| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155680 | A. BUILDING 00<br>B. WING | 05/19/2025 |

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| HOMEWOOD HEALTH CAMPUS | 2494 N LEBANON ST<br>LEBANON, IN 46052 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaints IN00454050, IN00454682, IN00455483, IN00455509, IN00456117, IN00458006, IN00458080 and IN00458258.<br><br>Complaint IN00454050-Federal/State deficiencies related to the allegations are cited at F658 and F725.<br>Complaint IN00454682-No deficiencies related to the allegation are cited.<br>Complaint IN00455483-No deficiencies related to the allegation are cited.<br>Complaint IN00455509-Federal/State deficiencies related to the allegations are cited at F725.<br>Complaint IN00456117-No deficiencies related to the allegation are cited.<br>Complaint IN00458006-Federal/State deficiencies related to the allegations are cited at F689 and F725.<br>Complaint IN00458080-Federal/State deficiencies related to the allegations are cited at F725 and F880.<br>Complaint IN00458258-Federal/State deficiencies related to the allegations are cited at F658, F689, F695 and F725.<br><br>Survey dates: May 12, 13, 14, 15, 16 and 19, 2025.<br><br>Facility number: 002703<br>Provider number: 155680<br>Aim Number: 200309250<br><br>Census bed type:<br>SNF: 10 | F 0000 | . | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Amisha Shah | Executive Director | 06/06/2025 |

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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| | SNF/NF: 41<br>Residential: 35<br>Total: 86<br><br>Census payor type:<br>Medicare: 6<br>Medicaid: 32<br>Other: 13<br>Total: 51<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review was completed on May 23, 2025. | | | |
| F 0552<br>SS=D<br>Bldg. 00 | 483.10(c)(1)(4)(5)<br>Right to be Informed/Make Treatment Decisions<br>Based on interview and record review, the facility failed to ensure an informed consent for antipsychotic medication use was obtained for 1 of 5 residents reviewed for unnecessary medication. (Resident 34)<br><br>Findings include:<br><br>The clinical record for Resident 34 was reviewed on 5/14/25 at 8:48 a.m. The diagnoses included, but were not limited to, dementia with psychotic disturbance, anxiety, and depression.<br><br>A physician's order, with a start date of 4/15/25, indicated Resident 34 was to take risperidone (an antipsychotic medication) 0.5 milligrams twice a day.<br><br>A care plan, dated 4/16/25, indicated Resident 34 was at risk for adverse consequences related to receiving an antipsychotic medication. | F 0552 | The submission of this plan of correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Homewood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for | 06/23/2025 |

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| | There was no documentation found in Resident 34's electronic health record to indicate the resident or the resident's representative was informed of the risks and benefits of the antipsychotic medication, treatment alternatives, and the option to choose the preferred treatment.<br><br>During an interview, on 5/15/25 at 5:20 p.m., Resident 34's daughter indicated Resident 34 was admitted to an area hospital for evaluation in April 2025. Resident 34 had been discharged from the hospital and had returned to the facility. The facility did not inform the family of the changes to Resident 34's medication regimen.<br><br>During an interview, on 5/16/25 at 8:33 a.m., the Interim Director of Nursing indicated Resident 34's medications were reviewed with Resident 34's Power of Attorney (POA) during a care planning meeting but informed consent was not completed at the time the meeting took place.<br><br>During an interview, on 5/16/25 at 2:54 p.m., Resident 34's POA indicated she was not aware of any medication changes made during the hospital stay. The facility had not informed her of black box warnings or the risks and benefits for any medications since Resident 34 had returned to the facility.<br><br>A current facility policy, titled "Psychotropic medication use and gradual dose reduction guidelines," dated 3/2025 and received from Clinical Support Nurse 4 on 5/16/25 at 1:43 p.m., indicated "...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefits with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...A consent shall be obtained upon | | substantial compliance.<br><br>1. Immediate actions taken for those residents identified:<br>Resident 34 was affected by alleged deficient practice. Resident 34 continues to resident in the campus with no adverse effects. Resident 34's resident representative was immediately informed of the risks and benefits of the antipsychotic medication, treatment alternatives and the option to choose the preferred treatment.<br><br>2. How the facility identified other residents:<br>All residents receiving antipsychotic medications have the potential to be affected. Licensed clinical staff were educated on Psychotropic medication guidelines. All residents receiving antipsychotic medication were reviewed to ensure that consent was received.<br><br>3. Measures put into place / System changes:<br>As a measure of ongoing compliance, DHS or designee to review residents receiving antipsychotic medications for consent upon admission and with medication changes 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x | |

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| | admission for ordered psychotropic medications to ensure appropriate indications for use and that the Resident/Responsible party is educated on the risks, benefits, alternative treatment options and applicable black box warnings...."<br><br>3.1-3(n)(2) | | 4 weeks, then monthly x 3 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |
| F 0558<br>SS=D<br>Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences<br>Based on interview and record review, the facility failed to ensure a resident's preference of having female caregivers was documented and followed for 1 of 1 resident reviewed for accommodation of needs. (Resident 25)<br><br>Findings include:<br><br>During an interview, on 5/12/25 at 1:55 p.m., Resident 25 indicated she preferred females to complete catheter care on her and there were males who would complete her catheter care.<br><br>During an interview, on 5/13/25 at 1:50 p.m., Certified Nursing Assistant (CNA) 8 indicated the staff knew Resident 25 did not like male staff members to complete peri-care or catheter care for her. It was known, females should be completing the catheter and peri-care for Resident 25 and not male staff members. | F 0558 | 1. Immediate actions taken for those residents identified:<br>Resident 25 was affected by alleged deficient practice. Resident 25 remains in the campus with no adverse effects. Resident 25 care plan was updated to include resident's preference of having female caregiver for peri-care.<br><br>2. How the facility identified other residents:<br>All residents requiring assistance with peri-care have the potential to be affected. All clinical staff were educated on Resident's Rights and Profile Care Guides. All residents were reviewed to ensure preferred caregiver gender, if | 06/23/2025 |

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| | The clinical record for Resident 25 was reviewed on 5/13/25 at 1:44 p.m. The diagnoses included, but were not limited to, Parkinson's disease and heart failure.<br><br>A physician's order, dated 12/21/21, indicated to complete catheter care every shift, three (3) times per day.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 3/12/25, indicated Resident 25 was cognitively intact and had indwelling catheter.<br><br>There was no documentation in the clinical record to indicate Resident 25 preferred female caregivers and there was no care plan related to Resident 25's preference for female caregivers prior to 5/13/25.<br><br>A Medication Administration Record (MAR), dated May of 2025, indicated the following:<br>a. catheter care was completed by Registered Nurse (RN) 15 (a male nurse) on the 3rd shift on 5/1/25, 5/14/25, and 5/18/25.<br>b. catheter care was completed by Licensed Practical Nurse (LPN) 14 (a male nurse) on the 3rd shift on 5/3/25, 5/9/25, and 5/12/25.<br>c. catheter care was completed by CNA 13 (a male CNA) on the 3rd shift on 5/5/25, 5/6/25, 5/7/25, 5/8/25, and 5/11/25.<br><br>During an interview, on 5/16/25 at 3:07 p.m., the Director of Nursing (DON) indicated it was known the resident did not want male staff members caring for her. This was an "off and on" thing for Resident 25.<br><br>A current facility policy, titled "Resident Rights Guidelines," dated 12/17/24 and received from | | applicable, is on the resident's profile care guide.<br><br>3. Measures put into place / System changes:<br>As a measure of ongoing compliance, MDSC or designee to review Profile Care Guide for preferred caregiver gender, if applicable, on 5 residents weekly x 3 months then monthly x 3 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | Clinical Support Nurse 4 on 5/19/25 at 10:40 a.m., indicated "...Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus. The following is a list of rights recognized by staff...Our residents have a right to...Be treated with dignity and respect. b. Be given the information necessary to participate in decisions which affect them both individually and cooperatively...Be consulted and encouraged to have input into their care plan which guides the services delivered to the residents...."<br><br>3.1-3(n)(3)<br>3.1-3(t)<br>3.1-3(u)(1)<br>3.1-3(u)(3)<br>3.1-3(v)(1) | | | |
| F 0628 SS=D Bldg. 00 | 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 48<br>Discharge Process<br><br>Based on interview and record review, the facility failed to ensure there was documentation the bed hold policy was provided to a resident for 1 of 1 resident reviewed for bed hold policy. (Resident 6)<br><br>Findings include:<br><br>The clinical record for Resident 6 was reviewed on 5/12/25 at 10:52 a.m. The diagnoses included, but were not limited to, falls, chronic pain, and low back pain.<br><br>A nursing progress note, dated 12/3/24, indicated the resident had sustained a fracture to the tail bone and was transported to the hospital.<br><br>A copy of the bed hold policy was not located in the resident's clinical record. | F 0628 | 1. Immediate actions taken for those residents identified:<br>Resident 6 was affected by alleged deficient practice.<br>Resident 6 remains in the campus with no adverse effects.<br><br>2. How the facility identified other residents:<br>All residents transferred to hospital or therapeutic leave have the potential to be affected.<br>Licensed clinical staff were educated on the need to provide the bed hold policy to the resident or resident representative for residents discharging to the hospital or therapeutic leaves. | 06/23/2025 |

