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
	155779	A. BUILDING 00 B. WING	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD EAST NOBLESVILLE, IN 46060

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00389656 and IN00392544. Complaint IN00389656 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725. Complaint IN00392544 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 17, 18, 19, 20, 21, 24 & 25, 2022 Facility number: 012305 Provider number: 155779 AIM number: 200987990 Census Bed Type: SNF/NF: 24 SNF: 33 Residential: 69 Total: 126 Census Payor Type: Medicare: 21 Medicaid: 17 Other: 19 Total: 57 These/This deficiencies/deficiency reflect/reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 27, 2022	F 0000	The submission of this plan of correction does not indicate an admission by Prairie lakes 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 Prairie Lakes Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenny McCurdy	RN, Clinical support nurse	11/12/2022

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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F 0675 SS=D Bldg. 00	483.24 Quality of Life § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.			
	Based on observation, interview and record review, the facility failed to ensure a resident with developmental disabilities received individualized services to maintain or improve quality of life for 1 of 1 resident reviewed. (Resident D) Findings include: Resident D's clinical record was reviewed on 10/21/22 at 10:17 a.m. Current diagnoses included, but were not limited to, congenital malformation of the corpus callussom (the bundle of nerve fibers which connect the two brain hemispheres), immobility syndrome, epilepsy, and intellectual disability/intellectual developmental disorder severe. The resident had a current physicians order for "General Diet: Soft foods, thin liquid, supplements via PEG tube. Special Instructions: prefers: pancakes, scrambled eggs with cottage cheese, mashed potatoes with gravy, oatmeal" This order originated 01/19/2022. A 6/15/22, "Notice of PASRR [Pre-Admission Screening and Resident Review] Level II Outcome" indicated the following:	F 0675	Resident D was affected. Resident D has been immediately assessed with no concerns noted. Resident D's care plan for individualized services was reviewed and updated with interventions updated as appropriate. All residents have the potential to be affected. IDT (interdisciplinary team) to be educated on appropriate individualized plan of care and interventions for residents with developmental disabilities. All campus staff to be educated on appropriate individualized programming for residents with developmental disabilities. As a measure of ongoing compliance, the ED (executive director) or designee will review personalized plan of care to ensure appropriate individualized services are documented and conducted on 5 residents weekly x4 weeks, then every other week	11/11/2022

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	"You have had limitations since birth, mobility, self care, self direction, learning, understanding and living independently. You are non-verbal, will smile and laugh. You are diagnosis of being blind. You do not have a mental health diagnosis. ...You do not have mental health diagnosis. You are non verbal, blind and need total care for all of you (sic) needs....You are severely impaired, profound intellectual disability. You find comfort in holding stuffed animals and soft blankets. ...You do not have a history of psychiatric hospitalization or outpatient mental health treatment. You enjoy listening to music and television. ...You are able to eat soft mushy foods by mouth but need help to eat ... You use a wheelchair to get around, wheeled by others...You would benefit from socialization with staff, residents, and others to help with symptoms of mental health and boredom. ...Self Direction/Planning is affected due to the condition." A 3/3/22, "Notice of PASRR Level II Outcome" indicated the following: "Medication review: Your previous records, current L1[level 1] PASRR, and the assessor reported that you are taking Risperdal, but this medication was not listed in your current medical record. You would benefit from review of your medications to ensure that they are appropriate and necessary for your needs. Obtain archives psychiatric records to clarify history: Your previous PASRR included limited information about a new diagnosis of Psychotic Disorder with no information about mood symptoms or behaviors to explain this diagnosis. Staff should obtain records to clarify whether you have this diagnosis and if you need treatment. ...Socialization/leisure/recreation activities: Staff should help you participate in activities you enjoy and help you spend time with others in the nursing home safely...You enjoy		x2 months, then monthly x3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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listening to cartoons on TV. ...You enjoy being around staff at the nursing home."

A current care plan problem/need, originated 7/29/21, indicated the resident was at risk for side effects due to anitpsychotic medication use. Approaches to this problem included, but were not limited to, "GDR [gradual dose reduction] at least twice a year unless contraindicated, Encourage resident to participate in intellectually appropriate leisure and structured activity (sic)."

A current care plan problem/need, originated 8/1/22, indicated the resident had limited mobility related to paraplegia.

A current care plan problem/need, originated 8/11/21, indicated the resident had a HAB (habilitation) plan with the objective for the resident to continue to make verbalizations to indicate needs and wants.

A current care plan problem/need, originated 7/29/21, indicated the resident had a diagnosis of intellectual disability and/or developmental disability. Approaches to this problem included, but were not limited to, "encourage the resident to participate in intellectually appropriate leisure and structured activity (sic)."

A current care plan problem/need, originated 7/29/21, indicated the resident had limited verbal communication due to aphagia. The goal to this problem was, "Resident's impaired ability to communicate due to: mental retardation will not result in unmet psychosocial needs."

A current care plan problem/need, originated 7/27/21, indicated the resident had the potential of limited activity participation due to her diagnosis.

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	A goal to this problem was, "My goal is to engage in activities of interest, such as listening to music, spending time outside, mindful moments, and hand massages." A second goal for this problem was, "My goal is to participate in a 15 min (minute) 1:1 (one to one activity), one time per week." A "1:1 Needs Assessment," dated 7/4/22, indicated the non-verbal resident, who could not self initiate activities, had experienced the following during the assessment period: "Resident receives visits from family, significant others or pastor several times a week; Resident watches TV and/or listens to audio books or radio of choice and makes preferences known; Resident listens to music of choice and makes preferences known; Resident attends activity programs." These responses resulted in a score of 12, indicating the resident should be provided at least one 1:1 activity, lasting 15 minutes, weekly. A quarterly Minimum Data Set (MDS) assessment, dated 7/30/22, indicated the resident was severely cognitively impaired, had no speech-absences of the spoken word, had severely impaired vision, had no hallucinations or delusions, displayed no maladaptive behaviors, used a wheelchair for mobility, required staff assistance for mobility, used an anitpsychotic medication seven of seven days during assessment, and the anitpsychotic medication had not had a GDR attempt or documented statement of contraindication. Review of the resident's activity attendance record for 9/24/22 to 10/24/22, which was provided by the Activity Director on 10/25/22 at 11:19 a.m., indicated the resident had attended only nine activities in the 30 day period as follows:			

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	10/24/22 at 4:22 p.m.-Music, Harp with (name) 10/24/22 at 8:51 a.m.-One On One, Mindful Moments 10//21/22 at 2:09 p.m.-One On One, Mindful Moments 10/21/22 at 8:53 a.m.-One On One, Mindful Moments 10/18/22 at 10:21 a.m.-One On One-Mindful Moments 10/12/22 at 9:01 a.m., One On One-Mindful Moments 10/6/22 at 8:40 a.m., One On One 9/27/22 at 4:38 p.m.-One On One-Talked to her 9/26/22 at 5:30 p.m.-Music, Harp During an interview on 10/25/22 at 11:19 a.m., the Activity Director indicated the information provided was the only record of activity attendance during the past month. A physician's progress note completed prior to the resident's admission to the long term care facility, dated 7/2/21, included, but was not limited to, the following: "Current Medication(s):...Risperdal 1 mg (milligram) tablet, take 1/2 (g] tablet in am [morning] and 1 tablet HS [at bedtime]. ...started on May 14, 2021...maintenance drug....risperdone 0.5mg tablet, 01 Tablet(s) GTube three times a day...start on May 11, 2021...maintenance drug. ...Psychiatric: The patient denied anxiety, ...obtained from [family member] due to mental capacity of patient. ... Non-verbal, She can smile and laugh, but cannot speak..." During an interview on 10/25/22 at 3:49 p.m., the MDS Coordinator indicated Resident D had not exhibited any maladaptive behaviors, including delusions.			

