DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CARMEL	12999 N PENNSYLVANIA ST CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit include a State Residential Licensure survey. This visit also included the Investigation of Complaints IN00435957, IN00436846, IN00438695 and IN00438807. Complaint IN00435957-State deficiencies related to the allegations are cited at R144 and R217. Complaint IN00436846-No deficiencies related to the allegations are cited. Complaint IN00438695-No deficiencies related to the allegations are cited. Complaint IN00438807-No deficiencies related to the allegations are cited. Survey dates: July 24, 25, 26, 29 and 30, 2024. Facility number: 001149 Provider number: 155618 AIM number: 200145500 Census Bed Type: SNF/NF: 31 SNF: 18 Residential: 79 Total: 128 Census Payor Type: Medicare: 5 Medicaid: 31 Other: 13 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The Creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of an violation of regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and REQUESTS DESK REVIEW IN LIEU OF POST SURVEY REVISIT on or after August 26, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Seib	Executive Director	08/19/2024

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

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	Quality review was completed on August 7, 2024.			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to provide a resident with a call light he was physically capable of activating for 1 of 1 resident reviewed for accommodation of needs. (Resident 40) Finding includes: During an observation, on 7/24/24 at 12:35 p.m., the resident was in the dining room. A nurse was assisting the resident to eat. The resident's hands were contracted with all fingers flat against his palms. He could not grip or use his thumbs. During an observation, on 7/25/24 at 9:50 a.m., the resident was in his room in his reclining Broda chair with a standard small push button call light clipped to his pant leg. The resident indicated he needed to go to the bathroom. He made multiple attempts to push the small red button on the call light. He tried several different ways but was never able to push the small button to activate the call system. The resident was visibly distressed and indicated he was frustrated because the call light did not work most of the time, so he had to call out for help. The resident's voice was low in volume and tone related to his Parkinson's disease. He could barely be heard just outside of his room with the door open. Staff were notified	F 0558	F 558 Reasonable Accommodations Needs / Preferences **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident 40 was provided a touch pad call light on 7/26/2024, prior to the conclusion of survey. Resident 40 plan of care reviewed to ensure that his individual needs and preferences are being met completed on or before 08/26/2024, including but not limited to, the provision/use of an adaptive call light he is physically capable of activating. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents who require adaptive push button call lights have the potential to be affected by the alleged deficient practice.	08/26/2024

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	the resident needed assistance but could not operate the call light. The resident indicated he used to have a soft touch pad call button; however, staff had removed it a while ago because he would occasionally roll over on it when he was in bed. He indicated he needed the soft touch call button to be able to call for assistance and wanted it back. The clinical record for Resident 40 was reviewed on 7/26/24 at 3:22 p.m. The diagnoses included, but were not limited to, Parkinson's disease, depression, anxiety, psychotic disorder with delusions, muscle wasting and atrophy of the right hand, muscle wasting and atrophy of the left hand, muscle wasting and atrophy in the right upper arm, muscle wasting and atrophy in the left upper arm, and repeated falls. A care plan, initiated on 2/7/23, indicated the resident had impaired physical mobility related to contractures to his hands and Parkinson's disease. The use of a touch pad call light was initiated, on 7/29/24, after the resident was observed to be unable to use the standard call light. During an interview, on 7/26/24 at 1:30 p.m., LPN1 indicated she thought the resident had a soft touch pad call light. She knew he used to have one because he could not use a regular call light with his hand contractures. She did not know why it would have been taken out of his room and would notify maintenance and her manager to get a soft touch call light in his room. A current facility policy, titled "Accommodation of Needs," not dated and received from the Director of Nursing (DON) on 7/30/24 at 6:15 p.m., indicated "...The resident's individual needs and		An audit of all residents was completed on or before 08/26/2024 to identify any residents in need of an adaptive call light. Facility staff will be in-serviced on policy “Accommodation of Needs” as well as STOP AND WATCH tool by ED/Designee by 08/26/2024 to ensure residents are reviewed on an ongoing basis to address changes in function. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Facility staff will be in-serviced on policy “Accommodation of Needs” as well as STOP AND WATCH tool by ED/Designee by 08/26/2024 to ensure residents are reviewed on an ongoing basis to address changes in function. A complete review of all residents was completed on or before 08/26/2024 to identify residents that may need a touch pad call light or other adaptive call light device. Any residents determined to be appropriate for a touch pad call light or other adaptive call light device were provided the same and resident Care Plans were up08/26/2024d as needed. Audit Tool Accommodation of Needs audit tool will be utilized	

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	preferences, including the need for adaptive devices...shall be...reviewed on an ongoing basis...." 3.1-3(v)(1)		by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Stop and Watch Audit Tool is evaluated daily as part of normal clinical processes to address resident needs and changes of condition. Audit Tool Accommodation of Needs audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters. Results of audit will be presented to the QAPI Committee Monthly for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 100% threshold is not achieved an action plan will be developed to achieve desired	

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			threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.			
	Based on interview and record review, the facility failed to ensure a new PASARR (pre-admission screening and resident review) level 1 request was submitted when changes in medications and diagnoses occurred for 3 of 3 residents reviewed for PASARR. (Resident 35, 40 and 46) Findings include: 1. The clinical record for Resident 35 was reviewed on 7/26/24 at 10:22 a.m. The diagnoses included, but were not limited to, general anxiety disorder, recurrent depressive disorder, Parkinson's disease without dyskinesia (involuntary movements),	F 0644	**F 644 Coordination of PASARR and Assessments** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** A new Preadmission Screening and Resident Review (PASARR) was submitted for Resident 35 on or before 08/26/2024. A new Preadmission Screening and Resident Review	08/26/2024

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	puerperal psychosis, dementia in other disease mild without behavioral symptoms, psychotic or mood disturbance, and anxiety. A PASARR level 1, dated 2/17/22, indicated no level 2 was required due to no significant mental illness, intellectual disability, or related conditions. The level 1 screen indicated a PASARR disability was not present because of the following reason: There was no evidence of a PASARR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occurred or new information refuted these findings, a new screen must be submitted. A physician's order, dated 10/5/23, indicated Nuplazid (an atypical antipsychotic medication) 34 mg (milligrams) daily for Parkinson's. During an interview, on 7/26/24 at 4:06 p.m., the DON (Director of Nursing) indicated a PASARR level 1 had not been requested for the new order of Nuplazid.2. The clinical record for Resident 40 was reviewed on 7/26/24 at 3:22 p.m. The diagnoses included, but were not limited to Parkinson's disease, depression, anxiety, and psychotic disorder with delusions. A Preadmission Screening and Resident Review (PASARR), dated 11/11/22, indicated the resident had diagnoses of depression and obsessive-compulsive disorder (OCD) with medications of olanzapine and quetiapine (Seroquel) for depression. A physician's order, dated 10/18/23 and discontinued 2/5/24, indicated risperidone (an antipsychotic medication) 0.5 mg, give 1 tablet two times a day for psychotic disorder with		(PASARR) was submitted for Resident 40 on or before 08/26/2024. A new Preadmission Screening and Resident Review (PASARR) was submitted for Resident 46 on or before 08/26/2024. The PASARR level 1 referrals for residents 35, 40, and 46 have been submitted at the time of this submission. Any recommendations from the PASARR level II determination and the PASARR evaluation shall be incorporated into the resident assessment, care plan, and transitions of care. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents who require a new PASARR level 1 request upon changes in medication and diagnosis occur have the potential to be affected by the alleged deficient practice. All level II residents and all residents with newly evident or possible serious mental disorders, intellectual disabilities, or related conditions for level II resident review and require a referral upon significant change in status assessment have the potential to be affected by the alleged deficient practice, including but not limited to changes in medication and	