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| | During an interview, on 5/19/25 at 1:45 p.m., the Corporate Minimum Data Set (MDS) nurse indicated a bed hold policy was not provided.<br><br>A current facility policy, titled "Bed Hold Notification," dated as last reviewed 1/8/25 and received from the Corporate MDS nurse on 5/19/25 at 1:59 p.m., indicated "...Residents and Responsible Parties have a right to be notified verbally and in writing on reserve bed payment policy per the state plan when someone goes out to the hospital...Before a nursing facility transfers a resident to a hospital...the nursing facility must provide written information to the resident and resident representative that specifies the duration of the state bed hold policy...."<br><br>3.1-12(a)(25)(A)<br>3.1-12(a)(25)(B) | | 3. Measures put into place / System changes:<br>As a measure of ongoing compliance, DHS or designee to audit all discharges to hospital or therapeutic leaves 5 times per week x 4 weeks, then 3 times per week x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |
| F 0641 SS=D Bldg. 00 | 483.20(g)(h)(i)(j)<br>Accuracy of Assessments<br><br>Based on observation, interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded correctly for 1 of 1 resident reviewed for MDS assessments. (Resident C)<br><br>Findings include:<br><br>During an observation, on 5/12/25 at 12:16 p.m., Resident C was receiving oxygen from a portable oxygen tank. | F 0641 | 1. Immediate actions taken for those residents identified:<br>Resident C was affected by insufficient practice. Resident did not have any adverse effects. MDS assessment was immediately corrected.<br><br>2. How the facility identified other residents:<br>All residents requiring | 06/23/2025 |

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| | During an observation, on 5/13/25 at 9:43 a.m., Resident C was receiving oxygen from a portable oxygen tank.<br><br>During an observation, on 5/13/24 at 1:54 p.m., Resident C was receiving oxygen.<br><br>During an observation, on 5/14/25 at 9:19 a.m., Resident C was receiving oxygen from a portable oxygen tank.<br><br>The clinical record for Resident C was reviewed on 5/14/25 at 10:45 a.m. The diagnoses included, but were not limited to, saddle embolus of the pulmonary artery with cor pulmonale (a clot at the bifurcation of the pulmonary artery which obstructed blood flow), pulmonary fibrosis, and atelectasis (part or full collapse of the lung).<br><br>Resident C's care plan, dated 11/5/24, indicated to administer oxygen per the physician's order.<br><br>A physician's order, dated 11/19/24, indicated to administer oxygen at four (4) liters per minute as needed to maintain saturation of 92 percent or greater.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 2/20/25, indicated the resident was not receiving oxygen administration.<br><br>During an interview, on 5/13/25 at 9:53 a.m., the Director of Nursing indicated Resident C received four (4) liters of oxygen.<br><br>During an interview, on 5/14/25 at 3:29 p.m., MDS Coordinator 11 indicated the resident was on supplemental oxygen and it was not correct on the MDS assessment. | | supplemental oxygen have the potential to be affected. MDSC was educated on accuracy of assessments. All residents receiving supplemental oxygen assessments were reviewed for accuracy.<br><br>3. Measures put into place / System changes:<br>As a measure of ongoing compliance, MDSC to review assessments for all residents receiving supplemental oxygen for accuracy weekly x 3 months then monthly x 3 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | A current facility document, titled "CMS's RAI Version 3.0," dated 10/2023 and received from the Executive Director on 5/16/25 at 9:33 a.m., indicated "...Code continuous or intermittent oxygen administered via mask, cannula, etc...."<br><br>3.1-31(c)(6) | | | |
| F 0658 SS=D Bldg. 00 | 483.21(b)(3)(i)<br>Services Provided Meet Professional Standards<br>Based on interview and record review, the facility failed to ensure documentation showed as needed (PRN) medications were administered under the direction of a licensed nurse for 1 of 1 resident reviewed for pain. (Resident 26)<br><br>Findings include:<br><br>The clinical record for Resident 26 was reviewed on 5/14/25 at 1:49 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, spondylosis of the lumbar region, and pain.<br><br>A current care plan, dated 10/19/23, indicated Resident 26 was at risk for pain and to administer medications as ordered.<br><br>1. A physician's order, dated 7/20/24, indicated to give acetaminophen 650 milligrams (mg) for mild to moderate pain every 6 hours as needed.<br><br>The Medication Administration Record (MAR) dated 5/1/25-5/16/25, indicated acetaminophen was given as needed for pain by a QMA without record of an assessment or permission from a licensed nurse on 5/2/25 and 5/8/25. | F 0658 | 1. Immediate actions taken for those residents identified:<br>Resident 26 was affected with no-adverse effects. All Residents were assessed and no adverse effects noted.<br><br>2. How the facility identified other residents:<br>All residents have the potential to be affected.<br><br>3. Measures put into place / System changes:<br>Staff nurses and QMAs educated on requirement to sign-off for PRN administration given by a QMA and documentation prior to administering PRN medications. The DHS/designee to continue audits for documentation of nurse sign-off for QMA administering PRN medication on 5 residents weekly x 4 weeks, 5 residents bi-weekly x 4 weeks, 5 residents monthly x 3 months.<br><br>4. How the corrective actions will | 06/23/2025 |

