4/25/23, 4/30/23 to 5/9/23 and 5/24/23 to 6/3/23. There was no documentation that indicated the resident refused the bathing. 3. Resident G was interviewed on 6/8/23 at 8:27 a.m., she indicated she had one shower last week and had not been getting showers twice a week. Resident G's record was reviewed on 6/8/23 at 2:20 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly MDS assessment, dated 2/22/23, indicated a moderately impaired cognition, no behaviors, and required extensive assistance with		**DON/Designee will conduct an ADL audit to ensure showers are being rendered per residents POC. Audits will be completed on 8 residents 5X/week for 4 weeks, 3X/week for 4 weeks then weekly.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7-2-23**	

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	bathing. A Care plan, dated 11/7/22, indicated a self-care deficit and the assistance was needed with activities of daily living. The Activity Preferences assessment, dated 4/18/23, indicated the preferred type of bathing was a shower and twice a week was acceptable. The showers were scheduled on Tuesday and Friday days. The Shower sheets indicated a bed bath was given on 5/12/23, a shower was received on 5/18/23, a bed bath was received on 5/22/23, 5/23/23, 5/25/23, and 5/26/23, a shower was received on 5/30/23 and a bed bath on 6/2/23. The Administrator and Director of Nursing were informed of bathing concerns on 6/8/23 at 5:45 p.m. No further information was received. This Federal tag relates to Complaint IN00408033. 3.1-38(b)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility	F 0684	**F- 684**	07/02/2023

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	failed to ensure a resident received medications as ordered by a Physician for 1 of 3 residents reviewed for quality of care related to medication administration. (Resident E) Finding includes: Resident E's record was reviewed on 6/7/23 at 11:37 a.m. The diagnoses included, but were not limited to, spinal cord injury of the thoracic spine, paraplegia, diabetes mellitus, hyperlipidemia, and depression. The Physician's Orders included the following medication orders and dates of the orders: 4/7/23 - humalog insulin - the amount of the insulin was to be determined by the blood sugar results (sliding scale) and was to be completed before each meal (7 a.m., 11 a.m., and 4 p.m.) and at bed time (8 p.m.). 4/7/23 - lantus insulin, 15 units was to be administered at bedtime daily (8 p.m.). 4/6/23 - gabapentin (nerve pain) - 100 mg (milligrams) was to be administered three times a day, at 8 a.m., 12 p.m., and 4 p.m. 4/6/23 - atorvastatin (cholesterol medication) - 20 mg was to be administered at 8 p.m. daily. 4/6/23 - escitalopram (antidepressant) - 20 mg was to be administered at 8 p.m. daily. The Medication Administration Record (MAR), dated 4/2023, indicated the following medications were not administered as ordered: - The lantus insulin was not administered as on 4/26/23. - The gabapentin was not administered on 4/20/23		The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1). Immediate actions taken for those residents identified:** **Resident E no longer resides at the facility.** **2) How the facility identified other residents:** **Any resident who receives a medication has the potential to be affected by the cited practice.** **3) Measures put into place/ System changes:** **DON/Designee to educate**	

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	at 12 p.m. - The blood sugars were not obtained and the humalog insulin had not been given on 4/21/23 at 11 a.m., 4/24/23 at 4 p.m., 4/26/23 at 4 p.m., and 4/27/23 at 8 p.m. - The escitalopram was not administered on 4/27/23 at 8 p.m. - The atorvastatin was not administered on 4/27/23 at 8 p.m. The MAR, dated 5/2023, indicated the following medications were not administered as ordered: - The lantus insulin was not administered on 5/4/23. - The blood sugar had not been obtained and the humalog insulin had not been administered on 5/4/23 at 8 p.m. - The escitalopram was not administered on 5/4/23. - The atorvastatin was not administered on 5/4/23. The Administrator was notified of the medications not being administered on 6/7/23 at 5:45 p.m. No further information was received. This Federal tag relates to Complaint IN00409616. 3.1-37		**Nurses/QMA'S on proper procedure for medication administration.** **4) How the corrective actions will be monitored:** **Don/Designee will review 5 resident's MARS 5X week, then 2X week, then weekly to ensure all medications are signed off after administration.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7-2-23**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 2 of 3 residents reviewed for pressure ulcers. (Residents E and H) Findings include: 1. Resident E's record was reviewed on 6/7/23 at 11:37 a.m. The diagnoses included, but were not limited to, spinal cord injury of the thoracic spine, paraplegia, diabetes mellitus, hyperlipidemia, and depression. An Admission Minimum Data Set assessment, dated 4/10/23, indicated an intact cognition, required extensive assistance of two staff for bed mobility and transfers, had two unstageable (full thickness tissue loss and unable to determine the depth due to eschar and/or slough) pressure ulcers at the time of the admission and pressure ulcer care was being administered. A Care Plan, dated 4/6/23, indicated a pressure ulcer on the left heel, the coccyx, and the right	F 0686	**F -686 Treatment/Sves to Prevent /Heal Pressure Ulcer** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** **Resident E no longer resides at the facility. Resident H's**	07/02/2023