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	delusions. A physician's order, dated 3/21/24, indicated klonopin (an antianxiety medication) 0.5 milligram (mg), give 1 tablet by mouth two times a day for anxiety. A physician's order, dated 7/20/23 and discontinued 9/20/23, indicated sertraline (an antidepressant medication) 50 mg, give 1 tablet by mouth for anxiety. A physician's order, dated 10/19/23 and discontinued 6/14/24, indicated sertraline 50 mg, give for anxiety. A physician's order, dated 6/15/24, indicated sertraline 50 mg, give 1 tablet by mouth one time a day for anxiety. A physician's progress note, dated 4/8/24 at 1:25 p.m., indicated the resident's psychiatric history included anxiety and depression. The resident was prescribed klonopin and Ativan for anxiety and sertraline for depressive disorder. The clinical record did not include any additional PASRR after additional medications and diagnoses were added.3. The clinical record for Resident 46 was reviewed on 7/26/24 at 9:38 a.m. The diagnoses included, but were not limited to, major depressive disorder, Parkinsons disease without dyskinesia (abnormal body movements), and other sleep disorder. A notice of PASARR level 1 outcome, dated 5/30/24, indicated no mental health diagnoses were known or suspected and no mental health medications were known of.		diagnosis. An audit of all residents was completed on or before 08/26/2024 to identify any resident needing referred for a significant change in newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon significant change and require a referral, including but not limited to changes in medication and diagnosis. Facility IDT will be in-serviced on policy “Preadmission Screening and Resident Review” by ED/Designee by 08/26/2024 to ensure Preadmission Screening and Resident Review is completed timely, accurate, and resubmitted upon significant Change when necessary. Facility IDT will be in-serviced on policy “Preadmission Screening and Resident Review” by ED/Designee by 08/26/2024 to ensure Preadmission Screening is verified for accuracy upon admission as part of weekly IDT audit. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Facility IDT will be in-serviced on policy	

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	A medical diagnosis list indicated the resident had a diagnosis of major depressive disorder. A current physician's order, with a start date of 6/7/24, indicated the resident was to take Trazodone (an antidepressant medication) 50 mg tablet, take 0.5 tablet by mouth. A current physician's order, with a start date of 7/24/24, indicated the resident was to take Fluoxetine HCL (an antidepressant medication) 10 mg capsule by mouth. During an interview, on 7/26/24 at 10:37 a.m., the Minimum Data Set (MDS) Coordinator indicated the diagnoses and medications were not on the PASARR. A current policy, titled "Pre-Admission Screening and Resident Review," dated as last revised in August 2020 and received from the Clinical Support Nurse on 7/30/24 at 4:35 p.m., indicated "...Level 1 and Level 2 Assessments will be reviewed upon admission and are included in the resident's medical record...A level 1 Assessment is completed with any new mental health diagnoses, symptoms, psychiatric hospitalizations and/or related medications...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		"Preadmission Screening and Resident Review" by ED/Designee by 08/26/2024 to ensure Preadmission Screening and Resident Review is completed timely, accurate, and resubmitted upon significant Change when necessary. Facility IDT will be in-serviced on policy "Preadmission Screening and Resident Review" by ED/Designee by 08/26/2024 to ensure Preadmission Screening is verified for accuracy upon admission as part of weekly IDT audit. An audit of all resident PASARR documentation and resident records was completed on or before 08/26/2024 to identify any resident needing referred for a significant change in newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon significant change and require a referral, including but not limited to changes in medication and diagnosis. PASARR Audit/Tracking Tool will be conducted for all new admissions, readmissions, AND any resident needing referred for a significant change in newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon significant change and require a referral,	

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			including but not limited to changes in medication and diagnosis to ensure that PASARR screening is complete and accurate. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** PASARR Audit/Tracking Tool will be conducted for all new admissions, readmissions, and any resident needing referred for a significant change in newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon significant change and require a referral, including but not limited to changes in medication and diagnosis to ensure that PASARR screening is complete and accurate. Results of audit will be presented to the QAPI Committee Monthly for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 90% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	

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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 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			

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	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. §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 interview and record review, the facility failed to develop a comprehensive care plan for the diagnoses of mental health conditions and the use of antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 19) Finding includes: The clinical record for Resident 19 was reviewed on 7/24/24 at 3:45 p.m. The diagnoses included, but were not limited to, bipolar type schizoaffective disorder, bipolar disorder, metabolic encephalopathy (a brain disorder caused by a chemical imbalance), intellectual disabilities, and type 2 diabetes mellitus. A physician's order, dated 6/28/24, indicated to give risperidone (an antipsychotic medication) 1 milligram (mg) two times a day related to schizophrenia. A psychiatry progress note, dated 7/23/24, indicated the resident was seen for ongoing monitoring and management of mood, behavior and cognition. The diagnoses included, but were not limited to, bipolar type schizoaffective disorder, bipolar disorder, and unspecified intellectual disabilities.	F 0656	**F 656 Develop/Implement Comprehensive Care Plan** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident 19 comprehensive care plan was reviewed and up dated 08/26/2024 to include the diagnosis of mental health conditions and use of antipsychotic medication on or before 08/26/2024. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents who require care plans for the diagnosis of mental health conditions and the use of antipsychotic medications have the potential to be affected by the alleged deficient practice. An audit of all residents with a diagnosis of mental health conditions and/or the use of antipsychotic medications was	08/26/2024

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	The care plans did not include the mental health diagnoses of schizoaffective disorder or bipolar disorder and did not include the use of an antipsychotic medication. During an interview, on 7/29/24 at 2:00 p.m., the Minimum Data Set (MDS) Coordinator indicated the mental health diagnoses and medications should have been added to the care plan. During an interview, on 7/29/24 at 2:54 p.m., the MDS Coordinator indicated the comprehensive care plan should be started immediately upon admission and in place by 14 days. The resident had been in the facility for 31 days and had been on the risperidone for 31 days. A current policy, titled "Comprehensive Care Plan," dated as last reviewed on 12/12/23 and received from the Director of Nursing on 7/29/24 at 3:24 p.m., indicated "...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident consistent with residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment...The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment...The comprehensive care plan will describe, at a minimum, the following...The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...Resident specific interventions...." 3.1-35(a)		completed on or before 08/26/2024 to identify any residents needing updates to their care plans. Facility IDT staff will be in-serviced on policy “Comprehensive Care Plan” by ED/Designee by 08/26/2024 to ensure residents comprehensive care plans are completed timely and accurately, including but not limited to care plans for diagnosis of mental health conditions and the use of antipsychotic medications. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Facility IDT staff will be in-serviced on policy “Comprehensive Care Plan” by ED/Designee by 08/26/2024 to ensure residents comprehensive care plans are completed timely and accurately, including but not limited to care plans for diagnosis of mental health conditions and the use of antipsychotic medications. An audit of all residents with a diagnosis of mental health conditions and/or the use of antipsychotic medications was completed on or before 08/26/2024 to identify any residents needing updates to their care plans. Audit Tool Mental Health Comprehensive Care Plans audit	

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tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters.

1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?

Facility IDT staff will be in-serviced on policy "Comprehensive Care Plan" by ED/Designee by 08/26/2024 to ensure residents comprehensive care plans are completed timely and accurately, including but not limited to care plans for diagnosis of mental health conditions and the use of antipsychotic medications.

Audit Tool Mental Health Comprehensive Care Plans audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters.

Results of audit will be presented to the QAPI Committee Monthly for compliance and

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			follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 100% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
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 interview and record review, the facility failed to ensure staff followed the physician ordered hold parameters for a medication and failed to ensure treatments were documented in the Treatment Administration Record for 3 of 3 residents reviewed for quality of care. (Resident B, 34 and 46) Finding includes: The record for Resident B was reviewed on 7/26/24 at 9:00 a.m. Diagnoses included, but were not limited to, hypertension, dementia, hallucination, and major depressive disorder A physician's order, dated 3/23/23, indicated hydralazine (a blood pressure medication) 10 mg	F 0684	**F 684 Quality of Care** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident B orders, care plans, and treatment administration record reviewed by DNS/Designee to ensure that staff followed physician ordered hold parameters and documented treatments in the Treatment Administration Record. (TAR) Resident 34 orders, care plans, and treatment administration record reviewed by	08/26/2024

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	was to be given by mouth three times a day related to hypertension and to hold if the systolic blood pressure (SBP) was less than 160. The Medication Administration Record (MAR), dated 7/1/24 through 7/31/24, indicated the following: a. the morning administration of hydralazine 10 mg was given to Resident B six (6) times when the systolic blood pressure was below the physician ordered hold parameters. b. the afternoon administration of hydralazine 10 mg was given to Resident B two (2) times when the systolic blood pressure was below the physician ordered hold parameters. c. the evening administration of hydralazine 10 mg was given to Resident B fifteen (15) times when the systolic blood pressure was below the physician ordered hold parameters. During an interview, on 7/26/24 at 10:49 a.m., RN 5 indicated the check mark under the documented blood pressure on the MAR indicated the medication was administered. During an interview, on 7/26/24 at 11:05 a.m., the Director of Nursing (DON) indicated the check marks on the MAR indicated a medication had been administered. He indicated the medication should not have been administered outside the physician ordered hold parameters. 2. The clinical record for Resident 34 was reviewed on 7/26/24 at 9:55 a.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, unspecified neuromuscular dysfunction of bladder, and dementia. A current physician's order, dated 5/29/24, indicated to assess the resident's vital signs every shift.		DNS/Designee to ensure that staff followed physician ordered hold parameters and documented treatments in the Treatment Administration Record. (TAR) Resident 46 orders, care plans, and treatment administration record reviewed by DNS/Designee to ensure that staff followed physician ordered hold parameters and documented treatments in the Treatment Administration Record. (TAR) Facility audited all residents to identify other residents with Hold Orders and treatments requiring documentation in the TARand shift to shift audits being performed daily to ensure documentation is complete. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents who have physician ordered hold parameters for medications and require documented tasks in the Treatment Administration Record (TAR) have the potential to be affected by the alleged deficient practice. A complete review of resident orders and corresponding TARs for physician ordered hold parameters and treatments requiring documentation in the Treatment Administration Record. (TAR) was conducted on or before	