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| | 2. A physician's order, dated 7/11/24, indicated to give Norco (a narcotic pain medication) 7.5 mg-325 mg for moderate to severe pain every 6 hours as needed.<br><br>The MAR, dated April 2025, indicated Norco was given as needed for pain by a QMA without a record of an assessment or permission from a licensed nurse on 4/4/25, 4/24/25, and 4/30/25.<br><br>The MAR dated 5/1/25-5/16/25, indicated Norco was given as needed for pain by a QMA without record of an assessment or permission from a licensed nurse on 5/10/25 and 5/16/25.<br><br>During an interview, on 5/15/25 at 10:43 a.m., LPN 2 indicated the QMA should let her know if a resident needed a PRN medication and she would assess the resident, verify the appropriateness of giving the medication, and then authorize the administration based on the physician's order. The process would all be charted in the medical record on the MAR.<br><br>During an interview, on 5/15/25 at 10:50 a.m., QMA 10 indicated if a resident needed a PRN medication, a licensed nurse on duty would be asked to assess the resident and give permission to administer the medication. It would then be charted the medication was given under the direction of the nurse on the MAR.<br><br>During an interview, on 5/16/25 at 2:55 p.m., Clinical Support Nurse 4 indicated a QMA was required to have a nurse assess the resident and give permission for the PRN administration.<br><br>A current facility policy, titled "ADMINISTRATION OF PRN MEDICATIONS," dated 12/13/24 and received from the Executive | | be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | Director (ED) on 5/16/25 at 1:25 p.m., indicated "...If PRN medication is to be administered by a QMA, the Standards of Practice for PRN medication administration by a Qualified Medication Assistant shall be observed under the direction of licensed nurse...."<br><br>A current facility policy, titled "MEDICATION ADMINISTRATION- GENERAL GUIDELINES," dated 11/18 and received from Clinical Support Nurse 4 on 5/19/25 at 3:58 p.m., indicated "...Medications are administered only by...personnel authorized by state laws and regulations to administer medications...."<br><br>A current job description, titled "Certified Resident Medication Associate," (QMA) received from the Clinical Support Nurse 4 on 5/16/25 at 2:55 p.m., indicated "...Follow the policies and procedures of the facility governing the administering of medications to residents...."<br><br>This citation relates to Complaints IN00454050 and IN00458258.<br><br>3.1-35(g)(1)<br>3.1-35(g)(2) | | | |
| F 0684 SS=D Bldg. 00 | 483.25<br>Quality of Care<br><br>Based on interview and record review, the facility failed to ensure staff obtained and documented a resident's vital signs prior to administering a medication with physician's ordered hold parameters for 1 of 1 resident reviewed for quality of care. (Resident 22)<br><br>Findings include: | F 0684 | 1. Immediate actions taken for those residents identified: Resident 22 was affected with no-adverse effects. Clinical staff was in-serviced on following MD orders on medication administration.<br><br>2. How the facility identified other | 06/23/2025 |

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| | The clinical record for Resident 22 was reviewed on 5/15/25 at 11:07 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic polyneuropathy and hypoglycemia, hypertension, cognitive communication deficit, edema, and bradycardia.<br><br>A physician's order, dated 4/18/25, indicated to give metoprolol succinate (a medication which lowers blood pressure and heart rate) 25 milligrams once a day with special instructions to hold the medication for a heart rate of less than 55 or a systolic blood pressure less than 110.<br><br>A physician's order, dated 4/18/25, indicated to obtain a blood pressure and heart rate reading twice a day for 7 days.<br><br>A Medication Administration Record (MAR), dated April 2025, indicated Resident 22's vital signs were obtained as ordered 4/18/25 through 4/26/25. Metoprolol was given with a documented heart rate of less than 55 on the following dates:<br>On 4/19/25, with a heart rate of 51.<br>On 4/20/25, with a heart rate of 48.<br>On 4/22/25, with a heart rate of 51.<br>After 4/26/25, the MAR did not include a documented heart rate or blood pressure to verify the safety of giving the metoprolol.<br><br>A MAR, dated 5/1/25 through 5/15/25, indicated the only vital signs recorded for Resident 22 was on 5/3/25. The heart rate recorded was 53. Metoprolol was administered. The MAR did not include any other documented heart rate or blood pressures to verify the safe administration of metoprolol according to the hold parameters for the remaining administrations. | | residents:<br>All residents have the potential to be affected.<br><br>3. Measures put into place / System changes:<br>Clinical staff educated on requirement to follow MD orders on medication administration. The DHS/designee to audits Medication administration on 5 residents weekly x 4 weeks, 5 residents bi-weekly x 4 weeks, 5 residents monthly x 3 months.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | During an interview, on 5/15/25 at 10:43 a.m., LPN 2 indicated vital signs should have been obtained and recorded on the MAR before administering a medication with physician ordered hold parameters.<br><br>During an interview, on 5/16/25 at 11:09 a.m., the Clinical Support Nurse 4 indicated she could not find any verification of vital signs being obtained prior to the medication administration.<br><br>A current facility policy, titled "MEDICATION ADMINISTRATION-GENERAL GUIDELINES," dated 11/18 and received from Clinical Support Nurse 4 on 5/19/25 at 3:58 p.m., indicated "...Medications are administered in accordance with written orders of the prescriber...."<br><br>3.1-37(a) | | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>Based on observation, interview and record review, the facility failed to ensure a resident was transferred according to the plan of care to prevent a fall and a post fall parameter mattress intervention was in place for 2 of 8 residents reviewed for accidents. (Resident 2 and 6)<br><br>Findings include:<br><br>1. The clinical record for Resident 2 was reviewed on 5/14/25 at 1:53 p.m. The diagnoses included, but were not limited to, age related osteoporosis, history of falling, and unspecified glaucoma.<br><br>A physician's order, dated 6/4/24, indicated to use the sit-to-stand lift to transfer Resident 2 in and out of bed only per Resident 2's request and | F 0689 | 1. Immediate actions taken for those residents identified:<br>Resident 2 and 6 were affected with no adverse reactions noted, all nursing staff were reeducated by DHS designee on proper transfer of residents.<br><br>2. How the facility identified other residents:<br>All residents have the potential to be affected.<br><br>3. Measures put into place / System changes:<br>All nursing staff were in-serviced | 06/23/2025 |

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| | therapy approval.<br><br>A current care plan, dated 10/10/24, indicated staff should use the sit-to-stand lift to transfer Resident 2 in and out of bed.<br><br>A nursing progress note, dated 4/28/25 at 6:24 p.m., indicated an aide was assisting the resident into bed when the resident started to lose strength and balance. The resident was then assisted to the floor without further incident. No injury was noted. Additional staff were able to assist Resident 2 off the floor and into bed.<br><br>An interdisciplinary team (IDT) note, dated 4/30/25 at 10:01 a.m., indicated the IDT team reviewed the incident, and it was found the staff did not use the sit-to-stand lift to transfer the resident to the bed. The root cause was the staff did not use the proper lift, and Resident 2 had an increased weakness.<br><br>During an interview, on 5/15/25 at 10:34 a.m., the Director of Nursing (DON) indicated the staff should have used the sit-to-stand lift to transfer the resident in and out of bed.<br><br>During an interview, on 5/15/25 at 10:42 a.m., the DON indicated the aide used the wrong transfer method. She was supposed to use the sit-to-stand lift.<br><br>During an interview, on 5/16/25 at 11:45 a.m., the DON indicated they did not complete audits on the other residents to ensure they were receiving proper transfers.2. The clinical record for Resident 6 was reviewed on 5/15/25 at 12:56 p.m. The diagnoses included, but were not limited to, falls, chronic pain, and low back pain. | | on Transferring Residents Policy. DHS/designee will complete audits on observations for Resident Transfers. Audits will be completed 5 residents weekly x 4 weeks, 5 residents bi-weekly x 4 weeks, 5 residents monthly x 3 months.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | An interdisciplinary team (IDT) note, dated 5/5/25 at 11:00 a.m., indicated Resident 6 was found lying on the floor in her room. She was more than two (2) feet from her bed. The bed was documented to be in a semi-low position. The resident had indicated to the staff she had rolled out of the bed. She was barefoot and laying on her right side. The root cause of the fall was related to the resident rolling from her bed. The intervention was to provide a perimeter mattress.<br><br>A care plan, dated 9/13/24, indicated the resident was at risk for falling related to weakness. An intervention, initiated on 5/5/25, indicated "...Perimeter mattress...."<br><br>During an observation and interview, on 5/16/25 at 1:51 p.m., the Director of Nursing indicated the mattress on the bed of Resident 6 was not a perimeter mattress. The resident should have had a perimeter mattress as it was part of her fall precautions.<br><br>During an interview, on 5/16/25 at 2:08 p.m., the Director of Nursing indicated the mattress had been moved to a different room during the remodeling of the resident's room. The mattress was not moved back to the resident's room after the remodel. It should have been moved back to her room with her.<br><br>A current facility policy, titled "Fall Management Program Guidelines," dated 12/17/24 and received from Clinical Support Nurse 4 on 5/19/25 at 10:40 a.m., indicated "...The purpose of this policy is to...mitigate fall risk factors and implement preventative measures...Care plan interventions should be implemented...Any orders received from the physician should be noted and carried out...." | | | |