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	The resident had a current physician's order for Risperdal 0.25 mg, one tablet twice a day. The order originated on 3/28/22. A diagnoses of "psychotic disorder due to another medical condition, with delusions," was added to the residents medical record on 10/4/2021. The clinical record lacked a medical evaluation, examination, or assessment related to this diagnoses. The clinical record lacked any documentation of physician's services related to a psychotic disorder or delusions prior to admission. The clinical record lacked any documentation of an evaluation or assessment for symptoms or conditions associated with a psychotic disorder or delusions following admission. The clinical record lacked any documentation regarding any symptoms of delusions. The clinical record for 8/1/22 to 10/20/22, had no documented episodes of delusions or any other maladaptive or psychotic behaviors. A 10/01/2022, Nurse Practitioners progress note indicated the following: "psychiatric: Unable to respond due to diagnosis..." The medication Risperdal and a psychotic disorder with delusions were not mentioned in this note. The note lacked any documentation regarding emotional distress or behavioral concerns. The note focused on pain management as it related to the resident's pain. A 10/2/22, "Psychotropic & Sedative/Hypnotic Utilization By Resident," pharmacy report indicated the following: Antipsychotic-Risperidone 0.5 mg -"Last GDR Date: Comments: 10/21 psych reduced to 0.5 mg bid [two times daily] (will try to taper and DC [discontinue])...3/22 reduced to 0.25 mg bid, 6/22			

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	psych pn [typo NP-nurse practitioner]-tolerating reduction in March without exacerbation; currently stable; no further adjustments at this time." The clinical record lacked any documented delusions or psychotic behaviors from March 2022 to October 25, 2022. During an interview on 10/25/22 at 1:31 p.m., the Administrator, Director of Nursing (DON), Activity Director and Social Services Director (SSD) were interviewed regarding the facilities method to assess/evaluate Resident D, and how she was provided on-going mental stimulation, socialization, and activity needs. How she was assessed for targeted behaviors for psychiatric medications use, and how the psychiatric diagnosis had been obtained, and how was the offering of foods and feeding assistance for nutrition and pleasure documented as being provided to the resident. On 10/25/22 at 3:55 p.m., the Administrator provided an untitled document which she indicated was in response to the questions asked on 10/25/22 at 1:31 p.m. The document indicated the following: "What we (are) doing to ensure that [Resident D's name] has socialization and stimulation for her developmental needs: Despite her Level II stating she has no specialized services or needs, we ensure that she has socialization and stimulation by interacting with her on a daily during ADL [activities of daily living] tasks (this includes AM/PM care, incontinence care, medication administration, pleasure/comfort feeding), bringing her to the common living room even if she can't participate in the group activity she is present for sounds and stimulation, she is taken to the dining room for restorative pleasure feeding, when she is in her			

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	room we turn on the radio. [Name] responses to stimulation are inconsistent for us to know if she is communicating or not...Life enrichment has revised her 1:1 care plan to increase to daily visits instead of one time per week, also noted to increase her attendance at music events...The life enrichment tool used to assess her activity ability is being revised..." Review of consumption records for 9/21/22 to 10/20/22, identified concerns for 16 of 30 days as follows: a. 10/17/22, no documentation of a meal being offered or meal consumption for breakfast, lunch or dinner. b. 10/16/22, no documentation of a meal being offered or meal consumption for breakfast, lunch or dinner. c. 10/15/22, no documentation of a meal being offered or meal consumption for lunch. d. 10/14/22, no documentation of a meal being offered or meal consumption for breakfast, lunch or dinner. e. 10/13/22, no documentation of a meal being offered or meal consumption for dinner. f. 10/12/22, the documentation indicated the resident had a physician's order for no food by mouth for breakfast, lunch and dinner. g. 10/11/22, no documentation of a meal being offered or meal consumption for dinner. h. 10/10/22, no documentation of a meal being offered or meal consumption for breakfast or lunch. i. 10/5/22, no documentation of a meal being offered or meal consumption for lunch or dinner. j. 10/04/22, no documentation of a meal being offered or meal consumption for dinner. k. 10/3/22, no documentation of a meal being offered or meal consumption for dinner. l. 10/2/22, no documentation of a meal being			

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	offered or meal consumption for breakfast, lunch or dinner. j. 10/1/22, no documentation of a meal being offered or meal consumption for dinner. k. 9/29/22, no documentation of a meal being offered or meal consumption for dinner. l. 9/28/22, no documentation of a meal being offered or meal consumption for breakfast, lunch or dinner. m. 9/26/22, no documentation of a meal being offered or meal consumption for dinner. n. 9/24/22, no documentation of a meal being offered or meal consumption for breakfast, lunch or dinner. o. 9/22/22, no documentation of a meal being offered or meal consumption for breakfast, lunch or dinner. p. 9/21/22, no documentation of a meal being offered or meal consumption for breakfast, lunch or dinner. During the survey, the following was observed: a. On 10/17/22 at 11:55 a.m., the resident was seated in the 200 hall lounge. There was no activity or event. No other resident or staff were interacting with Resident D. b. On 10/18/22 at 11:08 a.m., the resident was seated in her wheel chair in the 200 hall lounge. She was curled up with her legs drawn up toward her chest. The staff offered her a blanket. c. On 10/18/22 at 1:48 p.m., the resident was seated in her wheel chair in the 200 hall lounge. She was curled up in her wheelchair. Her chin was resting on her chest. d. On 10/19/22 at 10:27 a.m., the resident was seated in her wheel chair in the 200 hall lounge. Her chin was resting on her chest. e. On 10/19/22 at 2:34 p.m., the resident was seated in her wheel chair in the 200 hall lounge. Her head was titled back and her chin was toward the			

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	ceiling. She was seated away from the other residents in the lounge. She lacked a soft toy or blanket or any manipulative device. f. On 10/20/22 at 9:25 a.m., the resident was in bed in her room. g. On 10/20/22 at 11:59 a.m., the resident remained in bed in her room. h. On 10/21/22 from 9:40 a.m. to 11:22 a.m., (1 hour 43 minutes), Resident D was seated in her wheel chair in the 200 hall lounge. During this time, no staff member spoke to her, offered her food, offered her an activity. i. On 10/21/22 at 11:22 a.m., Resident D was seated in her wheel chair in the lounge interacting with the activity assistant for 5 minutes. 3.1-37(a)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review, the facility failed to provide individualized activities to meet resident needs for 1 of 1 resident reviewed (Resident D) Findings include:	F 0679	Resident D was affected. Resident D has been immediately assessed with no concerns noted. Resident D’s care plan for individualized services was reviewed and updated with interventions updated as appropriate.	11/11/2022