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	A Treatment Administration Record (TAR) indicated the following days did not have vital signs for Resident 34 documented: On 7/2/24, there were no vital signs documented for the 1st and 2nd shift. On 7/3/24, there were no vital signs documented for the 3rd shift. On 7/4/24, there were no vital signs documented for the 1st, 2nd and 3rd shift. On 7/8/24, there were no vital signs documented for the 2nd shift. On 7/10/24, there were no vital signs documented for the 3rd shift. On 7/11/24, there were no vital signs documented for the 1st and 3rd shift. On 7/13/24, there were no vital signs documented for the 1st shift. On 7/16/24, there were no vital signs documented for the 3rd shift. On 7/17/24, there were no vital signs documented for the 1st shift and 3rd shift. On 7/18/24, there were no vital signs documented for the 2nd shift. On 7/19/24, there were no vital signs documented for the 2nd shift. On 7/22/24, there were no vital signs documented for the 2nd shift. On 7/24/24, there were no vital signs documented for the 2nd shift. On 7/25/24, there were no vital signs documented for the 2nd shift. On 7/26/24, there were no vital signs documented for the 3rd shift. A current physician's order, dated 5/29/24, indicated to complete Foley catheter care every shift. The TAR indicated the following days did not		08/26/2024 Nursing staff will be in-serviced on “Medication Administration” and “Charting and Documentation” by DNS/Designee on or before 08/26/2024, including but not limited to physician ordered hold parameters for medications and required documentation of tasks in the Treatment Administration Record (TAR). **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Nursing staff will be in-serviced on “Medication Administration” and “Charting and Documentation” by DNS/Designee on or before 08/26/2024, including but not limited to physician ordered hold parameters for medications and required documentation of tasks in the Treatment Administration Record (TAR). TAR will be reviewed by licensed nursing staff as part of shift to shift hand off and monitored by DNS/ Designee. Treatment administration Record (TAR) and Medication administration record (MAR) is monitored daily by DNS/Designee to ensure compliance. **1.How corrective actions will**	

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	have Foley catheter care for Resident 34 documented: On 7/2/24, there was no Foley catheter care documented for the 1st and 2nd shift. On 7/3/24, there was no Foley catheter care documented for the 3rd shift. On 7/4/24, there was no Foley catheter care documented for the 1st, 2nd and 3rd shift. On 7/8/24, there was no Foley catheter care documented for the 2nd shift. On 7/10/24, there was no Foley catheter care documented for the 3rd shift. On 7/11/24, there was no Foley catheter care documented for the 1st and 3rd shift. On 7/16/24, there was no Foley catheter care documented for the 3rd shift. On 7/17/24, there was no Foley catheter care documented for the 1st shift and 3rd shift. On 7/18/24, there was no Foley catheter care documented for the 2nd shift. On 7/19/24, there was no Foley catheter care documented for the 2nd shift. On 7/22/24, there was no Foley catheter care documented for the 2nd shift. On 7/24/24, there was no Foley catheter care documented for the 2nd shift. On 7/25/24, there was no Foley catheter care documented for the 2nd shift. On 7/26/24, there was no Foley catheter care documented for the 1st and 3rd shift. 3. The clinical record for Resident 46 was reviewed on 7/26/24 at 9:55 a.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, dementia, neuromuscular dysfunction of bladder, and vitamin b12 deficiency anemia A current physician's order, with a start date of 6/10/24, indicated to observe Resident 46 for side effects of anticoagulant medication use every		**be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Treatment administration Record (TAR) and Medication administration record (MAR) is monitored daily by DNS/Designee to ensure compliance. TAR will be reviewed by licensed nursing staff as part of shift to shift hand off and monitored by DNS/ Designee. Audit Tool Treatment Administration will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. DNS will present results of Treatment Administration audit tool to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 90% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	

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	shift, and to document "y" if a side effect was observed and "n" if none were observed. The TAR indicated the following days did not have anticoagulant monitoring for Resident 46 documented: On 7/2/24, there was no anticoagulant monitoring documented for the 1st and 2nd shift. On 7/3/24, there was no anticoagulant monitoring documented for the 3rd shift. On 7/4/24, there was no anticoagulant monitoring documented for the 1st, 2nd, and 3rd shift. On 7/8/24, there was no anticoagulant monitoring documented for the 2nd shift. On 7/11/24, there was no anticoagulant monitoring documented for the 1st and 3rd shift. On 7/16/24, there was no anticoagulant monitoring documented for the 3rd shift. On 7/17/24, there was no anticoagulant monitoring documented for the 1st shift and 3rd shift. On 7/18/24, there was no anticoagulant monitoring documented for the 2nd shift. On 7/19/24, there was no anticoagulant monitoring documented for the 2nd shift. On 7/22/24, there was no anticoagulant monitoring documented for the 2nd shift. On 7/24/24, there was no anticoagulant monitoring documented for the 2nd shift. On 7/25/24, there was no anticoagulant monitoring documented for the 2nd shift. On 7/26/24, there was no anticoagulant monitoring documented for the 3rd shift. A current physician's order, with a start date of 6/10/24, indicated to observe for the side effects of antidepressant medication every shift, and document "y" if a side effect was observed and "n" if none were observed. The TAR indicated the following days did not			

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	have antidepressant medication monitoring for Resident 46 documented: On 7/2/24, there was no antidepressant medication monitoring documented for the 1st and 2nd shift. On 7/3/24, there was no antidepressant medication monitoring documented for the 3rd shift. On 7/4/24, there was no antidepressant medication monitoring documented for the 1st, 2nd, and 3rd shift. On 7/8/24, there was no antidepressant medication monitoring documented for the 2nd shift. On 7/11/24, there was no antidepressant medication monitoring documented for the 1st and 3rd shift. On 7/16/24, there was no antidepressant medication monitoring documented for the 3rd shift. On 7/17/24, there was no antidepressant medication monitoring documented for the 1st shift and 3rd shift. On 7/18/24, there was no antidepressant medication monitoring documented for the 2nd shift. On 7/19/24, there was no antidepressant medication monitoring documented for the 2nd shift. On 7/22/24, there was no antidepressant medication monitoring documented for the 2nd shift. On 7/24/24, there was no antidepressant medication monitoring documented for the 2nd shift. On 7/25/24, there was no antidepressant medication monitoring documented for the 2nd shift. On 7/26/24, there was no antidepressant medication monitoring documented for the 3rd shift. A current physician's order, with a start date of			

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	6/7/24, indicated to observe for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) every shift. The TAR indicated the following days did not have hypoglycemia and hyperglycemia monitoring for Resident 46 documented: On 7/2/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 1st and 2nd shift. On 7/3/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 3rd shift. On 7/4/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 1st, 2nd, and 3rd shift. On 7/8/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 2nd shift. On 7/11/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 1st and 3rd shift. On 7/16/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 3rd shift. On 7/17/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 1st shift and 3rd shift. On 7/18/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 2nd shift. On 7/19/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 2nd shift. On 7/22/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 2nd shift. On 7/26/24, there was no hypoglycemia and hyperglycemia monitoring documented for the 3rd shift.			