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| | This citation relates to Complaints IN00458006 and IN00458258.<br><br>3.1-45(a)(1)<br>3.1-45(a)(2) | | | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br><br>Based on interview and record review, the facility failed to ensure catheter urine output was accurately recorded as ordered for 1 of 1 resident reviewed for urinary catheters. (Resident 26)<br><br>Findings include:<br><br>The clinical record for Resident 26 was reviewed on 5/14/25 at 1:49 p.m. The diagnoses included, but were not limited to, sepsis, infection and inflammatory reaction due to indwelling urethral catheter, bacteremia, hematuria, obstructive and reflux uropathy, and retention of urine.<br><br>A physician's order, dated 11/11/24, indicated to place an indwelling urinary catheter for obstructive and reflux uropathy.<br><br>A physician's order, dated 1/26/24, indicated to monitor the catheter output three times a day.<br><br>A physician's order, dated 7/31/24, indicated give 20 milligrams of Lasix (a diuretic medication) twice a day for edema (swelling).<br><br>A facility document, dated 5/1/25 through 5/15/25, indicated the following:<br>On 5/2/25 at 3:19 a.m., large was recorded.<br>On 5/2/25 at 9:13 a.m., large was recorded.<br>On 5/3/25 12:28 p.m., medium was recorded.<br>On 5/3/25 10:22 p.m., large was recorded. | F 0690 | 1. Immediate actions taken for those residents identified:<br>Resident 26 was affected with no adverse reactions noted, all clinical staff were re-educated by DHS/ designee on proper and accurate recording of urine output.<br><br>2. How the facility identified other residents:<br>All residents that have a catheter have the potential to be affected.<br><br>3. Measures put into place / System changes:<br>All clinical staff were in-serviced on accurately recording catheter urine output as ordered by MD. DHS/designee will complete audits by reviewing POC charting for catheter urine output. Audits will be completed 5 residents weekly x 4 weeks, 5 residents bi-weekly x 4 weeks, 5 residents monthly x 3 months.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for | 06/23/2025 |

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| | On 5/4/25 12:04 p.m., medium was recorded.<br>On 5/4/25 9:06 p.m., medium was recorded.<br>On 5/5/25 12:57 p.m., large was recorded.<br>On 5/5/25 8:00 p.m., large was recorded.<br>On 5/5/25 9:57 p.m., large was recorded.<br>On 5/6/25 at 1:08 a.m., large was recorded.<br>On 5/6/25 at 12:56 p.m., medium was recorded.<br>On 5/6/25 at 8:15 p.m., large was recorded.<br>On 5/6/25 at 11:30 p.m., large was recorded.<br>On 5/7/25 at 10:59 a.m., medium was recorded.<br>On 5/7/25 at 2:22 p.m., medium was recorded.<br>On 5/7/25 at 8:18 p.m., large was recorded.<br>On 5/7/25 at 9:30 p.m., large was recorded.<br>On 5/8/25 at 12:58 a.m., large was recorded.<br>On 5/8/25 at 9:21 p.m., large was recorded.<br>On 5/9/25 at 3:12 p.m., medium was recorded.<br>On 5/9/25 at 9:31 p.m., large was recorded.<br>On 5/10/25 at 3:17 p.m., large was recorded.<br>On 5/10/25 at 11:36 p.m., large was recorded.<br>On 5/11/25 at 1:35 p.m., medium was recorded.<br>On 5/12/25 at 11:56 a.m., medium was recorded.<br>On 5/13/25 at 10:39 a.m., medium was recorded.<br>On 5/13/25 at 2:03 p.m., medium was recorded.<br>On 5/13/25 at 10:06 p.m., medium was recorded.<br>On 5/14/25 at 1:35 a.m., large was recorded.<br>On 5/14/25 at 12:27 p.m., large was recorded.<br>On 5/14/25 at 11:55 p.m., large was recorded.<br>On 5/15/25 at 1:09 p.m., large was recorded.<br><br>During an interview, on 5/15/25 at 10:39 a.m., Certified Nursing Assistant (CNA) 9 indicated the staff should use a urinal to measure the urine when emptying residents' catheters and then record the exact milliliter (ml) each shift in the medical record.<br><br>During an interview, on 5/16/25 at 2:57 p.m., Clinical Support Nurse 4 indicated it was not acceptable to use the terms "small", "medium", or "large" for catheter output in the medical record. | | compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | A current facility policy, titled "Emptying Urinary Bag," dated 12/16/24 and received from Clinical Support Nurse 4 on 5/16/25 at 2:55 p.m., indicated "...Assemble the equipment and supplies...Measuring container (calibrated)... Position the measuring container under the drainage bag...Measure and record the urinary output...The following information as applicable may be recorded in the resident's medical record...The amount of urine emptied from the drainage bag...."<br><br>A current facility policy, titled "Urinary Catheter Care," dated 12/16/24 and received from the Executive Director on 5/15/25 at 1:15 p.m., indicated "...Observe the resident's urine level for noticeable increases or decreases...Maintain an accurate record of the resident's daily output...."<br><br>3.1-41(a)(2) | | | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>Based on observation, interview and record review, the facility failed to ensure physician's orders were obtained and followed for 2 of 2 residents reviewed for oxygen administration. (Resident C and 109)<br><br>Findings include:<br><br>1. During an observation, on 5/12/25 at 12:16 p.m., Resident C was observed in the dining room with a portable oxygen tank set to administer two (2) liters per minute of oxygen via nasal cannula.<br><br>During an observation, on 5/13/25 at 9:43 a.m., Resident C was in an activity with a portable | F 0695 | 1. Immediate actions taken for those residents identified:<br>Resident C and 109 were affected and remained on campus with no adverse reactions noted. DHS immediately inspected the oxygen settings and corrected the setting per MD order. Clinical staff were re-educated to follow MD order.<br><br>2. How the facility identified other residents:<br>All like residents who use oxygen have the potential to be affected. All nurses have been educated to | 06/23/2025 |

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| | oxygen tank set to administer two (2) liters per minute of oxygen via nasal cannula.<br><br>During an interview, on 5/13/25 at 9:53 a.m., the Director of Nursing (DON) reviewed Resident C's physician's orders. She indicated Resident C was to receive four (4) liters per minute of oxygen and Resident C's tank was set at two (2) liters.<br><br>During an observation, on 5/13/24 at 1:54 p.m., Resident C's oxygen was set at four (4) liters per nasal cannula.<br><br>The clinical record for Resident C was reviewed on 5/14/25 at 10:45 a.m. The diagnoses included, but were not limited to, saddle embolus of the pulmonary artery with cor pulmonale (a clot at the bifurcation of the pulmonary artery which obstructed blood flow), pulmonary fibrosis, and atelectasis (part or full collapse of the lung).<br><br>A care plan, dated 11/5/24, indicated the resident had the potential for cardiovascular distress and to administer oxygen per the order.<br><br>A care plan, dated 11/5/24, indicated the resident had the potential for complications due to pulmonary fibrosis and to administer oxygen per the orders.<br><br>A physician's order, dated 11/19/24, indicated to administer oxygen at four (4) liters per nasal cannula as needed to maintain saturation of 92 percent or greater. The order was noted to be discontinued and a new order for oxygen at two (2) liters was initiated on 5/13/25 at 12:17 p.m.<br><br>2. During an observation, on 5/12/25 at 2:12 p.m., Resident 109 was observed to receive supplemental oxygen set between 2.5 and 3 liters | | ensure oxygen settings are correct and following physicians orders. A house wide audit has been completed in the health center to ensure all residents on oxygen have appropriate orders and settings.<br><br>3. Measures put into place / System changes:<br>All clinical staff were in-serviced on Administration of Oxygen SOP. DHS/designee will complete audits on Administration of Oxygen per MD order. Audits will be completed 5 residents weekly x 4 weeks, 5 residents bi-weekly x 4 weeks, 5 residents monthly x 3 months.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | per minute via nasal cannula.<br><br>During an observation, on 5/14/25 at 1:36 p.m., Resident 109 was observed with supplemental oxygen at three (3) liters per minute via nasal cannula.<br><br>The clinical record for Resident 109 was reviewed on 5/14/25 at 9:47 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, chronic lung disease, and emphysema.<br><br>A care plan, dated 4/17/25, indicated the resident had a potential for functional and cognitive decline related to pulmonary fibrosis. An intervention indicated to administer oxygen per the physician's orders.<br><br>A care plan, dated 4/17/25, indicated Resident 109 had the potential for shortness of breath while lying flat. An intervention indicated to administer oxygen per the physician's order and as needed.<br><br>A physician's order, dated 4/17/25, indicated the resident had chronic lung disease to manage oxygen administration in coordination with the physician to prevent respiratory acidosis.<br><br>Resident 109 did not have a physician's order which addressed how much oxygen the resident was to receive.<br><br>A current facility policy, titled "Administration of Oxygen," dated 12/13/24 and received from the Corporate Minimum Data Set (MDS) nurse, indicated "...Verify physician's order...."<br><br>This citation relates to Complaint IN00458258.<br><br>3.1-47(a)(6) | | | |