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	During an observation on 10/17/22 at 11:55 a.m., Resident D was seated in the 200 hall lounge with no activity or event taking place. No other residents or staff were interacting with the resident. During an observation on 10/18/22 at 11:08 a.m., the resident was seated in her wheel chair in the 200 hall lounge. She was curled up with her legs drawn up toward her chest. The staff offered her a blanket. During an observation on 10/18/22 at 1:48 p.m., the resident was in her wheel chair in the 200 lounge. She was curled up in her wheelchair. Her chin was resting on her chest. During an observation on 10/19/22 at 10:27 a.m., the resident was seated in her specialized wheelchair in the 200 lounge. Her chin was resting on her chest. During an observation on 10/19/22 at 2;34 p.m., the resident was seated in her wheel chair in the 200 lounge her head was titled back and her chin was toward the ceiling. She was seated away from the other residents in the lounge. She did not have a soft toy or blanket or any manipulative device. During an observation on 10/20/22 at 9:25 a.m., the resident were in bed in her room. During an observation on 10/20/22 at 11: 59 a.m., the resident remained in bed in her room. During an observation on 10/21/22 from 9:40 a.m. to 11:22 a.m., (1 hour 43 minutes) Resident D was in her specialized wheelchair in the 200 lounge. During this time no staff member spoke to her, offered her food, offered her an activity. During an observation on 10/21/22 at 11:22 a.m., Resident D was in her custom wheelchair in the lounge interacting with the activity assistant for 5 minutes. Resident D's clinical record was reviewed on		All residents have the potential to be affected. IDT (interdisciplinary team) to be educated on appropriate individualized plan of care and interventions for residents with developmental disabilities. All campus staff to be educated on appropriate individualized programming for residents with developmental disabilities. As a measure of ongoing compliance, the ED (executive director) or designee will review personalized plan of care to ensure appropriate individualized services are documented and conducted on 5 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	155779	A. BUILDING 00 B. WING	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD EAST NOBLESVILLE, IN 46060

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	10/21/22 at 10:17 a.m. Current diagnoses included, but were not limited to, congenital malformation of the corpus callussom (the bundle of nerve fibers which connect the two brain hemispheres), immobility syndrome, epilepsy, and intellectual disability/intellectual developmental disorder severe. The resident was admitted to the facility on 7/21/21. A 7/30/22, Quarterly, MDS (Minimum Data Set) Assessment indicated the resident was severely cognitively impaired, had no speech-absence of the spoken word, had severely impaired vision, used a wheelchair for mobility, and required staff assistance for mobility. A current care plan problem/need, which originated 7/27/21, indicated the resident had the potential of limited activity participation due to her diagnosis. A goal to this problem was, "My goal is to engage in activities of interest, such as listening to music, spending time outside, mindful moments, and hand massages." A second goal for this problem was, "My goal is to participate in a 15 min (minute) 1:1 (one to one activity), one time per week." A current care plan problem/need, which originated 8/1/22, indicated the resident had limited mobility related to paraplegia. A current care plan problem/need, which originated 7/29/21, indicated the resident had a diagnosis of intellectual disability and/or developmental disability. Approaches to this problem included, but were not limited to, encourage the resident to participate in intellectually appropriate leisure and structured activity (sic)."			

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	A "1:1 Needs Assessment", dated 7/4/22, indicated the non-verbal resident , who could not self initiate activities, had experienced the following during the assessment period "Resident receives visits from family, significant others or pastor several times a week", "Resident watches TV and/or listens to audio books or radio of choice and makes preferences known", "Resident listens to music of choice and makes preferences known", "Resident attends activity programs." These responses resulted in a score of 12 indicating the resident should be provided, "at least 1 1:1 15 min. (minutes)" weekly. A 6/15/22, "Notice of PASRR Level II Outcome" indicated the following: " You have had limitations since birth, mobility, self care, self direction, learning, understanding and living independently. You are non-verbal, will smile and laugh. You are diagnosis of being blind. ... You are non verbal, blind and need total care for all of you (sic) needs....You are severely impaired, profound intellectual disability. You find comfort in holding stuffed animals and soft blankets. ... You enjoy listening to music and television. ... You use a wheelchair to get around, wheeled by others...You would benefit from socialization with staff, residents, and others to help with symptoms of mental health and boredom. ...Self Direction/Planning is affected due to the condition." A 3/3/22, "Notice of PASRR Level II Outcome" indicated the following: "...Socialization/leisure/recreation activities: Staff should help you participate in activities you enjoy and help you spend time with others in the nursing home safety...You enjoy listening to cartoons on TV. ...You enjoy being around staff at the nursing home."			

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	Review of the resident's activity attendance record for 9/24/22 to 10/24/22, which was provided by the Activity Director on 10/25/22 at 11:19 a.m., indicated the resident had attended only 9 activities in the 30 day period as follows: 10/24/22 at 4:22 p.m.-Music, Harp with (name) 10/24/22 at 8:51 a.m.-One On One, Mindful Moments 10//21/22 at 2:09 p.m.-One On One, Mindful Moments 10/21/22 at 8:53 a.m.-One On One, Mindful Moments 10/18/22 at 10:21 a.m.-One On One-Mindful Moments 10/12/22 at 9:01 a.m., One On One-Mindful Moments 10/6/22 at 8:40 a.m., One On One 9/27/22 at 4:38 p.m.-One On One-Talked to her 9/26/22 at 5:30 p.m.-Music, Harp During an interview on 10/25/22 at 11:19 a.m., the Activity Director indicated the information provided was the only record of activity attendance during the past month. She additionally indicated the activity goal of one 1:1 activity one time per week did not consider the residents inability to self-initiate activities. During an interview on 10/25/22 at 1:31 p.m., the Administrator, DON, Activity Director and Social Services Director were interviewed regarding the facilities method to assess/evaluate Resident D and provide on-going mental stimulation, socialization, activity needs and the related assessments. On 10/25/22 at 3:55 p.m., the Administrator provided an untitled document which she indicated was in respond to the questions asked			

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	on 10/25/22 at 1:31 p.m. The document indicated the following: "What we (are) doing to ensure that [Resident D's name] has socialization and stimulation for her developmental needs: Despite her Level II stating she has no specialized services or needs, we ensure that she has socialization and stimulation by interacting with her on a daily during ADL tasks (this includes AM/PM care, incontinence care, medication administration, pleasure/comfort feeding), bringing her to the common living room even if she can't participate in the group activity she is present for sounds and stimulation, she is taken to the dining room for restorative pleasure feeding, when she is in her room we turn on the radio. [Name] responses to stimulation are inconsistent for us to know if she is communicating or not... Life enrichment has revised her 1:1 care plan to increase to daily visits instead of one time per week, also noted to increase her attendance at music events... The life enrichment tool used to assess her activity ability is being revised..." 3.1-33(a)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and			