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	A current physician's order, with a start date of 6/7/24, indicated to observe for the side effects of a diuretic medication every shift. The TAR indicated the following days did not have diuretic medication monitoring for Resident 46 documented: On 7/2/24, there was no diuretic medication monitoring documented for the 1st and 2nd shift. On 7/3/24, there was no diuretic medication monitoring documented for the 3rd shift. On 7/4/24, there was no diuretic medication monitoring documented for the 1st, 2nd, and 3rd shift. On 7/8/24, there was no diuretic medication monitoring documented for the 2nd shift. On 7/11/24, there was no diuretic medication monitoring documented for the 1st and 3rd shift. On 7/16/24, there was no diuretic medication monitoring documented for the 3rd shift. On 7/17/24, there was no diuretic medication monitoring documented for the 1st shift and 3rd shift. On 7/18/24, there was no diuretic medication monitoring documented for the 2nd shift. On 7/19/24, there was no diuretic medication monitoring documented for the 2nd shift. On 7/22/24, there was no diuretic medication monitoring documented for the 2nd shift. On 7/24/24, there was no diuretic medication monitoring documented for the 2nd shift. On 7/25/24, there was no diuretic medication monitoring documented for the 2nd shift. On 7/26/24, there was no diuretic medication monitoring documented for the 3rd shift. During an interview, on 7/29/24 at 1:25 p.m., the Director of Nursing (DON) indicated there were a lot of missing documentation in the TARs.			

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	A current facility policy, titled "Medication Administration," dated 1/2/2024 and received from the DON on 7/29/24 at 10:54 a.m., indicated "...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician...Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters..."			
	A current facility policy, titled "Charting and Documentation," dated as last revised in July 2017 and received from the Clinical Support Nurse on 7/30/24 at 4:35 p.m., indicated "...All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record...The following information is to be documented in the resident medical record...Treatments or services performed...."			
	3.1-37(a)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			
	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that			

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	must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and			

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	(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure catheter tubing was not touching the ground, oral care products were stored properly, and clean laundry and linen were stored and handled appropriately for 12 of 12 residents randomly observed for infection control. (Residents 34, 302, 4, 27, 11, 38, 13, 15, 4, 17, 9 and 30) Findings include: 1. During an observation, on 7/24/24 at 12:10 p.m., Resident 34's catheter tubing was touching the floor while she was in the commons area on the 1st floor. During an observation, on 7/29/24 at 1:27 p.m., Resident 34's catheter tubing was touching the ground. During an interview, on 7/29/24 at 1:28 p.m., the Director of Nursing (DON) indicated the catheter	F 0880	**F 880 Infection Prevention & Control** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Facility provided direct assistance to Residents 34 and 30 to ensure that their Catheter tubing was properly attached to their wheelchair to prevent it from touching the ground and provided direct education to care staff at that time. Facility has continued to monitor Residents 34 and 302 as no other residents have catheters in the facility at this time. Facility provided new toothbrushes and toothpaste to residents to residents 4, 27, 11,	08/26/2024

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tubing was touching the ground and needed fixed.

The clinical record for Resident 34 was reviewed on 7/26/24 at 9:55 a.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, neuromuscular dysfunction of the bladder, and dementia.

A current physician's order, with a revision date of 5/29/24, indicated may anchor a 10ml/14fr Foley catheter.

A current care plan, initiated on 6/3/24, indicated the resident was at risk for infection and complications related to an indwelling catheter.

2. During an observation, on 7/26/24 at 10:30 a.m., Resident 302 was being wheeled in a wheelchair by a staff member to the therapy room. The resident's catheter tubing was dragging on the ground as she was being wheeled to therapy.

During an interview, on 7/26/24 at 10:32 a.m., the DON indicated he would address the catheter tubing dragging the ground.

The clinical record for Resident 302 was reviewed on 7/29/24 at 2:41 p.m. The diagnoses included, but were not limited to, chronic kidney disease stage 4, obstructive and reflux uropathy, and unspecified dementia.

A current physician's order, with a start date of 7/23/24, indicated may anchor a 30ml/16fr Foley catheter for the diagnosis of obstructive neuropathy.

A current care plan, initiated on 7/24/24, indicated the resident was at risk for infection and complications related to an indwelling catheter. 3.

38, 13, 15, and 17. All dental material has been provided a sanitary storage container and a bag to contain dental items. The bag and dental items have been labeled.

Facility provided laundry services to clothing for residents 11, 9, and 30.

Facility provided education to Laundry services personnel as well as all other staff regarding the safe and sanitary delivery of linen, including but not limited to, direct education that: (1) linen is NOT to be hung on the handrails in the hallway outside resident rooms or other common areas; AND (2) that all clean linen must be covered and protected when transported.

1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?

All residents who require Catheter Tubing have the potential to be affected by the alleged deficient practice.

All residents who share a lavatory for dental care have the potential to be affected by the alleged deficient practice.

All residents who utilize facility laundry services have the potential to be affected by the alleged deficient practice.

An audit of all residents was completed on or before 08/26/2024

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	During an observation, on 7/24/24 at 10:43 a.m., in the bathroom of Residents 4 and 27, the toothbrushes were lying together on the sink behind the faucet. One was touching the surface of the sink, and the other was touching the wall. Neither toothbrush was labeled or had a covering for the bristles. The toothpaste was open with no lid. There was urine and toilet paper in the toilet. 4. During an observation, on 7/24/24 at 10:50 a.m., an uncovered toothbrush was lying on the sink touching the wall behind the faucet in the bathroom of Residents 11 and 38. 5. During an observation, on 7/26/24 at 10:26 a.m., uncovered and unlabeled toothbrushes were sitting on the sink next to the faucet in the bathroom of Residents 13 and 15. 6. During an observation, on 7/26/24 at 10:30 a.m., uncovered and unlabeled toothbrushes were lying together on the sink behind the faucet in the bathroom of Residents 4 and 17. Two tubes of toothpaste were unlabeled and did not have lids. During an interview, on 7/30/24 at 2:44 p.m., the DON indicated the toothbrush storage was a concern. 7. During an observation, on 7/25/24 at 9:44 a.m., two hangers with a shirt and pants were hanging on the handrail outside of Resident 11's room. LPN 1 took the clothing into the room and hung it in Resident 11's closet. 8. During an observation, on 7/29/24 at 9:37 a.m., two staff members transported clean towels and wash cloths on an open cart without any covering and placed the linen in closets on the 2nd floor unit.		to identify any residents with catheter tubing. An audit of all residents was completed on or before 08/26/2024 to identify any residents who need assistance to label and store their dental hygiene materials. New toothbrushes, tooth paste, a sanitary container and labeling was provided of the when needed. Facility provided education to Laundry services personnel as well as all other staff regarding the safe and sanitary delivery of linen, including but not limited to, direct education that: (1) linen is NOT to be hung on the handrails in the hallway outside resident rooms or other common areas; AND (2) that all clean linen must be covered and protected when transported. Facility staff will be in-serviced on policy “Infection Prevention and Control Program” by ED/Designee by 08/26/2024 to ensure residents are provided a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Facility staff will be in-serviced on policy “Infection Prevention and Control Program”	

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	9. During an observation, on 7/29/24 at 1:35 p.m., clean clothing was hung on the handrail in the hallway outside of the room of Resident 9 and 30. During an interview, on 7/30/24 at 2:44 p.m., the DON indicated all clean linen should be transported covered and protected. Clean clothing should not be hung on the handrails in the hallways. Covered linen carts were available and should be utilized. A current policy, titled "Infection Control," dated 1/02/24 and received from the Executive Director (ED) on 7/24/24, indicated "...The facility's infection prevention and control program (ICPC) is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections...." A current policy, titled "INFECTION PREVENTION AND CONTROL PROGRAM," dated as last revised on 12/12/23 and received from the Clinical Support Nurse on 7/30/24 at 4:35 p.m., indicated "...This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines...." The facility did not provide a policy which included keeping catheter tubing off the ground by the time of exit. 3.1-18(b)(1) 3.1-18(b)(5) 3.1-19(g)(2)		by ED/Designee by 08/26/2024 to ensure residents are provided a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. DNS / Designee conducted a thorough audit of practices at the facility to identify additional opportunities for infection control education on or before 08/26/2024. ED or Designee performs daily walking rounds and staff huddle to promote infection prevention and best practices. Facility utilizes infection prevention and control program which reports monthly to the safety committee. Audit Tool Infection Prevention and Control audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly thereafter. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS / Designee conducted a thorough audit of practices at the facility to identify additional opportunities for infection control education on or before 08/26/2024. ED or Designee performs daily walking rounds and staff	

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			huddle to promote infection prevention and best practices. Facility utilizes infection prevention and control program which reports monthly to the safety committee. Audit Tool Infection Prevention and Control audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly thereafter. Results of audit will be presented to the QAPI Committee Monthly for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 90% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
F 0882 SS=D Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;			