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	ischial tuberosity. The interventions included the treatments to the areas would be provided as ordered. The Wound Summary Forms indicated the following : a) The pressure area on the coccyx/sacral area was measured on 4/11/23. The area was present on admission, was unstageable, was 25% slough, had moderate serous drainage, and measured 13 centimeters (cm) by 17 cm , with a depth of 1 cm. The pressure wound on the coccyx/sacral area measurements on 5/23/23 were a stage 4 (full thickness skin loss with extensive destruction), 5% slough, heavy serous (clear yellow) drainage, and measured 13.5 cm by 11 cm with a 2 cm depth. The Physician's Orders for the treatments to the coccyx/sacral area were: On 4/7/23 to 5/9/23, the coccyx/sacral area was to have TheraHoney External Gel wound dressings applied every 3 days. On 5/10/23, the coccyx/sacral area was to be cleansed with normal saline, patted dry, and Dakin's (antiseptic) solution soaked gauze were to be applied. The area was to be covered with a dry dressing daily. On 5/27/23, the coccyx/sacral area was to be cleansed with normal saline, patted dry, gauze soaked Dakin's solution was to placed into the wound bed and covered with a dry dressing twice a day. b) The left heel pressure area was identified on admission and measured on 4/11/23 as an		**pressure areas are now healed.** **2) How the facility identified other residents:** **Any resident with a skin issue has the potential to be affected.** **3) Measures put into place/ System changes:** **Don/Designee to re-educate nursing staff of pressure areas and documentation in the TAR .** **4) How the corrective actions will be monitored:** **DON/Designee will review TARS to ensure treatments are completed as ordered .** **DON/Designee will review eight resident's 5xs week times 4 weeks, 3xs a week times 4 weeks then weekly .** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6**	

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	unstageable area, with a necrotic, hard, and firm covering, there was no drainage and measured 6 cm by 7 cm. The depth was unable to be determined. The left heel area was measurements on 5/24/23 indicated an unstageable, necrotic, hard, and firm area and was 6.5 cm by 3.5 cm. The depth was unable to be determined. The Physician's Orders for the treatments to the left heel were: On 4/7/23, the left heel was to be cleansed with wound cleanser, patted dry, skin prep (liquid film to reduce friction) was to be applied, and the area covered with a roll gauze daily on day shift. On 5/16/23 , the left heel was to be cleansed with wound cleanser, patted dry, and wiped with a betadine soaked gauze. The area was to be covered with a dry dry gauze and secured with tape every evening. c) On 5/15/23, a new pressure area was assessed on the right ischial tuberosity. The area was measured on 5/18/23, as a stage 3 (full thickness skin loss) with 50% slough, moderate serosanguinous drainage, and measured at 1 cm by 1 cm, with a 0.1 cm depth On 5/15/23, a Physician's Order to treat the area indicated the area was to be cleansed with Dakin's solution and covered with a dry gauze daily. d) On 5/15/23 a new pressure was assessed on the left lateral mallelous (ankle). The area was identified as a deep tissue pressure injury (DTI) (persistent non-blanchable area on the skin) and measured 1.5 cm by 0.7 cm with no depth.		**months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7-2-2023**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	06/09/2023

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On 5/15/23, a Physician's Order to treat the area indicated the area was to be cleansed with Dakin's solution and covered with a dry gauze daily.

e) On 5/16/23, a new pressure area on the perineum was assessed as a stage 3 pressure area, with 50% slough, scant serosanguinous (yellow/red) drainage, and measured at 2 cm by 2 cm with a 0.1 cm depth.

On 5/17/23, a Physician's Order indicated the area was to be cleansed with normal saline, patted dry, and therahoney was to be applied to the wound bed and followed by calcium alginate (absorb drainage), then covered with a dry dry dressing daily.