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	considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on observation, interview, and record review, the facility failed to provide sufficient staff to ensure individual resident needs were met regarding prompt call light responses, stimulation for cognitively impaired residents, supervision and assistance when dinning, Activities of Daily Living (ADLs) services for hygiene and elimination, and timely medication administration. This had the potential for affect 57 or 57 residents residing on the skilled care units of the facility. Findings include: 1. A confidential interview was conducted during the course of the survey. The confidential interviewee indicated several times the staffing consists of three staff for the three halls on the skilled care units. They indicated the staffing does affect resident care due to long call light waits and the inability to check and change incontinent	F 0725	Residents were not affected by the alleged deficit practice. Medication administration times have been reviewed and medications have been given in accordance to written orders. Call light audits have been conducted to ensure appropriate response times. Dining room supervision continues per schedule. Residents requiring assistance with ADL's (activities of daily living) continue to be monitored for response times and assisted per staff as warranted timely. All residents have the potential to be affected. Clinical have been educated on ensuring medications are signed out in medical record in accordance to the written order.	11/11/2022

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	residents in a timely manner. The facility Resident Census and Conditions of Residents form, submitted following entrance conference, indicated the total current residents residing on the skilled care units was 57. The form indicated the following: a. Residents who were occasionally or frequently incontinent of bladder was 45, or 79% of the resident census. b. Residents who were occasionally or frequently incontinent of bowel was 48, or 84 % of the resident census. c. Residents who required assistance of one or two staff for bathing, dressing, and transferring was 55, or 96.5% of the resident census. d. Residents who had a diagnoses of dementia was 31, or 54% of the resident census. e. Residents who required staff assistance of one to two staff for eating was 10, or 17.5% of the resident census. A review of the facility schedule and time Staffing Report for the week of 10/16/22 to 10/22/22, indicated the following staffing for the night shift for the 57 residents residing on all three halls on the skilled units: a. On 10/16/22, one registered nurse (RN) and two certified nursing assistants (CNA), or 3 staff members. b. On 10/17/22, two licensed practical nurses (LPN), one CNA, and one qualified medication aide (QMA), or 4 staff members. c. On 10/18/22, one LPN, one QMA, and one CNA, or 3 staff members. d. On 10/19/22, on LPN and two QMA's, or 3 staff members. e. On 10/20/22, three LPNs and one CNA, or 4		All staff have been educated on call light response and dining room supervision. All staff educated on appropriate engagement of cognitively impaired residents. As a measure of ongoing compliance, the ED or designee, will complete audits of 5 residents medication administration to ensure medications are given per written order 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. As a measure of ongoing compliance, the ED or designee, will complete audits of 5 call lights response time weekly x4 weeks, then every other week x2 month, the monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	staff members. f. On 10/21/22, one RN and one CNA, or 2 staff members. g. On 10/22/22, one RN, two QMA's and one CNA, or 4 staff members. During an interview on 10/25/22 at 4:21 p.m., the Administrator indicated there was no formula used to determine staffing. The facility assessment/status/condition/acuity are used to fill needs. Sometimes the facility was low on scheduled staff and administration would help when present. The facility had no policy regarding staffing. 2. During an observation on 10/21/22 from 9:40 a.m. to 11:22 a.m., (1 hour 43 minutes), Resident D, who was dependent on staff assistance for mobility, was unable to self initiate activities and was unable to ask for assistance, was in her specialized wheelchair in the 200 hall lounge. During this time no staff member spoke to her, offered her food, or offered her an activity. During an observation on 10/21/22 at 11:22 a.m., Resident D was in her custom wheelchair in the lounge interacting with the activity assistant for five minutes. Resident D's clinical record was reviewed on 10/21/22 at 10:17 a.m. Current diagnoses included, but were not limited to, congenital malformation of the corpus callussom (the bundle of nerve fibers which connect the two brain hemispheres), immobility syndrome, epilepsy, and intellectual disability/intellectual developmental disorder severe. A quarterly Minimum Data Set (MDS) assessment, dated 7/30/22, indicated the resident was severely cognitively impaired, had no speech-absence of the spoken word, had severely			

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impaired vision, used a wheelchair for mobility, and required staff assistance for mobility.

3. During an observation on 10/21/22 at 9:45 a.m., Resident F was assisted by an activity staff member to the table in the 200 hall lounge. Her wheelchair was placed at the table so the back wheel of the wheelchair were a few inches from the decorative cabinet. A breakfast meal tray was placed in front of her. The resident began to eat. The resident ate without a staff member present from 9:45 a.m. until 10:41 a.m., (56 minutes). On 10/21/22 at 10:41 a.m., the meal tray was moved from in front of the resident. At 10:48 a.m., the resident attempted to move her wheelchair away from the table but could not move it because it was placed too close to the cabinet. No staff were present to assist her. The resident moved her wheelchair back against the cabinet multiple times from 10:48 a.m. to 11:24 a.m., (24 minutes) with no staff in the area. At 11:24 a.m., an activity assistant offered the resident an activity and moved her wheel chair.

Resident F's clinical record was reviewed on 10/19/22 at 3:09 p.m. Current diagnosis included, but where not limited to, dementia and anxiety.

A quarterly MDS assessment, dated 7/19/22, indicated the resident was severely cognitively impaired, had unclear speech, holds food in her mouth, and needs limited assistance to eat.

4. During an observation on 10/21/22 from 9:25 a.m. to 10:39 a.m., (one hour and 15 minutes), Resident E was seated in his wheelchair at a table in the 200 hall lounge. There was a breakfast tray containing biscuits and gravy in front of the resident. The meal appeared uneaten. The resident was asleep with his chin on his chest,

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softly snoring. During the one hour and 15 minutes, the staff had not spoken to Resident E or encouraged him to eat. At 10:39 a.m., a staff member asked the resident if he was finished and took the uneaten breakfast tray away. The resident's coffee was freshened up and left in front of him. The resident took a few sips of coffee and feel asleep with his hand touching his coffee cup on the table. The resident slept at the table holding his coffee cup from 10:46 a.m. to 11:20 a.m., (34 minutes), with no staff speaking to the resident nor interacting with the resident.

Resident E's clinical record was reviewed on 10/21/22 at 2:43 p.m. Current diagnosis included, but were not limited to, dementia, chronic atrial fibrillation, diabetes mellitus, and hypertension.

An admission MDS assessment, dated 8/4/22, indicated the resident understood others, was understood by others, required supervision for eating, used a wheelchair for mobility, and often required staff assistance with mobility.

5. During an observation on 10/21/22 at 11:20 a.m., Resident G had taken the coffee cup from Resident E's hand. Resident G then propelled her wheel chair repeatedly into the wheels on Resident E's wheelchair. After successfully passing Resident E's wheelchair, Resident G began to drink from Resident E's used coffee cup. No staff were in the area to observe the resident drinking from the used coffee cup.

Resident G's clinical record was reviewed on 10/20/22 at 9:42 a.m. Current diagnosis included, but were not limited to, dementia.

An significant change MDS assessment, dated 8/20/22, indicated the resident was severely

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cognitively impaired.
6. During a continuous observation on 10/17/22 at 12:42 p.m., Resident C's call light was lit up above his door. Licensed Practical Nurse (LPN) 7 was seated at the computer in the 300 hall Nurse's Station. No other staff members were observed on the unit at this time. Resident C's light remained activated, with the door closed and a "Red Zone Isolation Sign" on the door. At 12:47 p.m., Resident C was heard excessively coughing while in the 300 hall. At 12:56 p.m., a soft tone was heard approximately every seven seconds near the computer at the 300 hall Nurse's Station. Resident C's call light remained activated. No staff members were located at the Nurse's Station. At 1:00 p.m. (18 minutes since the original observation), LPN 7 walked by Resident C's room with the call light still activated. At 1:06 p.m., an unidentified staff member came down the hallway and began to pass lunch trays. Resident C's call light remained unrecognized and the call light tone still sounded as the staff member passed lunch trays. At 1:16 p.m., (34 minutes after the observation began), LPN 7 knocked on Resident C's door and entered the room to deliver the resident's meal tray. The call light was answered and deactivated.