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| F 0725 SS=F Bldg. 00 | 483.35(a)(1)(2)<br>Sufficient Nursing Staff<br><br>Based on interview and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide nursing and related services to the residents and a licensed staff member was available on-call to cover the staffing needs of the facility. This deficient practice had the potential to affect 92 of 92 residents who resided in the facility.<br><br>Findings include:<br><br>1. A Casper Payroll Based Journal (PBJ) for the first quarter of 2025 indicated the facility had a 1-star staffing rating.<br><br>2. A nursing progress note, dated 4/19/25 at 2:30 a.m., indicated Licensed Practical Nurse (LPN) 12 heard an alarm sounding. A resident was at the end of the 200-hallway. LPN 12 ran to the end of the hallway. The resident opened the door and stepped outside. While trying to bring the resident back inside, the resident hit LPN 12 in the head with a glass vase full of water and flowers. The resident was brought back inside the facility. The Director of Nursing (DON), Executive Director (ED), Assistant Director of Nursing (ADON) was notified. LPN 12 was given an order from the ED to send the resident to the emergency room to be evaluated and treated. 911 was notified and the police and paramedics arrived to take the resident to the hospital.<br><br>During an interview, on 5/12/25 at 2:58 p.m., LPN 12 indicated the resident did hit her in the head with a vase and she sustained a concussion. She contacted the DON, and they could not find any staff to cover her. She was the only licensed staff | F 0725 | 1. Immediate actions taken for those residents identified:<br>On-call staff schedule including back-ups was immediately put in place. There were no residents adversely affected by the deficient practice.<br><br>2. How the facility identified other residents:<br>All residents have the potential to be affected.<br><br>3. Measures put into place / System changes:<br>A review of the facility assessment and resident acuity to determine the appropriate number and type of staff required for each shift was reviewed. Staffing levels will be adjusted daily based on resident needs. Nurse on-call along with a back-up person was immediately put in place. Written education of on-call person expectations have been completed. Support staff along with recruiting team assisting the facility in recruiting clinical staff. Education on call light policy has been completed with all staff to include not turning the call light off prior to meeting the residents' needs.<br><br>4. How the corrective actions will be monitored:<br>DHS/Designee will conduct 5 call | 06/23/2025 |

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| | 155680 | A. BUILDING 00<br>B. WING | 05/19/2025 |

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| | member in the building and no other licensed staff member came in to replace her all night.<br><br>During an interview, on 5/16/25 at 10:25 a.m., the ED indicated she was aware of the incident, and she had asked the nurse to seek medical treatment immediately. They called to get the nurse a replacement. No other staff member came in to relieve LPN 12. The facility's back up plan was an on-call staff member would come in if something were to happen. The back-up staff were not able to come in.<br><br>During an interview, on 5/16/25 at 10:56 a.m., the ED indicated the staff member on call the night of the incident was a Qualified Medical Assistant (QMA) and not a licensed staff member. They attempted to call the ADON. The DON lived out of state. The DON tried to make phone calls. They did not have a licensed staff on-call.<br><br>The facility did not have a licensed nurse available to replace the licensed nurse who was hit on the head with a glass vase and was told to go seek medical attention.<br>3. During a resident council meeting, on 5/14/25 at 10:01 a.m., Resident 14 indicated the facility had an issue with the call light response, he indicated it was "on and off". Resident 1 indicated she had rung the call light a bunch of times with no answer.<br><br>The resident council meeting notes were reviewed, on 5/14/25, and indicated:<br>a. The meeting note, dated 7/22/24, indicated concerns about call light response times. There were no further notes about call lights.<br>b. The meeting note, dated 8/19/24, indicated all residents at the meeting were upset about the waiting time for the call lights and indicated some | | light observations, and 5 resident or staff interviews 3 times weekly for two weeks, weekly for two weeks, then monthly for two months. Results of these audits will be submitted to the QAPI committee to ensure compliance goals. QAPI committee reserves the right to modify monitoring times according to outcomes. | |

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| | staff would come in, turn off the light, and not return.<br>c. The meeting note, dated 10/22/24, indicated residents were concerned about call lights. There were no further notes about the call lights.<br>d. The meeting note, dated 11/18/24, indicated residents had voiced concerns over the waiting time for call lights, and had indicated at times the wait was over an hour. It was noted all staff had been educated on answering call lights and everyone could answer the call light.<br>e. The meeting note, dated 1/21/25, indicated residents had voiced concerns about call lights. There were no other notes found addressing call lights.<br>f. The meeting note, dated 2/17/25, indicated residents voiced concerns over call light wait times. One resident indicated they had waited 25 minutes in the bathroom. It was noted staff were spoken to regarding waiting times and staff were educated to round and answer call lights in a timely manner.<br>g. The meeting note, dated 3/17/25, indicated residents voiced concerns over call light waiting times. Some residents indicated they had waited over an hour. It was noted staff were educated on call light expectations and answering call lights in a timely manner.<br>h. The meeting note, dated 4/21/25, indicated call light response times were worse between 2:00 p.m. and 6:00 p.m. It was noted staff were educated on the importance of answering call lights in an appropriate time frame.<br><br>4. During an observation, on 5/14/25 at 1:37 p.m., Resident 109 activated her call light to get assistance to lay down. The call light was responded to by CNA 9 on 5/14/25 at 1:43 p.m. The CNA was observed to enter the room, address the resident, and turn off the call light. | | | |

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| | The CNA did not assist the resident and instead, left the room.<br><br>During an interview, on 5/14/25 at 1:44 p.m., CNA 9 indicated she was not supposed to turn off the light without taking care of the residents' needs.<br><br>A current facility policy, titled "On-Call (Clinical and Caregivers) Policy," last updated in February 2023 and received from Clinical Support 4 on 5/19/25 at 10:40 a.m., indicated "...To deliver excellence in customer service, we must provide sufficient staff to meet the needs of our residents. The purpose of this policy is to provide guidance for efficient and orderly administration of the on-call policy...The on-call person will be required to come into the campus if there is a vacancy that has caused the campus to fall below their minimum staffing requirements...The person on-call must be available by phone and must be able to arrive at the campus within two (2) hours of a call...If a significant event or reportable occurs (e.g., abuse, misappropriation, elopement, significant injury, etc.) the ED and DHS/DPAS must be notified regardless of on-call status...."<br><br>A facility document, titled "Clinical In-Service," dated 4/2/25 and received from the Executive Director on 5/14/25 at 12:08 p.m., indicated "...Call lights are to be answered by everyone, not just the aids...."<br><br>A current facility policy, titled "Guidelines for Answering Call Lights," dated as last reviewed on 12/14/24 and received from Executive Director on 5/14/25 at 12:08 a.m., indicated "...Provide the service the resident requested and turn off the call light...."<br><br>This citation relates to Complaints IN00454050, | | | |