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	§483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control.			
	Based on interview and record review, the facility failed to have an Infection Preventionist (IP) who was able to fulfill the role at least part-time and was not preforming the duties of the full-time Director of Nursing (DON) for 1 of 1 Infection Preventionist reviewed. Finding includes: During an interview, on 7/24/24 at 11:15 a.m., the Executive Director (ED) indicated the facility's Infection Preventionist (IP) was the Director of Nursing (DON). He indicated it was not a separate position and no other employees held an infection prevention certification. During an interview, on 7/30/24 at 2:45 p.m., the DON indicated he performed all the infection prevention tracking and duties along with all his DON duties. He indicated he was the only employee who held an infection prevention certification, and no other employees assisted him with the infection control duties. The facility's employee records did not contain an employee with the title of Infection Preventionist. A current policy, titled "Infection Control," dated 1/02/24 and received from the Executive Director (ED) on 7/24/24, indicated "...The facility's infection prevention and control program (ICPC) is designed to provide a safe, sanitary, and	F 0882	**F 882 Infection Preventionist Qualifications / Role** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Following annual survey Facility began to utilize a part time certified infection preventionist consultant. ADNS is a registered nurse who works at least part time at the facility and completed training to be a certified Infection Preventionist on 08/26/2024. ADNS is currently responsible for the IPCP program. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** ADNS Infection Preventionist completed a review of the Infection Prevention and Control Program and became a certified IP on or before 08/26/2024. **1.What measures will be put**	08/26/2024

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	comfortable environment and to help prevent the development and transmission of communicable diseases and infections...." A current policy, titled "INFECTION PREVENTION AND CONTROL PROGRAM," dated as last revised on 12/12/23 and received from the Clinical Support Nurse on 7/30/24 at 4:35 p.m., indicated "...This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines...." 3.1-18(b)		**into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Facility has corrected the practice of using the Director of Nursing to act as the infection preventionist (IP) and will use a separate party moving forward to maintain compliance. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Facility has corrected the practice of using the Director of Nursing to act as the infection preventionist (IP) and will use a separate party moving forward to maintain compliance. Facility will utilize a part time service in the event that the position becomes vacant in the future.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaints IN00435957, IN00436846, IN00438695 and IN00438807. Complaint IN00435957-State deficiencies related to the allegations are cited at R144 and R217. Complaint IN00436846-No deficiencies related to the allegations are cited.	R 0000	The Creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of an violation of regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and REQUESTS DESK REVIEW IN	

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	Complaint IN00438695-No deficiencies related to the allegations are cited. Complaint IN00438807-No deficiencies related to the allegations are cited. Survey dates: July 24, 25, 26, 29 and 30, 2024. Facility number: 001149 Residential Census: 79 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 7, 2024.		LIEU OF POST SURVEY REVISIT on or after August 26, 2024.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel			

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	shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff met the requirements of first aid certified staff for 16 of 21 shifts reviewed for first aid training. (July 21, 22, 23, 24, 25, 26 and 27, 2024) Findings include: A record review completed on 7/30/24 at 11:00 a.m., indicated multiple shifts from Sunday 7/21/24 through Saturday 7/27/24 were not staffed with first aid certified staff. The dates and shifts included were: a. Sunday, 7/21/21, there was no first aid coverage for the day, evening and night shift. b. Monday, 7/22/24, there was no first aid coverage for the day, evening and night shift. c. Tuesday, 7/23/24, there was no first aid coverage for day and evening shift. d. Wednesday, 7/24/24, there was no first aid coverage for the day and evening shift. e. Thursday, 7/25/24, there was no first aid coverage for the day and night shift. f. Friday, 7/26/24, there was no first aid coverage for the day, evening and night shift. g. Saturday, 7/27/24, there was no first aid coverage for the day shift. There was a total of 16 shifts with no staff who had a first aid certification. During an interview, on 7/30/24 at 5:11 p.m., the Executive Director indicated he believed the first aid certification was included with the Cardiopulmonary Resuscitation (CPR) training. The facility did not have a policy on first aid	R 0117	**R 117 Personnel Deficiency – First Aid** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Following annual survey Facility provided First Aid Training to Assisted Living Staff to e(1) one ensure a minimum one (1)awake staff person, with current CPR and First Aid Certificates is on site at all times. Facility at the time of survey and currently is providing either LPN or RN nursing coverage for residential care 24 hours a day. The Facility was found to be in compliance with the CPR requirements. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residential care residents have the potential to be affected by the alleged deficient practice. Facility completed an audit of all Residential Care Staff to determine which staff have first aid training in order to ensure we meet the minimum requirement. A minimum one (1) awake staff	08/26/2024

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	requirements and the facility followed the state regulations.		person, with … First Aid Certificate is on site at all times. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Facility has added first aid training to its hiring education modules for all assisted living staff to educate staff upon hire. Additionally First Aid training /modules will be assigned and completed at least once a year by current staff to maintain compliance with the requirement for first aid certificates. Facility staff will be provided First Aid Training by ED/Designee by 08/26/2024 to ensure facility maintains compliance with the minimum requirement. A minimum one (1) awake staff person, with … First Aid Certificates is on site at all times. Facility has created a tracking log for staff to ensure First Aid Training remains current. **4 How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Facility has corrected the practice of relying on 24 hour LPN/RN coverage to satisfy the first aid minimum requirement of one awake staff member with	

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			current CPR and First aid training moving forward to maintain compliance. Facility has created a tracking log for staff to ensure First Aid Training remains current. The log will be audited monthly as part of Safety meeting to identify anyone that has an upcoming expiration of their first aid certificate so it can be addressed prior to its expiration. Results of audit will be presented to the QAPI Committee Monthly for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 100% First Aid Coverage threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview and record review, the facility failed to ensure the facility was clean and reasonable comfort was provided for all residents related to a resident with incontinent concerns for 1 of 1 resident reviewed for incontinence. (Residents J)	R 0144	F 144 Sanitation and Safety Standards **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?**	08/26/2024

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	Findings included: 1. An Indiana Department of Health Intake Information document, dated 6/4/24, indicated a resident could not control his bladder. He went around the facility with wet pants, urinated on the floors, and left puddles on the floor. The clinical record for Resident J was reviewed on 7/30/24 at 12:18 p.m. The diagnoses included, but were not limited to, skin picking disorder, parkinsonism, major depressive disorder, benign prostatic hyperplasia, and diabetes mellitus. A level of service assessment options, dated 3/18/24, indicated the resident always required assistance with personal hygiene and was incontinent requiring a change of clothes three or more times per week. During an observation, on 7/26/24 at 11:55 p.m., CNA 8 was carrying one bag of urine-soaked linens out of Resident J's room. CNA 8 indicated the resident was frequently incontinent and dripped urine on the floor. The resident and resident's room smelled of urine. During an interview, on 7/26/24 at 1:32 p.m., Resident K indicated Resident J's incontinence was getting worse. The resident ate downstairs in the dining room and left puddles under the chairs. The other residents in the dining room should not have to deal with smelling urine while they eat. Resident K and Resident L had to leave the dining room before because the smell was so bad. During an interview, on 7/26/24 at 1:35 p.m., Resident L indicated Resident J left puddles in the dining room and it smelled.		Facility conducts regular rounds within the facility to ensure that the facility is clean, orderly, and in a good state of repair, both inside and out, and is providing reasonable comfort for all residents. Facility has conducted a care conference with Resident J and his family regarding his service plan and to discuss issues regarding his urinary incontinence. Resident J Service Plan and Care Plan reviewed for accuracy to ensure that facility is providing for his needs and his medical condition. Staff educated regarding the incontinence assistance needs of Resident J. Staff educated regarding the clean up and management of resident incontinence episodes. The citation does not allege that facility failed to remediate or otherwise respond appropriately to the resident’s stated condition or that it failed to provide necessary clean up. Citation also fails to include evidence presented to surveyors that facility had been working with his family and resident J to meet his Medical needs in relation to his incontinence care being managed by a urologist to address his bladder incontinence and that he had been prescribed medication to address his medical condition.	