The Treatment Administration Record (TAR), dated 4/2023, indicated the following treatments had not been completed as ordered:
- Treatment to the left heel had not been completed on April 8, 9, 17, 21, and 28, 2023.
- Treatment to the coccyx/sacral area had not been completed on April 22 and 28, 2023.

The TAR, dated 5/2023, indicated the following treatments had not been completed as ordered:
- The treatments to the coccyx/sacral area had not been completed on May 12, 20, 22, and 26, 2023
- The treatments to the left ankle had not been completed on May 16, 21, and 22, 2023.
- The treatments to the left heel had not been completed on May 16, 21, and 22, 2023.
- The treatments to the perineum had not been completed on May 20, 22, and 26, 2023.
- The treatments to the right ischial area was not completed on May 16, 21, and 22, 2023.

The Administrator was notified of the treatments

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	not being completed on 6/7/23 at 5:45 p.m. No further information was received. 2. Resident H's record was reviewed on 6/8/23 at 3:01 p.m. The diagnoses included, but were not limited to, degenerative disk disease. An Admission MDS assessment, dated 4/6/23, indicated an intact cognitive status and no pressure ulcers were present. A Care Plan, dated 5/4/23, indicated a pressure ulcer on the left heel and coccyx. The interventions indicated wound care would be provided as ordered by the Physician. The Physician's Orders, indicated on 5/4/23, the left heel was to be cleansed, patted dry, and sure prep was to applied every shift. On 4/28/23, the area on the coccyx was to cleansed, patted dry, skin prep and a hydrocolloid (moist dressing) dressing was to be applied to the area on Monday, Wednesday, and Friday. The TAR, dated 5/2023, indicated the treatment had not been completed on Monday, May 1, 2023. During an interview on 6/8/23 at 4:29 p.m., the Director of Nursing indicated the treatment to the coccyx had not been signed as completed on 5/1/23. This Federal tag relates to Complaint IN00409616. 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

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	The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on record review and interview, the facility failed to ensure a resident who was exit seeking, received adequate supervision and assistance devices to prevent elopement from the facility, for 1 of 1 resident reviewed for elopement. (Resident M) Finding includes: A State Reported Incident Form indicated the incident occurred on 5/24/23 at 7:01 a.m.. Resident M per the report was in room 17-A (North Hall), was observed by an employee in the Employee Parking Lot, and was attempting to unlock an employee car. He had exited through an egress door. The follow up report, dated 5/30/23, indicated the resident was placed on one on one care until the door was secured and a company had come to the facility to place a more secured magnet on the door. All alarms were checked and functioning. Staff were interviewed by the facility and statements were written as follows: A typed statement, dated 5/24/23 by CNA 2, indicated approximately at 7:30 a.m. she had attempted to redirect Resident M. He had been extremely aggravated since 6 a.m., wanted to go home and thought his car was in the parking lot. He was unable to be redirected. He could not be	F 0689	F- 689 This Plan of Correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1). **Immediate actions taken for those resident's identified:** **All Staff were educated on all residents who are at risk for elopement along with their elopement interventions. All elopement assessments were reviewed to ensure accurate assessment.** **2). How the facility identified other resident's:** **An audit was performed for all residents at risk for elopement to ensure accurate assessment.**	07/02/2023

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	redirected to a room because he had been aggravated all night and she had been informed by the Midnight CNA he was moved to the Alzheimer's Care Unit (ACU) due to his agitation and had not been assigned a room. She left the hall unattended for less than a minute to get the Nurse to assist her. When they returned to the Unit they were unable to find the resident. They started searching immediately. He was brought back into the facility by a staff member. He was able to show them how he pushed the door open. A written and signed statement, dated 5/24/23 by CNA 3 indicated on 5/24/23 at 6:50 a.m., she had observed the resident outside in the parking lot through a window on the North Hall. She went outside and convinced the resident to return to the inside of the building. He had keys in his hands and was attempting to unlock a car. A hand written note, signed and dated 5/24/23 by Nurse 2, indicated around 6:30 a.m., CNA 2 came off the ACU and informed her the resident was attempting to leave the building. Nurse 2 and Nurse 3 immediately went to the Unit. They began searching the Unit rooms, bathrooms and windows. A hand written noted, signed by Nurse 3, indicated he and Nurse 2 entered the ACU and were unable to find Resident M. They inspected exit doors and windows. They showed no signs of him exiting or damage. The resident was found in the parking lot within 5 minutes. Resident M's closed record was reviewed on 6/9/23 at 10:35 a.m. The diagnoses included, but were not limited to, Dementia. The resident was at the facility for Respite Care.		**3). Measures put into place /System changes:** **All exit doors will be inspected daily for proper functioning and if alarms are turned on. Staff will be trained monthly, upon hire and yearly regarding Code Pink, Door Alarms IE: Ensuring alarms are turned on and functioning properly , and if not functioning or turned off staff will notify HFA and Maintenance Director immediately and doors will be monitored until issue is resolved , Elopement Binders, their interventions, including redirecting away from exit doors and symptoms of wanting to go home. Code Pink drills will be performed monthly and for all new hires during orientation.** **4). How the corrective actions will be monitored to ensure the deficient practice will not recur:** **Care Plans of any residents identified as being at risk for elopement will be reviewed and revised, as necessary, along with the elopement risk assessments and elopement binders by Social Service Director /Designee. Elopement binders will be reviewed weekly to ensure accuracy.**	