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| | IN00455509, IN00458006, IN00458080 and IN00458258.<br><br>3.1-17(a)<br>3.1-17(b)(2)<br>3.1-17(c)(2)<br>3.1-17(d) | | | |
| F 0757 SS=D Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>Based on interview and record review, the facility failed to ensure Abnormal Involuntary Movement Scale (AIMS) assessments were completed for evaluation of adverse reactions related to antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 19)<br><br>Findings include:<br><br>The clinical record for Resident 19 was reviewed on 5/14/25 at 11:10 a.m. The diagnoses included, but were not limited to, psychosis not due to a substance or known physiological condition, dementia with psychotic disturbance, psychotic disorder with hallucinations due to a known physiological condition, delirium due to known physiological condition, major depressive disorder, anxiety disorder, auditory hallucinations, and visual hallucinations.<br><br>A physician's order, dated 8/12/24, indicated to give olanzapine (an antipsychotic medication) 5 milligrams at bedtime.<br><br>A psychiatry progress note, dated 9/23/24, indicated the resident was taking olanzapine and the last AIMS assessment was completed on 6/21/23. | F 0757 | 1. Immediate actions taken for those residents identified:<br>Resident 19 was affected with no adverse reactions noted. DHS completed the AIMS assessment for resident 19. All residents reviewed for current AIMS assessment completed.<br><br>2. How the facility identified other residents:<br>All residents on antipsychotic medications have the potential to be affected. IDT team educated on reviewing and updating AIMs assessment with residents receiving antipsychotic medications.<br><br>3. Measures put into place / System changes:<br>All nurses were in-serviced on completion of AIMS assessment prior to the resident beginning antipsychotic medication. DHS/designee will complete house wide audits. After, audits will be completed 5 residents weekly x 4 weeks, 5 residents | 06/23/2025 |

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| | A care plan, dated 11/1/24, indicated Resident 19 was at risk for adverse consequences related to antipsychotic medications and to conduct an AIMS test per guidelines.<br><br>During an interview, on 5/16/25 at 11:09 a.m., Clinical Support Nurse 4 indicated the facility could not find a documented AIMS assessment and one should have been conducted.<br><br>A current facility policy, titled "Guidelines for: Abnormal Involuntary Movement Scale," dated 12/17/24 and received from the Executive Director on 5/16/25 at 1:25 p.m., indicated "...To assess residents that have prescribed antipsychotic medications to identify symptoms that may indicate the presence of Tardive Dyskinesia; a neurologic disorder characterized by abnormal involuntary movements which may occur...The AIMS assessment will be completed...at the earliest possible time; either after admission; after medications...are prescribed; and with dosage changes. 3. The AIMS assessment will be repeated...every six months...."<br><br>3.1-48(a)(3) | | bi-weekly x 4 weeks, 5 residents monthly x 3 months.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br><br>Based on observation, interview and record review, the facility failed to ensure medications were labeled with pharmacy labels and the date the medications were opened in 2 of 2 medication carts reviewed for medication storage. (100 hall and 200 hall)<br><br>Findings include: | F 0761 | 1. Immediate actions taken for those residents identified:<br>No adverse reactions noted related to one medication not labelled with open date and two medications missing pharmacy labels on 2 medication carts.<br><br>2. How the facility identified other | 06/23/2025 |

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| | 1. The medication cart, on the 100-hall, was reviewed on 5/15/25 at 10:11 a.m. The following was observed:<br>a. The first drawer contained an open bottle of Carbamide Peroxide 6.5% (ear drops). The medication was not labeled with the date it had been opened.<br>b. The second drawer contained an open bottle of liquid Haloperidol (an antipsychotic medication). The bottle was half empty and was not labeled with the date the medication had been opened.<br><br>During an interview, on 5/15/25 at 10:20 a.m., LPN 2 indicated the medications should have been labeled with the date they were opened.<br><br>2. The medication cart, on the 200-hall, was reviewed on 5/15/25 at 10:55 a.m. The following was observed in the top drawer:<br>a. Spiriva (an inhalation spray), with a sticker, indicating the medication should be discarded 90 days after being opened. The medication was not labeled with the date it had been opened.<br>b. Lispro (an insulin injection pen) without a pharmacy label.<br>c. Lantus (an insulin injection pen) without a pharmacy label.<br><br>During an interview, on 5/15/25 at 10:55 a.m., QMA 3 indicated the pharmacy labels must have fallen off the insulin injection pens, and all medications should be dated when they are opened.<br><br>A current facility policy, titled "Medication Storage in the Facility," dated 11/18 and received from the Executive Director on 5/16/25 at 9:57 a.m., indicated "...Medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the | | residents:<br>All residents have the potential to be affected. All medication carts to be audited to ensure that medications are labelled and dated according to policy. All staff nurses and QMAs were educated on proper labelling and storage of medications.<br><br>3. Measures put into place / System changes:<br>All nurses were in-serviced on Medication storage in the facility SOP. As a measure of ongoing compliance, the DHS or designee will audit medication carts for proper labelling and dating weekly x4 weeks, every other week x 2 months, then monthly x 3 months.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | supplier...All medications dispensed by the pharmacy are stored in the container with the pharmacy label...When the original seal of a manufacturer's container or vial is initially broke, the container or vial will be dated...A ["date opened"] sticker shall be placed on the medication...The expiration date of the vial or container will be [(30)] days unless the manufacturer recommends another date or regulations/guidelines require different dating...."<br><br>3.1-25(j)<br>3.1-25(k)(1)<br>3.1-25(k)(2)<br>3.1-25(k)(3)<br>3.1-25(k)(4)<br>3.1-25(k)(5)<br>3.1-25(k)(6)<br>3.1-25(k)(7) | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br><br>Based on observation, interview and record review, the facility failed to ensure staff wore personal protective equipment (PPE) correctly, performed hand hygiene, and changed gloves for 2 of 2 randomly observed staff members reviewed for infection control. (QMA 10 and RN 7)<br><br>Findings include:<br><br>During an observation, on 5/15/25 at 1:17 p.m., RN 7 and QMA 10 tied PPE gowns at the back of their neck, neither staff member tied the gowns closed at their waist and entered Resident C's room.<br><br>1. QMA 10 with gloves on, cleaned Resident C's mouth with a toothette (an oral swab) and discard it. QMA 10 then moved the mechanical lift into | F 0880 | 1. Immediate actions taken for those residents identified:<br>Resident C was affected with no adverse reactions noted. DHS completed re-education with the clinical staff on proper PPE use and hand hygiene.<br><br>2. How the facility identified other residents:<br>All residents have the potential to be affected. DHS provided training to staff providing direct care to residents. Training included hand hygiene, donning and doffing PPE, standard infection control practices. | 06/23/2025 |

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| | place. She picked up the resident's catheter drainage system with her left gloved hand and attached the bag to the mechanical lift strap. She ensured the sling was properly connected to the mechanical lift and used the control to lift the resident. The resident was then lowered to the bed. QMA 10 removed the resident's hearing aids and put them onto the charger. She assisted the resident to turn onto her left side. QMA 10 was then observed to handle the resident's oxygen line/nasal cannula and place it on the resident. She was not observed to remove her gloves, perform hand hygiene, or apply new gloves. QMA 10 then assisted in removing the resident's pants. QMA 10 held the catheter bag and tubing to guide it through the resident's pant leg. QMA 10 was observed to handle the cleaning wipe packaging and remove a clean wipe for RN 7. QMA 10 retrieved another clean wipe from the package and handed it to the RN. After handing more wipes to RN 7, QMA 10 was then observed to remove her gloves. She indicated she needed to get washcloths and wash her hands with soap and water.<br><br>During an interview, on 5/15/25 at 1:28 p.m., QMA 10 indicated she had not changed her gloves between the observed tasks.<br><br>2. During an observation, on 5/15/25 at 1:32 p.m., RN 7 used wipes to clean Resident C's bowel movement. She removed and discarded her gloves and put on a pair of clean gloves. She was not observed to have performed hand hygiene after removing her gloves or before applying new gloves. Resident C was then positioned for wound care to the left coccyx area. RN 7 was observed to clean the wound area with normal saline. She then wiped all around the surrounding area and then back to the wound. She repeated | | 3. Measures put into place / System changes:<br>All staff were in-serviced on wearing PPE and hand hygiene. In addition, clinical staff were in serviced on changing gloves after handling the catheter bag and in between tasks. To ensure ongoing compliance the DHS/designee will complete 5 random observations of handwashing and/or donning and doffing PPE weekly x4 weeks, every other week x 2 months, and monthly x 3 months.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |