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	155618	A. BUILDING 00 B. WING	07/30/2024

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	During an interview, on 7/26/24 at 1:50 p.m., Dietary 7 indicated Resident J would come down into the dining room and urinate on the floor. The resident would sometimes wear a brief if he did not refuse one. The resident would return to the dining room in shorts which had dried urine on them, and it smelled. During an interview, on 7/30/24 at 11:48 a.m., the Assisted Living Clinical Director indicated the resident needed reminded and assistance to use protective undergarments. The resident had episodes of soiling clothes and bedding. The staff were supposed to change the resident every two hours. The staff should not have to change a resident every two hours on assisted living. He would smell like urine even if he was showered unless the facility got rid of everything in his room A current policy, titled "Resident Rights," dated 12/1/23 and received from the Executive Director on 7/30/24 at 5:12 p.m., indicated "...The resident has the right to a dignified existence, self-determination, and communication with an access to persons and services inside and outside the facility...The resident has a right to be treated with respect and dignity...The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely...." This citation relates to Complaint IN00435957.		**1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Facility conducts regular rounds within the facility to ensure that the facility is clean, orderly, and in a good state of repair, both inside and out, and is providing reasonable comfort for all residents, including but not limited to any remediation due to incontinence episodes. Any issues identified by walking rounds are immediately addressed and appropriate management staff notified depending on the issue. An audit of all residents was completed on or before 08/26/2024 to identify any residents in need of assistance for bladder incontinence that may affect the clean and reasonable comfort of other residents. Facility staff will be in-serviced on policy "Resident Rights" by ED/Designee by 08/26/2024 including but not limited to the requirement that the staff ensure the facility is clean and reasonable comfort is provided for all residents as it relates to the incontinence of other residents living in the facility. Staff have further been instructed to report	

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			episodes of new or worsening incontinence for review by facility IDT. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Facility conducts regular rounds at the facility to ensure that the facility is clean, orderly, and in a good state of repair, both inside and out, and is providing reasonable comfort for all residents, including but not limited to any remediation due incontinence episodes. Any issues identified by walking rounds are immediately addressed and appropriate management staff notified depending on the issue. Facility staff will be in-serviced on policy “Resident Rights” by ED/Designee by 08/26/2024 including but not limited to the requirement that the staff ensure the facility is clean and reasonable comfort is provided for all residents as it relates to incontinence concerns. A complete review of all residents was completed on or before 08/26/2024 to identify residents in need of additional assistance for bladder incontinence. Any residents determined to need assistance for incontinence was reviewed by facility IDT and	

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			service plan/care plan updated as needed. Audit Sanitation and Safety audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor the sanitation and Safety of the facility. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Resident service plans and care plans are updated at least semiannually and upon known substantial change including but not limited to an assessment of incontinence needs. Facility conducts regular rounds at the facility to ensure that the facility is clean, orderly, and in a good state of repair, both inside and out, and is providing reasonable comfort for all residents, including but not limited to any remediation due incontinence episodes. Any issues identified by walking rounds are immediately addressed and appropriate management staff notified depending on the issue. Facility staff will be in-serviced on policy “Resident	

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			Rights” by ED/Designee by 08/26/2024 including but not limited to the requirement that the staff ensure the facility is clean and reasonable comfort is provided for all residents related to incontinence concerns. A complete review of all residents was completed on or before 08/26/2024 to identify residents in need of additional assistance for bladder incontinence. Any residents determined to need assistance for incontinence was reviewed by facility IDT and service plan/care plan updated as needed. Audit Sanitation and Safety audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor sanitation and safety of the facility. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters. Results of audit will be presented to the QAPI Committee Monthly for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 90% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted	

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			to the QAPI committee overseen by the ED for review and follow-up.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to update a service plan to include the services required for a resident who was incontinent and soiled the common areas for 1 of 1	R 0217	R217 – Evaluation **1.What corrective actions will be accomplished for those residents found to have been**	08/26/2024

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	resident reviewed for incontinence care. (Resident J) Finding includes: During an interview, on 7/26/24 at 1:32 p.m., Resident K indicated Resident J's incontinence was getting worse. The resident ate in the common area dining room and would leave puddles under the chairs he would sit in. Resident K would leave the dining room since the smell of urine was so bad. The clinical record for Resident J was reviewed on 7/30/24 at 11:48 a.m. The diagnoses included, but were not limited to, recurrent major depressive disorder, heart failure, Parkinson's disease, and diabetes. A service plan, dated 3/31/23, indicated the resident could use the bathroom independently but was frequently incontinent and required incontinent checks on every shift. The service plan did not include the resident was incontinent in the common areas and soiled the chairs in the common areas. A behavior care plan, dated 7/13/23, indicated the resident had a mental health diagnosis of major depressive disorder and had behaviors of being sexually inappropriate. The behavior care plan did not include the resident's incontinence episodes in the common areas. During an interview, on 7/30/24 at 11: 55 a.m., the Assisted Living Clinical Director indicated the resident's behavior care plan did not address his		**affected by the alleged deficient practice?** - Resident J Service Plan and Care Plan reviewed for accuracy and updated to include assistance due to episodes of incontinence in the common areas - Staff educated regarding the incontinence assistance needs of Resident J and interventions associated with his condition. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** - All residents who have episodes of bladder incontinence in common areas have the potential to be affected by the alleged deficient practice. - An audit of all residents was completed on or before 08/26/2024 to identify any residents in need of assistance for episodes of bladder incontinence in common areas, Service Plans and Behavior Care Plans updated as needed. - Facility staff will be in-serviced on policy "Residency-Assisted Living" by ED/Designee by 08/26/2024, specifically the that a resident must be able to manage his/her activities of daily living independently or with the assistance available…if current	

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	issues of soiling himself while in the common areas and sitting in the common areas and getting the chairs wet. The resident would refuse staff assistance to change clothing and to be cleaned from the incontinence. She was not sure if it was a behavior or a medical condition. The common areas would need cleaning from the resident's urinary incontinence. The staff were supposed to try to change the resident every 2 hours to prevent the issues. The resident had indicated he was more depressed due to the incontinence and other residents not accepting him due to the urine odor. She was not aware if the resident was using different incontinence supplies or if there was a plan to prevent the soiling of the common areas. The service plan did not include the incontinence in the common areas. A current policy, titled " Residency-Assisted Living," dated as last revised September 2020, and received from the Executive Director on 7/30/24 at 4:45 p.m., indicated "...Must be able to manage his/her activities of daily living independently or with the assistance available...If current residents or prospective residents have difficulty with one or more of the above criteria an assistance/service plan to meet his/her needs will be developed with the resident/residents, staff, family or home health agency...." This citation related to Complaint IN00435957.		residents or prospective residents have difficulty with one or more of ADLs as assistance/service plan to meet his/her needs will be developed with the resident/residents, staff, family or home health agency…" specifically as it relates to bladder incontinence in common areas. - - Staff have further been instructed to report episodes of new or worsening incontinence for review by facility IDT. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** - Facility IDT staff will be in-serviced on policy "Residency-Assisted Living" by ED/Designee by 08/26/2024, specifically the that a resident must be able to manage his/her activities of daily living independently or with the assistance available…if current residents or prospective residents have difficulty with one or more of ADLs as assistance/service plan to meet his/her needs will be developed with the resident/residents, staff, family or home health agency…" specifically as it relates to bladder incontinence in common areas. - Staff have further been instructed to report episodes of new or worsening incontinence for	

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			review by facility IDT. - A complete review of all residents was completed on or before 08/26/2024 to identify residents in need of assistance for bladder incontinence. - Any resident determined to need assistance for incontinence was reviewed by facility IDT and service plan/care assistance/service plan to meet his/her needs was developed/reviewed with the resident/residents, staff, family or home health agency. - An audit of all residents was completed on or before 08/26/2024 to identify any residents in need of assistance for episodes of bladder incontinence in common areas, Service Plans and Behavior Care Plans up08/26/2024d as needed. - Audit Tool Bladder Incontinence Service Plan / Behavior Care Plan audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**	

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			- Resident assistance/service plans and care plans are updated at least semiannually and upon known substantial change including but not limited to an assessment of incontinence needs. - Audit Tool Bladder Incontinence Service Plan / Behavior Care Plan audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters. - Results of audit will be presented to the QAPI Committee Monthly for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. - If 100% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate			

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	authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.			
	Based on interview and record review, the facility failed to ensure as needed (PRN) medications were authorized by a licensed nurse and documented in the nursing notes to indicate the time and date of the contact prior to the Qualified Medication Aide (QMA) administering the medications for 1 of 7 residents reviewed for PRN medications. (Resident 81) Finding includes: The clinical record for Resident 81 was reviewed on 7/30/24 at 12:15 p.m. The diagnoses included, but were not limited to, lymphedema and fracture of the left lower leg. A physician's order, dated 11/28/23, indicated to give one tablet of oxycodone-acetaminophen (an opioid pain medication) 10-325 milligram (mg) every 6 hours as needed for pain. A Medication Administration Record (MAR), dated April 2024, indicated QMA 2 administered oxycodone-acetaminophen to Resident 81 on April 4, 7, 10 and 11. The record did not show QMA 2 received authorization from a nurse to give the PRN medication. During an interview, on 7/30/24 at 12:20 p.m., the Assisted Living Clinical Director indicated the staff should have entered a note in the progress notes to show the QMA had authorization to give the PRN oxycodone-acetaminophen. The Clinical Director reviewed the progress notes and	R 0246	**R 246 Health Services** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident 81 had discharged the facility at the time of annual licensure survey. All Qualified Medication Aids working in the assisted living were provided education by ED/Designee by 08/26/2024 regarding the of the standard for administration of PRN medications by a QMA, specifically: PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Facility audited all residents to identify other residents with PRN orders to monitor medication administration of PRN	08/26/2024