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	An Admission Minimum Data Set assessment, dated 5/26/23, indicated a severely impaired cognitive status, no behaviors, required supervision of transfers and ambulation, and had no falls. An Elopement Risk Assessment, dated 5/23/23, indicated there had been no exit seeking behaviors and he was not a risk for elopement. An Admission 72 hour Progress Note, dated 5/23/23 at 9:54 p.m., indicated he transferred independently without support, required supervision with walking in his room and corridor. There was no documentation of the resident being agitated or exit seeking since admission on 5/23/23 to 5/24/23 at 7:10 p.m. A Nurse's Progress Note, dated 5/24/23 at 7:10 p.m., indicated he had not exhibited any exit seeking on the shift, remained in the ACU, was in good spirits and he was being monitored. There was no documentation in the Progress Notes of the elopement until 5/30/23 at 6:14 p.m. and Interdisciplinary Note indicated the resident had exited the building unattended. He was located in the facility parking lot and was escorted by the staff back into the building. He had pushed on the exit door causing the door to disengage. The State Reportable Incident had not indicated the resident was on the ACU when he exited, if the alarm on the exit door had activated, and how far the resident had walked once outside of the building. During an interview on 6/9/23 at 11:50 a.m., the		**The results of these audits will be reviewed in Quality Assurance Meeting monthly X6 months or until an average of 100% compliance or greater is achieved X3 consecutive months. The QA Committee will identify any trends or pattern's and make recommendations to revise the plan of correction as indicated.** **5). Date of Compliance: 7/2/23**	

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	Administrator was interviewed. The Corporate RN was present during the interview. The Administrator was unsure if the alarm had been activated. She indicated it was not written on the statements if the alarm had been activated. She indicated the alarm on the door had been shut off for only a few minutes so the Construction Workers could bring cabinets in through the door. CNA 3 had observed the resident outside and immediately went out to assist him back to the facility. She indicated she had not informed the State on the incident report the resident had exited the ACU and how far he had walked after leaving the building. CNA 2 was interviewed on 6/9/23 at 11:50 a.m. She indicated she had come into work at 6 a.m. on 5/24/23 and had received report from the Midnight CNA the resident had been moved to the ACU around 5 a.m. due to his agitation. He had not been assigned a room so she was unable to redirect him back to a room. He remained agitated and she was unable to redirect him. He walked with her to the corridor exit doors. She exited the doors to get help from the Nurses. Nurse 2 was on the other side of the doors and Nurse 3 was at the desk. They both immediately came to the ACU. When they returned, they did not see the resident and they started looking for him. There was no alarm activated. Everything happened from approximately 7:10 a.m. to 7:15 a.m. Staff checked every room and bathroom and checked the door at the end for the hall because he had been looking out that door. Nurse 3 had gone outside the door to look for the resident when CNA 3 brought the resident back to the ACU. No one had informed her the alarm was off. She was later told it had been shut off to bring the cabinets in. There were no Construction Workers observed on the ACU until around 8 a.m.			