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| | the process of cleaning the wound then the surrounding area including the wound area.<br><br>During an interview, on 5/15/25 at 1:50 p.m., RN 7 indicated she should have cleaned the wound from the inside to the outside, their gowns should have been tied correctly, and gloves should have been changed after handling the catheter bag and in between tasks.<br><br>During an interview, on 5/16/25 at 8:32 a.m., the Director of Nursing indicated wounds were to be cleaned from the inside to the outside.<br><br>A current facility document, titled "SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)," undated, and received from the Executive Director on 5/16/24 at 9:17 a.m., indicated "...GOWN...fasten in back at neck and waist...."<br><br>A current facility policy, titled "Guidelines for Handwashing/Hand Hygiene," dated 12/17/24 and received from the Executive Director on 5/16/25 at 9:17 a.m., indicated "...Health Care Workers...shall use hand hygiene at times such as...After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc...."<br><br>This citation relates to Complaint IN00458080.<br><br>3.1-18(b)(2)<br>3.1-18(l) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure | R 0000 | . | |

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| | Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaints IN00454050, IN00454682, IN00455483, IN00455509, IN00456117, IN00458006, IN00458080 and IN00458258.<br><br>Complaint IN00454050-Federal/State deficiencies related to the allegations are cited at F658 and F725.<br>Complaint IN00454682-No deficiencies related to the allegation are cited.<br>Complaint IN00455483-No deficiencies related to the allegation are cited.<br>Complaint IN00455509-Federal/State deficiencies related to the allegations are cited at F725.<br>Complaint IN00456117-No deficiencies related to the allegation are cited.<br>Complaint IN00458006-Federal/State deficiencies related to the allegations are cited at F689 and F725.<br>Complaint IN00458080-Federal/State deficiencies related to the allegations are cited at F725 and F880.<br>Complaint IN00458258-Federal/State deficiencies related to the allegations are cited at F658, F689, F695 and F725.<br><br>Survey dates: May 12, 13, 14, 15, 16 and 19, 2025.<br><br>Facility number: 002703<br><br>Residential Census: 35<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on May 23, 2025. | | | |
| R 0092 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - | | | |

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| | 155680 | A. BUILDING 00<br>B. WING | 05/19/2025 |

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| Bldg. 00 | Noncompliance<br>Based on interview and record review, the facility failed to ensure the fire department was invited to participate in a fire/disaster drill at the facility at least every six months during the 12 months reviewed for fire drills.<br><br>Findings include:<br><br>The facility fire drills were reviewed on 5/15/25 at 8:53 a.m.<br><br>A facility document, dated 5/3/24, indicated the fire department was invited to attend a fire drill.<br><br>A facility document, dated 5/12/25, indicated the fire department was invited to attend a fire drill.<br><br>There was no documentation provided to show the fire department had been invited to attend a fire and disaster drill between 5/2024 and 5/2025.<br><br>During an interview, on 5/19/25 at 9:23 a.m., Corporate Support Nurse 4 indicated the facility did not have documentation to show the fire department had been invited to attend a fire/disaster drill and the facility was supposed to invite the fire department twice a year<br><br>A current facility policy, titled "Fire Drills" did not address inviting the fire department to observe/conduct a fire or disaster drill with the facility. | R 0092 | The submission of this plan of correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Homewood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.<br><br>1. Immediate actions taken for those residents identified:<br>No residents were affected. Local fire department was immediately invited to participate in the next scheduled fire/disaster drill. Documentation of the invitation will be maintained for all future drills.<br><br>2. How the facility identified other residents:<br>All residents have the potential to be affected. Executive Director educated on Regulatory | 06/23/2025 |

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| | | | Requirements for Fire drills.<br><br>3. Measures put into place / System changes:<br>As a measure of ongoing compliance, Executive Director or designee will review fire drills for completion and invitation to the fire department monthly x 6 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the audit observations will be reported, reviewed and trended for compliance through facility Quality Assurance Committee for a minimum of 1 year to ensure 100% compliance is met. | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br><br>Based on record review and interview, the facility failed to ensure staff on duty met the requirements of cardiopulmonary resuscitation (CPR) skills validation training in accordance with the applicable state laws for 2 of 21 shifts reviewed for valid CPR certifications. (2 of 21 shifts)<br><br>Findings include:<br><br>The staffing schedules for the week of 5/11/25 through 5/17/25 were reviewed on 5/19/25 at 10:05 a.m.<br><br>There were no staff members with current CPR | R 0117 | 1. Immediate actions taken for those residents identified:<br>No residents were affected by insufficient practice. All schedules were reviewed immediately to ensure a CPR certified staff member is present at all times.<br><br>2. How the facility identified other residents:<br>All residents with a full code status have the potential to be affected. All licensed clinical staff | 06/23/2025 |

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| | certification which included skills validation on duty during the night shift (10:00 p.m.-6:00 a.m.) on 5/15/25 and 5/16/25.<br><br>During an interview, on 5/19/25 at 2:45 p.m., the Executive Director (ED) indicated the facility had provided all the current CPR certifications for the staff. She indicated the facility must ensure someone in the building had valid CPR.<br><br>The American Heart Association (AHA) 2020 HeartCode Courses Frequently Asked Questions (FAQs), dated 10/21/2020, retrieved on 5/23/25 at 12:55 p.m., at https://cpr.heart.org/en/-/media/CPR2-Files/Course-Materials/2020-BLS/2020-BLS-FAQs/2020-HeartCode-Course-FAQ_ucm_506791.pdf?sc_lang=en indicated, " ...HeartCode is the online portion of BLS [Basic Life Support], ACLS [Advanced Cardiovascular Life Support], or PALS [Pediatric Life Support] blended learning that will prepare students for hands-on practice and testing of skills...After completing the eLearning component, students perform their skills with an AHA Instructor or a HeartCode compatible manikin that provides real-time audio and visual feedback. Students must successfully complete both the cognitive portion and the hands-on skills session to receive an AHA BLS, ACLS, or PALS Provider eCard, valid for two years ..."<br><br>The undated American Red Cross (ARC) CPR Training in Indiana website, retrieved on 5/23/25 at 1:00 p.m., at https://www.redcross.org/local/indiana/take-a-class/cpr indicated, " ...In Indiana, CPR classes are available in person, online, and via our blended Simulation Learning experience, which combines online coursework with in-person skills sessions. Although successful completion of any of our | | that do not currently possess a CPR certification are required to obtain a certification.<br><br>3. Measures put into place / System changes:<br>As a measure of ongoing compliance, Director of Health Services or designee to audit employee CPR certificates monthly x 6 months, or until 100% compliance is maintained, to ensure licensed clinical staff CPR certifications are current.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, a facility designee will conduct monthly audits and will be reported, reviewed and trended for compliance through facility Quality Assurance Committee for a minimum of 1 year to ensure 100% compliance is met. | |