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	indicated the authorization was not included in the progress notes and it should have been. During an interview, on 7/30/24 at 5:50 p.m., the Executive Director indicated the facility did not have a policy for the administration of PRN medication by QMAs. A current policy, titled "Administering Medications," dated as last revised April 2019 and received from the Executive Director on 7/30/24 at 5:14 p.m., indicated "...Medications are administered in a safe and timely manner, and as prescribed...Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so...."		medication. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents who are administered PRN medication have the potential to be affected by the alleged deficient practice. A complete review of residents with orders for PRN Medications was conducted on or before 08/26/2024. All Qualified Medication Aids working in the assisted living were provided education by ED/Designee by 08/26/2024 regarding the of the standard for administration of PRN medications by a QMA, specifically: PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 08/26/2024 including but	

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			not limited to, “Only licensed or permitted by this state to prepare, administer and document the administration of medications may do so” Specifically the state requirement for a QMA to get permission to administer PRN medication i.e. PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** All Qualified Medication Aids working in the assisted living were provided education by ED/Designee by 08/26/2024 regarding the of the standard for administration of PRN medications by a QMA, specifically: PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate	

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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
			authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 08/26/2024 including but not limited to, “Only licensed or permitted by this state to prepare, administer and document the administration of medications may do so” Specifically the state requirement for a QMA to get permission to administer PRN medication i.e. PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. All QMA will be educated by ED/Designee upon hire and quarterly thereafter that: PRN medications may be administered by a qualified medication aide	

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			(QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. All QMA will be educated by ED/Designee upon hire and quarterly thereafter that: PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Audit Tool PRN administration audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed Next business day for One month, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters.	

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			1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? All Qualified Medication Aids working in the assisted living were provided education by ED/Designee by 08/26/2024 regarding the of the standard for administration of PRN medications by a QMA, specifically: PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 08/26/2024 including but not limited to, “Only licensed or permitted by this state to prepare, administer and document the administration of medications may do so” Specifically the state requirement for a QMA to get permission to administer PRN medication i.e. PRN medications	

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			may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. All QMA will be educated by ED/Designee upon hire and quarterly thereafter that: PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Audit Tool PRN administration audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed Next business day for One month, weekly X4 weeks, monthly X2 months, and quarterly thereafter	

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			until compliance is maintained for at least two consecutive quarters. DNS will present results of PRN Administration audit tool to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 90% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to notify and document the physician was notified of an on-going medication error for 1 of 7 residents reviewed for as needed (PRN) medications. (Resident J) Finding includes: The clinical record for Resident J was reviewed on 7/30/24 at 11:48 a.m. The diagnoses included, but were not limited to, recurrent major depressive disorder, heart failure, Parkinson's disease, and diabetes.	R 0247	**R 247 Pharmaceutical Services** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident J orders and care plans reviewed for accuracy by DNS/Designee. MD was notified and consulted regarding medication error. Pharmacy Audit completed on or before 08/26/2024. Facility audited all residents	08/26/2024

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	A physician's order, dated 1/23/24, indicated to give hydralazine (a medication to treat high blood pressure) 10 milligrams (mg) by mouth as needed for a systolic blood pressure greater than 150 four (4) times daily. A Medication Administration Record (MAR), dated January 2024, indicated the facility nursing staff only took the resident's blood pressure three times daily. There were no blood pressure readings for the fourth time of the day from January 23, 2024, through January 31, 2024, and it was not known if the medication needed to be administered. The electronic health record (EHR) did not include the physician was notified of the missed blood pressure readings from 1/23/24 through 1/31/24. A MAR, dated February 2024, indicated the blood pressure readings for the fourth time of the day were missed on all days except 2/11/24 and 2/22/24. The fourth time of the day, timeslot did not include an actual time to take the blood pressure and administer the medication if needed. The resident needed the hydralazine on 2/11/24 and on 2/22/24. The EHR did not include the physician was notified of the missed blood pressure readings for the month of February. A MAR, dated March 2024, indicated the blood pressure readings for the fourth time of the day were missed on all days of March. The fourth time of the day, timeslot did not include an actual time to take the blood pressure and administer the medication if needed. The blood pressure readings for the third time of the day were missed		to identify other residents with PRN orders based upon vitals monitoring including but not limited to blood pressure. Facility audited MAR for medication errors. Any Medication errors with actual or potential detrimental effects on the resident were documented and physician was notified. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents who are administered medication have the potential to be affected by the alleged deficient practice. Facility audited MAR for medication errors. Any Medication errors with actual or potential detrimental effects on the resident were documented and physician was notified. Pharmacy Audit completed on or before 08/26/2024. A complete review of residents with medication orders dependent on blood pressure monitoring was conducted on or before 08/26/2024. Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 08/26/2024, including but not limited to administration of medication based upon blood pressure monitoring.	

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	on March 10, 25, 29 and 30. The EHR did not include the physician was notified of the missed blood pressure readings for the month of March. A MAR, dated April 2024, indicated all the blood pressure readings for the fourth time of day were missed during the month of April. The fourth time of the day, timeslot did not include an actual time to take the blood pressure and administer the medication if needed. The blood pressure readings for the second time of the day were missed on March 17 and the blood pressure readings for the third time of the day were missed on March 7 and 20. The EHR did not include the physician was notified of the missed blood pressure readings for the month of April. A MAR, dated May 2024, indicated the blood pressure readings for the fourth time of the day were missed from May 1 through May 8, 2024. The fourth time of the day, timeslot did not include an actual time to take the blood pressure and administer the medication if needed. The EHR did not include the physician was notified of the missed blood pressure readings for the month of May. During an interview, on 7/30/24 at 12:05 p.m., the Assisted Living Clinical Director indicated the pharmacy made a recommendation in April 2024 to make sure the blood pressure was recorded four times daily on the MAR. The facility then realized the blood pressures were not recorded, and the physician's order was not followed.		Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 08/26/2024, including but not limited to notification of physician and documentation of errors in medication administration when there are actual or potential detrimental effects on the resident. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 08/26/2024, including but not limited to administration of medication based upon blood pressure monitoring. Direct Care Staff will be in-serviced on “Administering Medications” by DNS/Designee on or before 08/26/2024, including but not limited to notification of physician and documentation of errors in medication administration when there are actual or potential detrimental effects on the resident. Facility as well as pharmacy regularly monitors the administration of medication to ensure compliance with physician orders. The referenced concern for resident J was identified and corrected through this process. Facility will review all pharmacy recommendations for potential	

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	A current policy, titled "Administering Medications," dated as revised on April 2019 and received from the Executive Director on 7/30/24 at 5:14 p.m., indicated "...Medications are administered in a safe and timely manner, and as prescribed...Medications are administered in accordance with prescriber orders, including any required time frame...Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training...The following information is checked/verified for each resident prior to administering medications...vital signs, if necessary...If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose...The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones...A required or indicated for a medication, the individual administering the medication records in the resident's medical record...The date and time the medication was administered...The dosage...The route of administration...Any complaints or symptoms for which the drug was administered...The signature and title of the person administering the drug...."		medication errors in order to document and notify physician as required. Facility will use pharmacy recommendation audit log to monitor. Audit Tool Administration of Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Audit Tool Administration of Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance daily x5 days, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. Facility as well as pharmacy regularly monitors the administration of medication to ensure compliance with physician orders. The referenced concern for resident J was identified through this process. Facility will review all pharmacy recommendations for potential medication errors in order to document and notify physician as	

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			required. Facility will use pharmacy recommendation audit log to monitor. DNS will present results of Administration of Medication audit tool Pharmacy Recommendation Audit Log to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 90% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview and record review, the facility failed to ensure refrigerated medications were kept at a safe temperature, daily temperatures were recorded, medication labels had opened dates and to dispose of loose pills in the medication cart drawers for 1 of 1 medication room and 1 of 1 medication cart reviewed for medication storage. (300 hall) Findings include: 1. During an observation, on 7/29/24 at 3:50 p.m.,	R 0297	**R 297 Pharmaceutical Services** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Facility Refrigerator was malfunctioning at time of annual survey and was replaced during survey and an appropriate temperature log attached. Facility audited all	08/26/2024