Review of the Respiratory Surveillance Line Listing on 10/19/22 at 3:53 p.m., indicated 23 residents in healthcare were COVID-19 positive from 10/13/22 to 10/19/22. These resident were dispersed throughout all units.

During an interview on 10/21/22 at 03:22 p.m., Certified Nurse's Aide (CNA) 6 indicated they usually were scheduled with one Nurse and one CNA for the 300 hall Unit. The facility never have enough staff to get all of the showers completed timely and provide timely resident care. The

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	facility had a Shower Aide scheduled in the past, but this position was not scheduled anymore. There had been other times, especially when someone called in, that some units had no CNA scheduled. Many times the nursing staff was left on hall by themselves to pass medications and complete resident care. Several residents had told her they had not been showered according to their preference every week. The lack of showers had been reported to the Director of Nursing, Assistant Director of Nursing, and the Scheduler. It had been reported to management that the staff were exasperated from working without sufficient staff. Resident C's clinical record review was completed on 10/25/22 at 10:50 a.m. The resident admitted to the facility on 9/14/22. Diagnoses included, but were not limited to, COVID-19 acute respiratory disease, chronic obstructive pulmonary disease, syncope and collapse, dysphasia, bilateral primary osteoarthritis of knee, repeated falls, and unspecified abnormalities of gait and mobility. An admission MDS assessment indicated the resident was cognitively intact. He required extensive assistance from one staff member for dressing, toileting, and personal hygiene and extensive assistance from two staff for bed mobility and transfers. The resident was always incontinent of urine and frequently incontinent of bowel. During an interview at the time of observation on 10/25/22 at 11:36 a.m., CNA 6 indicated they had not had anyone scheduled to work at the Nurse's Station during the shift to alert the staff of activated call lights. The soft tone that sounded every seven seconds at the time of interview at the Nurse's Station was the normal tone of the call			

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light notification. This tone was unable to be heard when a staff member was in a resident's room especially the rooms that were not near the Nurse's Station. Staff did not have a way to know if a call light had been activated when they were in a resident's room because they had not had a device that alerted them if they could not see the lights.

During an interview on 10/25/22 at 3:38 p.m., the Corporate Nurse Consultant indicated they would typically monitor call lights by performing audits. A request was made for the audits at this time. Further documentation of call light monitoring was not provided.

During an interview on 10/25/22 at 4:39 p.m., the DON indicated she was aware of a lack of timely showers for residents. She was uncertain of the timeframe when this occurred. Regarding staffing for the 300 hall unit, the facility continued to staff at baseline with one Nurse and one CNA for the 300 Unit. She indicated the baseline staffing for the 300 Unit had unchanged when the 300 unit had increased acuity related to 10 out 16 COVID-19 positive residents in isolation during the survey observations.

7. During an interview on 10/18/22 at 10:26 a.m., Resident H indicated she required assistance with her showers but due to a shortage of help she had only received her showers once each week rather than her agreed upon plan of showers twice weekly.

Resident H's clinical record was reviewed on 10/20/22 at 4:26 p.m. She admitted to the facility on 9/10/22. Diagnoses included, but were not limited to, fracture of unspecified part of neck of left femur, subsequent encounter for closed

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fracture with routine healing, syncope and collapse, and other chronic pain.

An admission MDS assessment, dated 9/15/22, indicated the resident was cognitively intact, required limited assistance from staff for transfers and total dependence on staff for bathing. The resident lacked any rejection of care behaviors.

A care plan for Activities of Daily Living (ADL), dated 9/27/22, indicated the resident required staff assistance to complete ADL tasks completely and safely.

A care plan for Profile Care Guide, dated 9/27/22, indicated the resident preferred showers on Wednesdays and Saturdays on the evening shift.

During an interview on 10/21/22 at 03:22 p.m., CNA 6 indicated they usually were scheduled with one Nurse and one CNA for the 300 Unit and they never have enough staff to get all of the showers completed timely and provide timely resident care. They used to have a Shower Aide but this position was not scheduled anymore. There have been other times, especially when someone called in, that some halls did not have an Aide. These times left the nurse on the whole unit by herself for medication pass and resident care. Random residents told her they have not been showered according to their preference every week and it has been reported to the Director of Nursing, Assistant Director of Nursing, and the Scheduler. Often, it was also expressed to management how staff were exasperated from working without sufficient staff. Upon management notification of a lack of timely shower care, CNA 6 was encouraged to try to get the showers worked in during the shift but they were not always done by the end of the shift. The

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	residents should have had 2 showers every week. If they missed a regular shower, it was required to have been made up on Sunday. She indicated any shower refusals were documented in the electronic medical record in the same location they document the showers provided. She indicated this information was required to be documented when the shower was provided or refused. During an interview on 10/25/22 at 10:35 a.m., the Corporate Nurse Consultant was requested to provide all documentation of bathing for the resident. Review of the ADL Report from 9/10/22 to 10/25/22, indicated the resident only received showers on the following dates: 9/17/22, 9/28/22, 10/5/22, 10/19/22, and 10/24/22. Further shower documentation was not provided prior to survey exit on 10/25/21 at 5:45 p.m. During an interview on 10/25/22 at 4:39 p.m., the DON indicated she was aware of a lack of timely showers for residents. She was uncertain of the timeframe when this occurred. Regarding staffing for the 300 Unit, the facility continued to staff at baseline with 1 Nurse and 1 Aide for the 300 Unit. She indicated the baseline staffing for the 300 Unit was unchanged when the 300 unit had increased acuity related to 10 out 16 COVID positive residents in isolation during the survey observations. A document, revised 12/15/21, titled, "Facility Assessment Tool," provided by the Administrator following entrance conference, included, but was not limited to, the following: "Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident			

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	Population Every Day and During Emergencies...3.3 Individual staff assignment...Campus considers census, resident acuity, resident preferences, and staff competencies to determine the number and competency requirements of staff in order to meet each resident's needs....Review of some areas included but are not exclusive list:...2. The number of residents assigned to each staff member. 3. Acuity of the resident on assignment....5. Patterns of resident care needs being met: Bathing, toileting needs, call lights response time, resident assisted timely, etc." This Federal Citation is related to Complaint IN00389656. 3.1-17(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and			

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	documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on observation, interview and record review, the facility failed to ensure residents who received antipsychotic medications had documented medical indications for use, had appropriate diagnoses for use, had gradual dose reductions and/or contraindication for reductions for 1 of 3 residents reviewed for psychoactive medication use. (Residents D) Findings include:	F 0758	Resident D lacked documentation of appropriate diagnosis for the use of psychotropic medication use. Documentation of appropriate documentation has been obtained for these residents. All residents with orders for psychotropic medications have the potential to be affected. The DHS (Director of health services),	11/11/2022