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| | CPR classes results in a two-year certification, online-only courses do not allow you to demonstrate your skills to a certified instructor, and therefore may not meet the requirements for workplace safety certification ..." | | | |
| R 0214<br><br>Bldg. 00 | 410 IAC 16.2-5-2(a)<br>Evaluation - Deficiency<br><br>Based on interview and record review, the facility failed to ensure semi-annual evaluations were completed for 3 of 7 residents reviewed for semi-annual evaluations. (Residents 3, 6 and 7)<br><br>Findings include:<br><br>1. The clinical record for Resident 3 was reviewed on 5/16/25. The diagnoses included, but were not limited to, chronic kidney disease.<br><br>Resident 3 did not have a semi-annual evaluation included in the clinical record.<br><br>2. The clinical record for Resident 6 was reviewed on 5/19/25 at 11:19 a.m. The diagnoses included, but were not limited to pain, constipation, and nausea.<br><br>Resident 6 did not have a semi-annual evaluation included in the clinical record.<br><br>3. The clinical record for Resident 7 was reviewed on 5/19/25. The diagnoses included, but were not limited to, Alzheimer's disease.<br><br>Resident 7 did not have a semi-annual evaluation included in the clinical record.<br><br>During an interview, on 5/19/25 at 1:32 p.m., Clinical Support 4 indicated Resident 7's | R 0214 | R214 Evaluation<br>1. Immediate actions taken for those residents identified:<br>Resident 3, 6 and 7 were affected by insufficient practice. Residents 3, 6, and 7 remain in the campus with no-adverse effects. Service plans were immediately completed.<br><br>2. How the facility identified other residents:<br>All residents have the potential to be affected. Licensed clinical staff were educated on AL Service Plan Guidelines.<br><br>3. Measures put into place / System changes:<br>As a measure of ongoing compliance, DHS or designee to review service plans for completion and timeliness on all new admissions and 3 residents weekly x 3 months then monthly x 3 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results | 06/23/2025 |

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| | semi-annual evaluation was not completed and it should have been. She also could not find semi-annual evaluations for Resident 3 or 6.<br><br>A current facility policy, titled "AL-Evaluation and Service Plan Guidelines," dated as last revised on 12/16/24 and received from Clinical Support 4 on 5/19/25 at 2:22 p.m., indicated "...Upon admission, semi-annually and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychosocial functioning and care needs...." | | of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |
| R 0217<br><br>Bldg. 00 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br><br>Based on interview and record review, the facility failed to ensure service plans were signed by the resident or resident's representative for 3 of 7 residents reviewed for service plans. (Resident 4, 6, and 8)<br><br>Findings include:<br><br>1. The clinical record for Resident 4 was reviewed on 5/19/25 at 9:57 a.m. The diagnoses included, but were not limited to, history of stroke, hypertension, and hyperthyroidism.<br><br>Resident 4 did not have a signed service plan included in the clinical record.<br><br>2. The clinical record for Resident 6 was reviewed on 5/19/25 at 11:19 a.m. The diagnoses included, but were not limited to, pain, constipation, and nausea.<br><br>Resident 6 did not have a signed service plan included in the clinical record. | R 0217 | 1. Immediate actions taken for those residents identified:<br>Resident 4, 6 and 8 were affected by alleged deficient practice. Residents 4, 6, and 8 remain in the campus with no adverse effects. Service plans were immediately reviewed with the resident and or POA and signatures were obtained.<br><br>2. How the facility identified other residents:<br>All residents have the potential to be affected. Licensed clinical staff were educated on AL Service Plan Guidelines.<br><br>3. Measures put into place / System changes:<br>As a measure of ongoing compliance, DHS or designee to review service plans for signatures | 06/23/2025 |

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| | 3. The clinical record for Resident 8 was reviewed on 5/19/25 at 11:52 a.m. The diagnoses included, but were not limited to, coronary artery disease.<br><br>Resident 8 did not have a signed service plan included in the clinical record.<br><br>During an interview, on 5/19/25 at 1:32 p.m., Clinical Support 4 indicated the service plans were not signed. Residents 4, 6, and 8 did not have a signed service plan and the service plans should have been signed.<br><br>The facility did not have a policy related to signing the service plan. | | on all new admissions and 3 residents weekly x 3 months then monthly x 3 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |
| R 0241<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(1)<br>Health Services - Offense<br><br>Based on observation, interview and record review, the facility failed to ensure a resident had a physician's order for the use of oxygen for 1 of 7 residents reviewed for physician's orders. (Resident 3)<br><br>Findings include:<br><br>During an observation, on 5/16/25 at 2:35 p.m., Resident 3 had oxygen on at 2-liters per minute.<br><br>The clinical record for Resident 3 was reviewed on 5/16/25 at 2:40 p.m. The diagnoses included, but were not limited to, chronic kidney disease.<br><br>Resident 3 did not have a physician's order for the use of oxygen located in the clinical record.<br><br>During an interview, on 5/16/25 at 3:06 p.m., the | R 0241 | 1. Immediate actions taken for those residents identified:<br>Resident 3 was affected by insufficient practice. Resident remains in the campus with no adverse effects.<br><br>2. How the facility identified other residents:<br>All residents requiring supplemental oxygen have the potential to be affected. Licensed clinical staff were educated on physician's orders guidelines. All residents were reviewed for proper oxygen use.<br><br>3. Measures put into place / System changes: | 06/23/2025 |

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| | Director of Nursing (DON) indicated there was not a physician's order for the resident to use oxygen located in the medical record and there should have been an order.<br><br>A current facility policy, titled "Physician's orders Guidelines," dated as last revised on 12/17/24 and received from Clinical Support 4 on 5/19/25 at 3:45 p.m., indicated "...Physician orders for medications and treatments shall be obtained prior to or at admission...." | | As a measure of ongoing compliance, DHS or designee to review all residents for oxygen use weekly x 3 months then monthly x 3 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met. | |
| R 0410<br><br>Bldg. 00 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br><br>Based on interview and record review, the facility failed to ensure two-step tuberculosis testing was completed for 3 of 7 residents reviewed for tuberculosis testing. (Resident 5, 2 and 4)<br><br>Findings include:<br><br>1. The clinical record for Resident 5 was reviewed on 5/19/25 at 10:35 a.m. The diagnoses included, but were not limited to, major depressive disorder and psychotic disorder.<br><br>Resident 5 was admitted to the facility on 4/8/25.<br><br>There was no documentation to show that two-step tuberculosis testing had been completed. | R 0410 | 1. Immediate actions taken for those residents identified:<br>Resident 5, 2 and 4 were affected by alleged deficient practice. Residents 5, 2, and 4 remain in the campus with no adverse effects.<br><br>2. How the facility identified other residents:<br>All residents have the potential to be affected. Licensed clinical staff were educated on TB Test guidelines.<br><br>3. Measures put into place / System changes: | 06/23/2025 |

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| | 2. The clinical record for Resident 2 was reviewed on 5/15/25 at 11:04 a.m. The diagnosis included, but were not limited to, hypothyroidism, vitamin deficiency, and hyperlipidemia (high cholesterol).<br><br>Resident 2 was admitted to the facility on 8/31/24.<br><br>A first-step tuberculosis skin test was administered on 8/31/24. A second step tuberculosis skin test was not located in the clinical record.<br><br>3. The clinical record for Resident 4 was reviewed on 5/19/25 at 9:57 a.m. The diagnoses included, but were not limited to, cerebral infarction, hypertension, and hypothyroidism.<br><br>Resident 4 was admitted to the facility on 4/8/25.<br><br>There was no documentation to show two-step tuberculosis testing had been completed.<br><br>During an interview, on 5/19/25 at 1:32 p.m., Corporate Support Nurse 4 indicated tuberculosis testing was not completed for Resident 2 or 5 and a second step test was not completed for Resident 6.<br><br>A current facility policy, titled "Guidelines for TB Control Plan for Residents-Indiana," dated as last reviewed on 12/17/24 and received from Corporate Support Nurse 4 on 5/19/25 at 2:22 p.m., indicated "...Upon admission a base line two-step TST (tuberculosis skin test) shall be completed...." | | As a measure of ongoing compliance, DHS or designee to review new admissions and 3 residents for completion of TB Testing per policy weekly x 3 months then monthly x 3 months or until 100% compliance is maintained.<br><br>4. How the corrective actions will be monitored:<br>As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance though the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained of 100% compliance is met. | |