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	During an interview on 6/9/23 at 12:02 p.m., the Maintenance Director indicated he had shut the alarm off about 7 a.m. They were putting new cabinets in the Dining Room on the ACU. The Construction Company were supposed to tell him when they were done bringing the cabinets in so he could reset the alarms. He had reset the alarm after he was made aware of the elopement. It had been turned off for approximately 30 minutes. He indicated he had informed the Nurse the alarm had been shut off, but he could not remember which Nurse he had informed. Nurse 2 was interviewed on 6/9/23 at 12:07 p.m. She indicated she had arrived at work at 6 a.m. She was at the Medication Cart when CNA 2 came and requested help. She and Nurse 3 immediately went to the ACU. She thought the CNA came to her about 6:30 a.m. Upon entering the ACU they did not see the resident and began looking in every room and bathroom. They could not find him and a "Code Pink" (missing resident) was called about the same time CNA 3 was bringing the resident back to the facility. There was no alarm sounding. If the alarm was sounding, she indicated staff would have looked outside the exit immediately. Everything had happened quickly and it had not seemed he was out of the building for very long. 3.1-45(a)(2)			
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the			

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	facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on record review and interview, the facility failed to ensure residents maintained an acceptable parameter of nutritional status, related to weights not obtained as ordered by a Physician and interventions for documented weight loss not initiated timely resulting in a significant weight loss. (Resident D) The facility also failed to document all meal intakes, the percentage of dietary supplements consumed as weight loss interventions, initiate interventions of weight loss timely, and to notify the Physician and Responsible Party in a timely manner of weight loss for 3 of 3 residents reviewed for weight loss. (Residents D, G, and F) Findings include: 1. Resident D's record was reviewed on 6/8/23 at 9:10 a.m. The diagnoses included, but were not limited to, dementia. An Admission Minimum Data Set assessment, dated 2/25/23, indicated a moderately impaired	F 0692	**F – 692** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:**	07/02/2023

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	cognitive status, able to feed herself with set up, weighed 111 pounds, had no significant weight loss or gain, and was on a therapeutic diet. A Care Plan, dated 2/27/23, indicated a history of weight loss. The interventions included the weight would be obtained and monitored per facility protocol, the dietary intakes would be monitored and recorded with each meal, and the Registered Dietician (RD) would evaluate and make diet change recommendations as needed. A Physician's Order, dated 2/22/23, indicated a no added salt diet. A Physician's Order, dated 2/27/23, indicated a weekly weight was to be obtained for four weeks. The weekly weights indicated on 2/27/23 the weight was 112 pounds and on 3/2/23 the weight was 112 pounds. The weights were not obtained and an NA (not applicable) was marked for the weekly weights of 3/13/23 and 3/20/23. The weight on 4/6/23 (next weight after the 3/2/23 weight) was 101.5 pounds, which was a 9.37% weight loss in a month. There was no documentation the Physician and Responsible Party had been notified of the significant weight loss on 4/6/23. No weight loss interventions were initiated at the time of the significant weight loss. No re-weigh was obtained after the weight of 4/6/23 to ensure accuracy. A Registered Dietician (RD) Progress Note, dated 4/13/23, indicated the weight was 101.5 pounds, a		**Resident D discharged from facility on 6-16-23. Resident G's family and MD will be notified of her significant weight loss by 6-30-23. Resident F's family and MD will be notified of her significant weight loss by 6-30-23.** **2) How the facility identified other residents:** **All residents have the potential to be affected by the cited practice. A full house audit of weight loss for the last 30 days was completed to ensure any resident with a weight loss had family/MD notifications made.** **3) Measures put into place/ System changes:** **DON/Designee to re-educate nursing staff on documenting the percentage that a resident consumes on any supplements. Nursing staff will be educated on documenting the percentage of meal intakes that a resident consumes. Nurse/Dietary Manager will be educated on notifying family/Md of any significant weight loss an on any interventions that were put in place.**	

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	9.4% weight loss in 30 days. The body mass index (BMI) was 18.6, which indicated underweight, and she had consumed 50-100% of most meals. A house supplement twice a day to help with calories and protein was recommended. A Physician's Order was received on 4/13/23 for the house supplement to be given twice a day. Another weight was obtained on 5/4/23 and was 101 pounds. A Physician's Order, dated 5/5/23, indicated Ensure pudding was to be given three times a day and mirtazapine (antidepressant, used as appetite stimulant) 7.5 mg (milligrams) was to be given at bed time. The order for the pudding was discontinued on 5/17/23. The Nurses' Progress Notes, dated 5/5/23 at 8:36 p.m., 5/6/23 at 12:15 p.m., 5/6/23 at 3:20 p.m., and 5/7/23 at 6:52 p.m., indicated the Ensure pudding had been unavailable and had not been given as ordered. An RD Progress Note, dated 5/17/23, indicated the resident was underweight, mirtazapine was ordered on 5/5/23 to enhance her appetite and the house supplement was administered three times a day. A Physician's Order, dated 6/7/23, indicated the house supplement was to be given three times a day and the mirtazpine was increased to 15 mg at bed time. The Medication Administration Record, dated 4/2023 and 5/2023, indicated the house supplements had been given to the resident, the amount consumed had not been documented.		**4) How the corrective actions will be monitored:** **DON/Designee will review meal/supplement intake, during clinical meeting to ensure supplement percentage is documented, MD and Registered Dietitian are notified, family notification, and recommendations including supplements and increased weight monitoring are noted. Audits will be completed 5 times a week X 4 weeks, 2 times a week then weekly to ensure compliance.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7-2-23**	