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	the refrigerator in the medication room contained several insulin pens and the thermometer in the refrigerator was reading 50 degrees Fahrenheit. The temperature log was not available for review. During an interview, on 7/29/24 at 3:54 p.m., LPN 4 indicated the temperature in the refrigerator was too high at 50 degrees Fahrenheit and the medication should be destroyed. The refrigerator had not been working correctly for a while and she did not know where the temperature logs were kept. LPN 4 indicated she thought the night shift nurse was responsible for recording the temperatures. During an interview, on 7/29/24 at 4:19 p.m., the Assisted Living Clinical Director indicated the night shift nurse was responsible for recording the refrigerator temperatures. The nurse could not find a blank temperature form and did not start a log for July. The temperature in the medication refrigerator was too high and all the medication stored in the refrigerator should be destroyed and reordered. During an interview, on 7/30/24 at 9:46 a.m., the Assisted Living Clinical Director indicated she could not locate 5 out of the 7 months of temperature logs. 2. During an observation, on 7/29/23 at 12:48 p.m., the 300 hall medication cart had the following: a. One Aspart (rapid acting) insulin vial for Resident 16 which was opened and not dated. b. One bottle of Dextromethorphan HBR (used for coughs) for Resident 20 opened and not dated. c. One Toujeo Solostar (long acting) unopened insulin pen for Resident 76 with a label to refrigerate until opened. d. One bottle of Miralax and one bottle of Milk of		medication carts and med storage to ensure: refrigerated medications are being kept at a safe temperature; daily temperatures are recorded; medication labels had open dates; and there was no loose pills in the medication cart drawers on or before 08/26/2024. Facility replaced all medications found to be improperly stored at the time of citation as well as upon discovery during audit. Facility initiated a Pharmacy Audit through Medscript Pharmacy to review carts on or before 08/26/2024. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents who are administered medication have the potential to be affected by the alleged deficient practice. Facility Refrigerator was malfunctioning at time of annual survey and was replaced during survey and an appropriate temperature log attached. Facility audited all medication carts and med storage to ensure: refrigerated medications are being kept at a safe temperature; daily temperatures are recorded;	

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	Magnesium for Resident 77 opened and not dated. e. Two unidentified pink pills and two unidentified white loose pills in the bottom of the cart. A physician's order for Resident 16, dated 1/25/24, indicated to give Aspart insulin 36 units subcutaneous (SQ) before meals. A physician's order for Resident 20, dated 4/24/24, indicated to give 10 ml (milliliters) of Dextromethorphan HBR every 12 hours. A physician's order for Resident 76, dated 7/17/24, indicated to give 70 units of Toujeo SQ daily. A physician's order for Resident 77, dated 6/26/24, indicated to give 3.4 grams of Metamucil 4 in 1 fiber (laxative) daily and to give 30 ml of Milk of Magnesia daily as needed. During an interview, on 7/29/24 at 3:54 p.m., Licensed Practical Nurse (LPN) 4 indicated the insulin pens and unopened insulin vials needed to stay in the refrigerator until opened. The medication bottles needed to have an opened date and the loose pills in the bottom of the cart should be removed and destroyed. During an interview, on 7/29/24 at 4:19 p.m., the Assisted Living Clinical Director indicated she was notified by LPN 4 of the loose pills in the cart and bottles not having an opened date. The loose pills should not be left in the cart and the bottles should be labeled. A current policy, titled "Storage of Medication," dated as revised on April, 2019 and received from the Executive Director (ED) on 7/30/24 at 2:45 p.m., indicated "...The facility stores all drugs and		medication labels had open dates; and there was no loose pills in the medication cart drawers on or before 08/26/2024. Facility initiated a Pharmacy Audit through Medscript Pharmacy to review carts on or before 08/26/2024. Direct Care Staff will be in-serviced on policy “Storage of Medication” by DNS/Designee on or before 08/26/2024. Direct Care Staff will be in-serviced on policy “Equipment Temperature Monitoring” by DNS/Designee on or before 08/26/2024. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Direct Care Staff will be in-serviced on policy “Storage of Medication” by DNS/Designee on or before 08/26/2024. Direct Care Staff will be in-serviced on policy “Equipment Temperature Monitoring” by DNS/Designee on or before 08/26/2024. DNS/Designee will monitor medication storage temperature log daily to ensure medications are kept at a safe temperature and temperatures are being recorded. Audit Tool Storage of medication will be utilized by the	

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	biologicals in a safe, secure, and orderly manner...Drugs and biologicals used in the facility are stored in locked compartments under proper temperature light and humidity controls...The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner...Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly...." A current policy, titled "Equipment Temperature Monitoring," dated October, 2018 and received from the ED on 7/30/24 at 2:45 p.m., indicated "...Temperatures of refrigeration/freezer equipment will be monitored twice per day...Thermometers in each location will be checked twice daily and recorded on the equipment monitoring log...Equipment identified as not holding food within the safe food holding temperature range will be indicated as "do not use" until appropriate repairs are made. All foods will be removed from the unit and stored in other unites until the repair is complete...."		Executive Director, Director of Nursing and/or designee to monitor compliance 5 days a week x4 weeks, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Direct Care Staff will be in-serviced on policy “Storage of Medication” by DNS/Designee on or before 08/26/2024. Direct Care Staff will be in-serviced on policy “Equipment Temperature Monitoring” by DNS/Designee on or before 08/26/2024. DNS/Designee will monitor medication storage temperature log daily to ensure medications are kept at a safe temperature and temperatures are being recorded. Audit Tool Storage of Medication will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance 5 days a week x4 weeks, weekly x4 weeks and monthly x 3 month and quarterly thereafter until compliance is achieved for two consecutive quarters. DNS will present results of Storage of Medication audit tool	

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			Pharmacy Recommendation Audit Log to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 90% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure residents had an annual statement to show there was no evidence of tuberculosis in an infectious stage verified upon admission and yearly thereafter for 2 of 7 residents reviewed for annual health statements. (Resident 22 and 81) Findings include: 1. The clinical record for Resident 22 was reviewed on 7/30/24 at 11:03 a.m. The diagnoses included, but were not limited to, recurrent major depressive disorder, iron deficiency anemia, and diabetes mellitus. During an interview, on 7/30/24 at 11:07 a.m., the	R 0409	**R 409 Infection Control** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident 22 health assessment completed. Resident does not show evidence of past or present infectious disease and no evidence of tuberculosis in an infectious stage. Resident 81 had discharged from the facility at the time of annual survey. Facility completed an audit	08/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CARMEL	12999 N PENNSYLVANIA ST CARMEL, IN 46032

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	Assisted Living Clinical Director indicated the resident had an annual health statement, dated 5/16/22, and no annual health statement for 2023 or 2024. 2. The clinical record for Resident 81 was reviewed on 7/30/24 at 12:15 p.m. The diagnoses included, but were not limited to, lymphedema and fracture of the left lower leg. During an interview, on 7/30/24 at 12:16 p.m., the Assisted Living Clinical Director indicated the resident did not have an annual health statement entered on admission in 2022 or an annual health statement for 2023 and 2024. The health statement should have been done with the admission orders. A current facility policy, titled "Resident Screening for Tuberculosis," dated 2024 and received upon entrance to the facility indicated "...This facility screens residents for tuberculosis in accordance with state requirements as part of the facility's overall infection prevention and control program...."		of all residents for an annual health assessment on or before 08/26/2024. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Facility completed an audit of all residents for an annual health assessment on or before 08/26/2024. Any noncompliance identified addressed immediately. Facility IDT will be in-serviced on the health assessment requirement by ED/Designee by 08/26/2024 specifically, “Each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** Facility IDT will be in-serviced on the health assessment requirement by ED/Designee by 08/26/2024	

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			specifically, “Each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Facility will keep annual health assessment log for all residents to identify the 08/26/2024 of their last annual health assessment, including a statement on TB. Audit Tool Health Assessment audit tool will be utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters. **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** Facility will keep annual health assessment log for all residents to identify the 08/26/2024 of their last annual health assessment, including a statement on TB. Audit Tool Health Assessment audit tool will be	

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			utilized by the Executive Director, Director of Nursing and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly X2 months, and quarterly thereafter until compliance is maintained for at least two consecutive quarters. Results of audit will be presented to the QAPI Committee Monthly for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. If 90% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	