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	Resident D's clinical record was reviewed on 10/21/22 at 10:17 a.m. Current diagnoses included, but were not limited to, congenital malformation of the corpus callussom (the bundle of nerve fibers which connect the two brain hemispheres), immobility syndrome, epilepsy, and intellectual disability/intellectual developmental disorder severe. The resident was admitted to the facility on 7/21/21. A physician's progress note, completed prior to the residents admission to the long term care facility, dated 7/2/21, indicated the following: "Current Medication(s): ...Risperdal [an antipsychotic medication] 1 mg [milligram] tablet, Take 1/2 [0.50 mg] tablet in am [morning] and 1 tablet HS [at bedtime]. ...started on May 14, 2021...maintenance drug.... risperdone 0.5 mg tablet, 01 Tablet(s) GTube three times a day...start on May 11, 2021...maintenance drug. ... Psychiatric: The patient denied anxiety, ...obtained from [family member] due to mental capacity of patient. ... Non-verbal, She can smile and laugh, but cannot speak..." The resident had a current physician's order for risperidone/risperal (an anitpsychotic medication) tablet, 0.25 mg, one twice a day. The order originated 3/28/22. A diagnoses of "psychotic disorder due to another medical condition, with delusions" was added to the resident's medical record on 10/4/2021. The clinical record lacked a medical evaluation, examination, or assessment related to this diagnoses. The clinical record lacked any documentation of physician's services related to a psychotic disorder or delusions prior to		ADHS (assistant director of health services), SSD social services director and MDS (minimum data set) nurse have been educated to ensure that an appropriate diagnosis is correlated with psychotropic medications as well as correct diagnosis for perspective medications. A house wide audit has occurred to ensure appropriate diagnosis are correlated with psychotropic medications. As a measure of ongoing compliance, the DHS or designee, will complete audits of 5 residents to ensure appropriate diagnosis is in place for psychotropic medication use. Audits to be completed 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	admission. The clinical record lacked any documentation of an evaluation or assessment for symptoms or conditions associated with a psychotic disorder or delusions following admission. The clinical record lacked any documentation regarding how this none verbal resident displayed symptoms of delusions. The clinical record for 8/1/22 to 10/20/22, lacked documentation of episodes of delusions, any other maladaptive, or psychotic behaviors. A 10/2/22, "Psychotropic &Sedative/Hypnotic Utilization By Resident" pharmacy report, indicated the following: Anitpsychotic-Resperidone 0.5 mg -"Last GDR Date: Comments: 10/21 psych reduced to 0.5 mg bid { two times daily] (will try to taper and DC [discontinue])...3/22 reduced to 0.25 mg bid, 6/22 psych pn [typo NP-nurse practioner]-tolerating reduction in March without exacerbation; currently stable; no further adjustments at this time." The clinical record lacked any documented delusions or psychotic behaviors from March 2022 to October 25, 2022. A quarterly Minimum Data Set (MDS) assessment, dated 7/30/22, indicated the resident had severe cognitive impairment, had no speech-absence of the spoken word, had severely impaired vision, had no hallucination or delusions, displayed no maladaptive behaviors, used an antipsychotic medication seven of seven days during assessment, and the antipsychotic medication lacked a gradual dose reduction (GDR) attempt or statement of contraindication. A current care plan problem/need, which originated 7/29/21, indicated the resident was at risk for side effects due to antipsychotic use. Approaches to this problem included, but were			

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not limited to, "GDR at least twice a year unless contraindicated, Encourage resident to participate in intellectually appropriate leisure and structured activity (sic)."

A 6/15/22, "Notice of PASRR [Pre-Admission Screening and Resident Review] Level II Outcome" indicated the following:
"You have had limitations since birth, mobility, self care, self direction, learning, understanding and living independently. You are non-verbal, will smile and laugh....You do not have mental health diagnosis.....You are severely impaired, profound intellectual disability..... You do not have a history of psychiatric hospitalization or outpatient mental health treatment."

A 3/3/22, "Notice of PASRR Level II Outcome" indicated the following: "Medication review: Your previous records, current L1[level 1] PASRR, and the assessor reported that you are taking Risperdal, but this medication was not listed in your current medical record. You would benefit from review of your medications to ensure that they are appropriate and necessary for your needs. Obtain archives psychiatric records to clarify history: Your previous PASRR included limited information about a new diagnosis of Psychotic Disorder with no information about mood symptoms or behaviors to explain this diagnosis. Staff should obtain records to clarify whether you have this diagnosis and if you need treatment."

A 10/01/2022, Nurse Practitioners note indicated the following:
"psychiatric: Unable to respond due to diagnosis..." The medication Risperdal and a psychotic disorder with delusions were not mentioned in this note. The note lacked any

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	documentation regarding emotional distress or behavioral concerns. The note focused on pain management. During an observation on 10/17/22 at 11:55 a.m., the resident was seated in the 200 lounge no activity or event was taking place. No other resident or staff were interacting with Resident D. During an observation on 10/18/22 at 11:08 a.m., the resident was seated in her wheel chair in the 200 lounge. She was curled up with her legs drawn up toward her chest. The staff offered her a blanket. During an observation on 10/18/22 at 1:48 p.m., the resident was in her wheel chair in the 200 lounge. She was curled up in her wheelchair. Her chin was resting on her chest. During an observation on 10/19/22 at 10:27 a.m., the resident was seated in her specialized wheelchair in the 200 lounge. Her chin was resting on her chest. During an observation on 10/19/22 at 2;34 p.m., the resident was seated in her wheel chair in the 200 lounge her head was titled back and her chin was toward the ceiling. She was seated away from the other residents in the lounge. She did not have a soft toy or blanket or any manipulative device. During an observation on 10/20/22 at 9:25 a.m., the resident were in bed in her room. During an observation on 10/20/22 at 11: 59 a.m., the resident remained in bed in her room. During an observation on 10/21/22 from 9:40 a.m. to 11:22 a.m., (1 hour 43 minutes) Resident D was in her specialized wheelchair in the 200 lounge. During this time no staff member spoke to her, offered her food, offered her an activity. During an observation on 10/21/22 at 11:22 a.m., Resident D was in her custom wheelchair in the lounge interacting with the activity assistant for 5			

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minutes.

During an interview on 10/25/22 at 1:31 p.m., the Administrator, DON, Activity Director and Social Services Director were interviewed regarding the facilities method to assess/evaluate Resident D's targeted behavior for psychiatric medications, how the psychiatric diagnoses was obtained. As of the exit on 10/25/22 the facility had not provided information regarding the resident obtaining a psychiatric diagnosis or how the resident displayed delusions.

During an interview on 10/25/22 at 3:49 p.m., the DMS Coordinator indicated Resident D did not exhibit any maladaptive behaviors including delusions.

A current, 9/17/12, facility policy, titled "Psychoactive Drug Monitoring", which was provided by the Social Services Director in 10/25/22 at 3:28 p.m., indicated the following:
" Residents receive a psychoactive medications only if designated medically necessary by the prescriber. ...
Residents receive anti-psychotic medication only for behaviors that are quanitively and objectively documented ...
Residents receive anti-psychoactive medications only for behaviors that are persistent, that are not caused by a preventable reasons, and are causing the resident to: Present a danger it self or others, Continuously scream, yell, or pace, Experience psychotic symptoms..."