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The diet intake records for the past 30 days (May 12 to June 7), indicated meals were not monitored for breakfast on May 12, 27, 28, 29, 30, 2023 and June 1, 5, and 7, 2023, for lunch on May 27, 28, 29, 30, 2023 and June 1, 2, 5, and 7, 2023, and for supper on June 6, 2023.

On 6/8/23 at 12:00 p.m., the Director of Nursing (DON) and Administrator were informed of the weights not obtained as ordered, a significant weight loss was present when the weight was obtained and interventions had not been initiated for seven days after the significant weight loss. They were also informed the Physician and Responsible Party had not been notified timely. No further information was received at the time.

During an interview on 6/8/23 at 1:40 p.m., the DON indicated the Ensure pudding had been discontinued due to the inability to get it. She was unsure why fortified pudding or other nutritional supplements available at the facility were not given.

2. Resident G's record was reviewed on 6/8/23 at 2:20 p.m. The diagnoses included, but were not limited to, dementia.

A Quarterly MDS assessment, dated 2/22/23, indicated a moderately impaired cognitive status, able to feed herself with set up, weighed 100 pounds, had a significant weight loss, was on a prescribed weight loss regimen, and was on a mechanically altered diet.

A Care Plan, dated 11/20/22, indicated she left 25% or more of her food uneaten for most meals and refuses/failure to eat. The interventions included, provide dietary supplements as ordered

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

and monitor and record intake every shift.

The monthly weights were:
On 11/7/23 - 113 pounds.
On 12/4/22 - 109.5 pounds.
On 1/3/23 - 101 pounds.
On 2/9/23 - 100 pounds.
On 3/2/23 - 99 pounds.
On 4/4/23 - 91 pounds.
On 5/4/23 - 97 pounds a 14.15% weight loss in 6 months

The Physician's Orders, indicated a mechanical soft diet on 11/7/22, mirtazpine 15 mg at bed time on 11/9/22, and health shakes with meals were ordered on 1/3/23.

A Physician's Order, dated 5/18/23, two weeks after the significant weight loss, indicated house nutritional supplement twice a day.

The Nurses' Progress Notes lacked documentation that the Responsible Party and Physician had been notified of the significant weight loss on 5/4/23.

A re-weight had not been obtained.

An RD Progress Note, dated 5/17/23, indicated a nutritional risk due to an unplanned weight loss of 14.2% in six months. She consumed 50-75% of meals and had a house nutritional supplement twice a day. The plan of care was appropriate to meet the estimated nutrition needs at this time.

The MAR, dated 5/2023, indicated the house supplement was provided. The amount consumed had not been documented.

The Dietary intake forms for the past 30 days,

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	155572	A. BUILDING 00 B. WING	06/09/2023

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dated 5/12/23 through 6/8/23, indicated there had been no dietary intake for breakfast and lunch on 5/12/23, lunch on 5/15/23, breakfast and lunch on 5/21/23, lunch on 5/24/23, breakfast and lunch on 5/26/23, supper on 6/1/23, lunch and supper on 6/2/23, breakfast, lunch and supper on 6/3/23, breakfast and lunch on 6/4/23, breakfast and lunch on 6/6/23, and breakfast, lunch, and supper on 6/7/23.

On 6/8/23 at 4 p.m., the Administrator indicated the planned weight loss on the MDS assessment was incorrect.

3. Resident F's record was reviewed on 6/8/23 at 12:49 p.m. The diagnoses included, but were not limited to, Parkinson's disease.

A Quarterly MDS assessment, dated 3/7/23, indicated a moderately impaired cognitive status, required limited assistance with meals, weight was 123 pounds, had a significant weight loss, and was on a therapeutic diet.

A Care Plan, dated 11/16/21 and revised on 6/6/23, indicated she was on a therapeutic diet. The interventions included encouragement to consume the diet ordered. The Care Plan had not been updated with the significant weight loss.