3.1-48(b)

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483.80(a)(1)(2)(4)(e)(f)
Infection Prevention & Control
§483.80 Infection Control

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	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 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,			

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	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 (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 proper infection prevention and control strategies to mitigate the spread of COVID-19 during a facility COVID-19 outbreak and high community transmission for 5 of 10 residents reviewed for infection control. (Resident 10, Resident 30, Resident 33, Resident 41 and Resident 43) Findings include:	F 0880	Residents 10, 30, 33, 41, 43 were affected by this alleged deficient practice. Resident immediately assessed with no adverse effects. Staff were immediately educated on proper infection prevention and control strategies to mitigate the spread of COVID-19. All residents have the potential to be affected. All staff to be	11/11/2022

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	1. During an observation on 10/17/22 at 11:34 a.m., Resident 30's room contained a Red Zone contact/droplet isolation sign on the door closed. Required personal protective equipment (PPE) was listed as, an N95 (respirator) facemask, eye protection, gown, gloves and frequent hand hygiene. During an observation on 10/17/22 at 12:10 p.m., Licensed Practical Nurse (LPN) 7 entered the resident's Red Zone isolation room with a surgical mask worn underneath an N95 facemask. Red Zone isolation signs remained on the door during the observation. During an observation on 10/17/22 at 12:21 p.m., LPN 7 exited the resident's room after he doffed (removed) his PPE, pulled the door closed, then opened the PPE container to the left of the door and obtained a new N95 facemask and face shield. Hand hygiene was not observed before he touched the PPE container outside the room or before he donned (applied) the new facemask and eye protection. Review of the Respiratory Surveillance Line Listing on 10/19/22 at 3:53 p.m., indicated Resident 30 had tested positive for COVID-19 on 10/16/22 with a symptom onset date of 10/16/22. The resident resided on the 300 unit. 2. During a random observation on 10/17/22 at 11:36 a.m., Housekeeper 8 was observed in Resident 43's Red Zone isolation room. She had on a surgical mask with an N95 facemask worn over the top of the surgical mask while she cleaned the resident's room with the resident in the room. A Red Zone sign indicated the room was a contact/droplet isolation. Required personal		educated, following CDC and facility policy. The Executive Director (ED), Director of Health Services (DHS), Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same team will review the Long-Term Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. As a measure of ongoing compliance, the following audits and/or observations for 5 employees will be conducted by the ED, campus IP, or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: Proper hand hygiene and proper donning and doffing of PPE. All findings from the RCA, if different from current audit, will result in additional audits. The ED, campus IP, or designee will round the campus daily to ensure appropriate infection control practices are maintained and for any needs as determined from RCA findings for a minimum of 6 weeks and will continue thereafter until 100% compliance is	

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	protective equipment included an N95 facemask, eye protection for all health care providers regardless of vaccination status, gown, gloves, and frequent hand hygiene. During an interview on 10/17/22 at 11:59 a.m., LPN 7 indicated the facility had not designated dedicated staff member to enter the Red Zone Isolation rooms, but all staff were required to wear appropriate PPE for contact/droplet isolation before they entered. Review of the Respiratory Surveillance Line Listing on 10/19/22 at 3:53 p.m., indicated Resident 43 had tested positive for COVID-19 on 10/16/22 with symptom onset date of 10/16/22. This resident resided on the 300 unit. During an interview on 10/21/22 at 11:03 a.m., Housekeeper 8 indicated an N95 facemask over a surgical mask was not appropriate in a Red Zone isolation room. 3. During an observation on 10/17/22 at 12:00 p.m., Resident 41's door was closed with a Red Zone sign that indicated contact/droplet isolation. During an interview with the Director of Nursing (DON) on 10/18/22 at 9:47 a.m., she indicated six more residents had tested positive for COVID-19 on the health care units and two more staff members had tested positive for COVID-19. During an observation on 10/19/22 at 2:53 p.m., the Social Service Director (SSD) had on a surgical mask and approached Resident 41's Red Zone isolation room. A Red Zone contact/droplet isolation sign remained on the door with a list of the required PPE. PPE required for the resident's room included an N95 facemask, eye protection,		maintained. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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gown, gloves and frequent hand hygiene. She donned an N95 mask over the top of her surgical mask, a face shield, gown and gloves then entered the resident's room and assisted the resident.

During an interview at the time of observation on 10/19/22 at 3:01 p.m., the SSD exited the resident's room. She indicated she should not have placed the N95 facemask over the top of the surgical mask before she entered the resident's Red Zone isolation room because the N95 facemask would not fit properly against the face with the surgical mask worn under it. She had prior training on proper masking but she had been in a hurry to get in the room. While she was in the resident's room she held the resident's hand to calm her down. She indicated an improperly donned N95 facemask in an isolation room increased risk for potential spread of COVID-19.

During an interview on 10/19/22 at 3:39 p.m., the DON indicated Resident 41 had tested positive for COVID-19.

Review of the Respiratory Surveillance Line Listing on 10/19/22 at 3:53 p.m., indicated Resident 41 had tested positive for COVID-19 on 10/16/22 with symptom onset date of 10/16/22. This resident resided on the 300 unit.

During an interview on 10/19/22 at 3:57 p.m., the DON indicated staff who entered a Red Zone isolation room were required to have worn an N95 facemask, goggles or face shield, gloves and a gown. An N95 facemask should not be donned over a surgical mask to enter a Red Zone isolation room due to lack of appropriate seal against the face.

4. During a random observation on 10/17/22 at

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	12:34 p.m., an unidentified Certified Nurse's Aide (CNA) walked down the 100 Unit hallway with a surgical mask secured to her ears but worn below her nose with her entire nose visible. She approached Resident 10's Red Zone isolation room to answer an activated call light, donned a gown and gloves without sanitizing hands, and entered the resident's room with her surgical mask below her nose. She had not donned an N95 facemask or eye protection before she entered. The door contained a Red Zone sign that listed required PPE as an N95 facemask, eye protection, gown, gloves and frequent hand hygiene. Review of the Respiratory Surveillance Line Listing on 10/19/22 at 3:53 p.m., indicated Resident 10 had tested positive for COVID-19 on 10/16/22 with symptom onset date of 10/16/22. This resident resided on the 100 Unit. 5. During an observation of medication administration on 10/21/22 at 10:14 a.m., Qualified Medication Aide (QMA) 9 indicated Resident 33 was in Red Zone contact/droplet isolation. The resident's room door contained a Red Zone isolation sign and indicated required PPE. QMA 9 retrieved the resident's moxifloxacin 0.5% solution (antibiotic eye drops) from the center compartment of the top drawer in the 200 hall medication cart with other resident's eye drop containers. The eye drop bottle was in a prescription bottle container and placed on top of the medication cart during preparation. The eye dropper was not removed from the prescription bottle. QMA 9 donned PPE and the prescription bottle for the eye drops was picked up and taken into the resident's room. The prescription bottle was place on the overbed table with out a barrier, within one foot of the resident. QMA 9 removed the dropper for administration with her gloved			

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	hands, pulled down the resident's lower right eye lid, instilled the drop, placed the container back into the prescription bottle, and put the prescription bottle in to her pocket without cleaning the bottle. She doffed her attire in the room and performed hand hygiene upon exit. She removed the prescription bottle from her pocket with bare hands and placed it on top of the medication cart without a barrier. Without performing hand hygiene, QMA 9 unlocked the medication cart with her keys, opened the top center drawer of the medication cart and placed the eye drop prescription bottle back into the compartment against the other residents' containers stored in the same compartment. The prescription bottle was not disinfected at any time during the observation. During an interview on 10/21/22 at 10:48 a.m., QMA 9 indicated she should not have taken the bottle into the room and set it on the resident's table without cleaning it. She would typically have taken the drops out of the prescription bottle before she entered the resident's room and cleaned it before she placed it back into the medication cart. The lack of proper infection prevention and control practices caused a risk for the spread of infection. Review of the Respiratory Surveillance Line Listing on 10/19/22 at 3:53 p.m., indicated Resident 33 had tested positive for COVID-19 on 10/17/22 with symptom onset date of 10/17/22. This resident resided on the 200 unit. During an interview on 10/21/22 at 10:55 a.m., the Corporate Nurse Consultant indicated the medication container should not have been set on the residents over bed table in a Red Zone isolation room and placed back into the			

medication cart without a cleaning process.

During an interview on 10/25/22 at 5:05 p.m., the Administrator indicated the facility followed the Center for Disease Control (CDC) and Indiana Department of Health guidelines and regulations regarding infection prevention and control during a COVID-19 facility outbreak and high community transmission.

During an interview on 10/25/22 at 5:09 p.m., the Administrator indicated the community COVID-19 transmission rate had been high from 10/7/22 through 10/25/22, except for 10/24/22 when the community transmission was indicated as substantial.

A current policy, titled, "Infection Prevention and Control Program," provided by the Administrator on 10/17/22 following the entrance conference, included, but was not limited to, the following:

"PURPOSE...To 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....PROCEDURES 1. The campus has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that: a. Covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement b. Is based on the individual facility assessment c. Follows accepted national standards..."

3.1-18(b)(1)
3.1-18(l)

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00389656 and IN00392544. Complaint IN00389656 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725. Complaint IN00392544 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 17, 18, 19, 20, 21, 24 & 25, 2022 Facility number: 012305 Residential Census: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 27, 2022	R 0000	The submission of this plan of correction does not indicate an admission by Prairie lakes 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 Prairie Lakes Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
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,			

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	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 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 was competent in First Aid and cardiopulmonary resusitation (CPR) certifications for 5 of 7 days reviewed 69 residents resided in the facility. Findings include: On 10/25/22 at 9:10 a.m., a review of the employee schedule indicated no staff member with First Aid certifications and CPR certifications had been on site during the following shifts: a. Night shifts on 10/16/22, 10/18/22, 10/21/22, and 10/22/22. b. Evening shift on 10/19/22. During an interview on 3/12/19 at 3:00 p.m., the Executive Director indicated the information included in the certification binder was current. The facility has no policy for regarding First Aid	R 0117	Facility lacked documentation of competencies for first aid and Cardiopulmonary resuscitation (CPR) certifications for 5 of 7 days. No residents were affected by this alleged deficient practice. Clinical staff scheduled for CPR and first aide course to ensure competency of training in this discipline. As a measure of ongoing compliance, the ED (executive director) or designee, will complete audits of 5 employees to ensure proper CPR/first aide training is in compliance. Audits to be completed weekly x4 weeks, then every other week x 4 weeks, then monthly x4 months	11/11/2022

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	and CPR certifications.		The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to ensure proper infection prevention and control strategies to mitigate the spread of COVID-19 during a facility COVID-19 outbreak and high community transmission for 1 of 5 residents reviewed for infection control. (Resident 29) Findings include:	R 0407	Resident 29 was affected by this alleged deficient practice. Resident immediately assessed with no adverse effects. Staff were immediately educated on proper infection prevention and control strategies to mitigate the spread of COVID-19. All residents have the potential to be affected. All staff to be	11/11/2022

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	Review of the Respiratory Surveillance Line Listing on 10/19/22 at 3:53 p.m., indicated 6 residents in Assisted Living were positive for COVID-19 from 10/16/22 to 10/19/22. Resident 29 tested positive for COVID-19 on 10/17/22 with symptom onset date of 10/17/22. This resident resided on the 500 unit. During an interview on 10/19/22 at 3:57 p.m., the Director of Nursing indicated staff who entered a Red Zone isolation room were required to have worn an N95 facemask, goggles or face shield, gloves and a gown. It was not appropriate use of personal protective equipment (PPE) to don (apply) an N95 facemask over the top of a surgical mask in a Red Zone because it impaired the seal against the face. During an observation on 10/25/22 at 11:06 a.m., Resident 29's door contained Red Zone isolation restrictions signage and indicated PPE was required. Registered Nurse (RN) 3 approached the resident's room with a surgical mask on her face. She donned a gown, gloves, an N95 mask over her surgical mask, and eye protection before she entered the resident's Red Zone isolation room and obtained vitals. During an observation on 10/25/22 at 11:10 a.m., Nurse Practitioner (NP) Student 4 approached Resident 29's Red Zone isolation room with a surgical mask on her face. She donned a gown, gloves, N95 mask over top of her surgical mask and eye protection before she entered the resident's isolation room. During an interview on 10/25/22 at 11:11 a.m., RN 3 indicated staff were required to have worn an N95, face shield or goggles, gown and gloves when they entered a Red Zone room. She usually		educated, following CDC and facility policy. The Executive Director (ED), Director of Health Services (DHS), Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same team will review the Long-Term Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. As a measure of ongoing compliance, the following audits and/or observations for 5 employees will be conducted by the ED, campus IP, or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: Proper hand hygiene and proper donning and doffing of PPE. All findings from the RCA, if different from current audit, will result in additional audits. The ED, campus IP, or designee will round the campus daily to ensure appropriate infection control practices are maintained and for any needs as determined from RCA findings for a minimum of 6 weeks and will continue thereafter until 100% compliance is	

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	removed the surgical mask before she donned the N95 mask but she had forgotten to remove the surgical mask before she placed the N95 on her face and entered the resident's isolation room. This practice would have probably affected the ability of the N95 to have a good seal. The resident was in Red Zone isolation because she was positive for COVID-19. Her last education regarding proper masking was on 10/21/22. During an interview on 10/25/22 at 11:20 a.m., the NP Student 4 indicated it was her second day and the facility had not given her any education regarding proper mask usage for infection prevention and control. She would not have typically worn an N95 over her surgical mask and entered a Red Zone isolation room but she forgot and entered the isolation room. During an interview on 10/25/22 at 5:05 p.m., the Administrator indicated the facility followed the Center for Disease Control (CDC) and Indiana Department of Health guidelines and regulations regarding infection prevention and control during a COVID-19 facility outbreak and high community transmission. During an interview on 10/25/22 at 5:09 p.m., the Administrator indicated the community COVID-19 transmission had been high from 10/7/22 through 10/25/22 except for 10/24/22 when the community transmission was substantial. A current policy, titled " Infection Prevention and Control Program," provided by the Administrator on 10/17/22 following entrance conference, indicated the following: "PURPOSE...To establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the		maintained. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	development and transmission of communicable diseases and infections....PROCEDURES 1. The campus has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that: a. Covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement b. Is based on the individual facility assessment c. Follows accepted national standards..."			