The monthly weights were:
On 11/8/22 - 140 pounds.
On 12/14/23 - 132.5 pounds.
On 1/4/23 - 131 pounds.
On 2/14/23 - 130.5 pounds.
On 3/2/23 - 122.5 pounds, a 6.13% weight loss from the previous month.
On 4/6/23 - 120.5 pounds.
On 5/8/23 - 123.5 pounds, a 11.8% weight loss in 6 months.

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There was no documentation that indicated the Physician and Responsible Party had been notified of the 6.13% weight loss on 3/2/23 and on 5/8/23.

The had been no re-weight completed.

The Physician's Orders indicated a 120 milliliters of a house supplement was administered from 12/19/22 to 3/6/23, 120 milliliters of health shake was administered from 3/7/23 to 5/17/23, a no added salt diet was ordered on 4/14/23, and a house supplement was to be given three times a day starting on 5/18/23.

The MAR, dated 5/2023 and 6/2023, indicated the supplements had been given, the amount consumed had not been documented.

A RD's Progress Note, dated 5/17/23, indicated the resident was a nutritional risk related to an unplanned weight loss at 11.8% in 6 months, which could be related to the Parkinson's disease. She consumed 50-100% of most meals and the house nutritional supplement three times a day had been clarified. The nutritional approach was adequate to meet the nutritional needs with intervention clarified.

The Dietary intake forms for the past 30 days, dated 5/12/23 through 6/8/23 indicated there had been no dietary intake for lunch on 5/12/23, breakfast and lunch on 5/27/23, 5/28/23, 5/29/23, 5/30/23, Lunch on 6/1/23, breakfast and lunch on 6/5/23 and 6/7/23.

A facility policy on weights, dated 11/14/23 and received from the DON as current, indicated residents identified at a nutritional risk may be

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	weighed weekly or bi-weekly. A re-weight should be obtained if there is a difference of five pounds or greater (loss or gain) since the previous recorded weight. The re-weight should be taken as soon as possible, usually within 72 hours, prior to calling the Physician. Undesired weights of gains/losses of 5% in 30 days, 7.5% in three months, or 10% in six months were to be reported to the Physician, the RD and/or the Dietary Manager. A House Nutritional Supplement policy, received as current from the Dietary Manager on 6/8/23 at 1:05 p.m., indicated residents identified as needing additional nutrition interventions related to unplanned weight loss may consist of pudding, ice cream, health shakes, chocolate milk, Med Pass, a super donut, cookies and fortified cookies, a Magic Cup, name brand supplements if available, and yogurt/frozen yogurt. A facility policy for Physician and family notification, dated 11/13/18, indicated the Physician and family would be notified with a significant change in status or a need to alter treatment. This Federal tag relates to Complaint IN00408033. 3.1-46(a)(1)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the			

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	information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be			

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	retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure medical records were complete and accurately documented, related to follow up appointments with clinics, removal of a tunneled PICC (peripherally inserted central catheter), and vital sign assessments, for 2 of 10 residents reviewed for medical records. (Residents K and E) Findings include: 1. Resident K's record was reviewed on 6/9/23 at 8:29 a.m. The diagnoses included, but were not limited to, osteomyelitis of vertebra, sacral, and sacrococcygeal region and sacral pressure ulcer. a) A Physician's Order, dated 3/323, indicated the resident was to be transferred to the hospital for a removal of a tunneled PICC by the Radiology Department.	F 0842	**F- 842 Residents Records** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	07/02/2023

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	There was no documentation that indicated the resident went to the hospital and/or the PICC was discontinued. During an interview on 6/9/23 at 9:40 a.m., the Director of Nursing (DON) indicated there was no documentation the PICC had been removed. During an interview on 6/9/23 at 10:20 a.m., the DON indicated the Hospital was notified and the PICC was removed on 3/3/23 and paperwork would be placed in the record. b) The Discharge Instructions, dated 4/4/23, indicated the vital signs and oxygen saturation levels were not assessed at the time of the discharge. The temperature documented was dated 3/19/23 at 1 p.m., respirations were dated 2/12/23 at 8 p.m., the oxygen saturation was dated 2/12/23 at 8:01 p.m., and the blood pressure and pulse was dated 3/30/23 at 9:15 a.m. A Nurse's Progress Note, dated 4/4/23 at 1:15 p.m., indicated the resident was discharged to home and vital signs were stable upon discharge. There were no current vital signs recorded at the time of discharge. During an interview on 6/9/23 at 9:09 a.m., the Director of Nursing indicated the vital signs were not current at the time of the discharge. 2. Resident E's record was reviewed on 6/7/23 at 11:37 a.m. The diagnoses included, but were not limited to, spinal cord injury of the thoracic spine, paraplegia, diabetes mellitus, hyperlipidemia, and depression.		*federal and state law.* **1)Immediate actions taken for those residents identified:** **Resident K and E discharged from the facility.** **2) How the facility identified other residents:** **All residents have the potential to be affected by the cited practice. Medical Records to conduct an audit on resident appointments for the last 2 weeks to ensure any applicable paperwork is present in patients charts.** **3) Measures put into place/ System changes:** **DON/Designee will educate nurses on obtaining paperwork from outside appointments , documenting patients refusal to go to an appointment and obtaining vital signs upon discharge .** **4) How the corrective actions will be monitored:** **DON/Designee to complete an audit on any resident who had an appointment outside the facility to ensure paperwork**	

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	A Nurse's Progress Note, dated 5/15/23 at 4:11 p.m., indicated orders were received from the Wound Clinic for a follow up appointment on 5/22/23 at 9:45 a.m. There was no documentation that indicated the resident went to the appointment on 5/22/23. The Wound Nurse was interviewed on 6/8/23 at 9:44 a.m. She indicated the resident refused to go back to the Wound Clinic and said once he was discharged from the facility, the Veteran's Administration would take over his care. He and his family had not wanted to pay for the Wound Clinic. This Federal tag relates to Complaint IN00409616. 3.1-50(a)(1) 3.1-50(a)(2)		**was obtained or refusal documented. Audits will be completed 5X week X's 4 Weeks, 2X's week times 4 weeks then weekly .** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7-2-2023**	
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00405486. This visit included the Investigation of Nursing Home Complaints IN00408033 and IN00409616. Complaint IN00405486 - State deficiency related to the allegations is cited at R0240. Complaint IN00408033 - Federal/State deficiencies related to the allegations are cited at F677 and	R 0000		

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	F692. Complaint IN00409616 - Federal/State deficiencies related to the allegations are cited at F624, F684, F686, and F842. Unrelated deficiency is cited. Survey dates: June 7, 8, & 9, 2023 Facility number: 000471 Residential Census: 8 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/19/23.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility failed to ensure assistance was provided with ADL's (activities of daily living) related to bathing for 1 of 2 residents reviewed for bathing. (Resident B) Finding includes: Interview with Resident B on 6/7/23 at 11:30 a.m., indicated he had Home Health services to assist him with bathing but had only received a few showers since he had been admitted to assisted living. Resident B's record was reviewed on 6/7/23 9:42 a.m. Diagnoses included, but were not limited to,	R 0240	**R-240** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of*	07/02/2023

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	heart failure, neuropathy, and diabetes mellitus. He was admitted to the facility on 3/24/23. A Service Plan, dated 4/3/23, indicated the resident was oriented to person, place, and time with occasional forgetfulness. He required assistance with bathing and was only able to wash his face and hands. He also required assistance getting in and out of the shower. A Home Health Aide Visit Note, dated 4/3/23, indicated assistance with showering had been provided. There was lack of any documentation prior to 4/3/23 that the resident had been assisted with bathing. Interview with the Director of Nursing (DON) on 6/7/23 at 9:46 a.m., indicated staff would assist residents with bathing if they required minimal assistance, but if further assistance was required they would refer them to Home Health Services to assist with bathing. Interview with the DON and the Administrator on 6/7/23 at 3:07 p.m., indicated the resident was admitted to the facility on 3/24/23, was evaluated and admitted by the Home Health Service on 3/29/23, and received a shower per Home Health on 4/3/23. They were unable to provide any further bathing documentation prior to 4/3/23. This state residential finding relates to Complaint IN00405486.		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Facility immediately ensured that resident was receiving showers from Home Health Company. Documentation obtained from Home Health.** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice** **3) Measures put into place/ System changes:** **DON/Designee to monitor presence of Home Health shower documentation to ensure showers are completed per resident preference and present in Binder.** **4) How the corrective actions will be monitored:** **Don/Designee to audit Home Health Binder to ensure**	

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			presence of documentation 1X week for 4weeks then monthly until 90% compliance is achieved. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **Date of Compliance: 7/2/2023**	