

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2021
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NAME OF PROVIDER OR SUPPLIER WALNUT CREEK ALZHEIMER'S	STREET ADDRESS, CITY, STATE, ZIP CODE 525 BENTEE WES COURT EVANSVILLE, IN 47715
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00351663.</p> <p>Complaint IN00351663 - Substantiated. State Residential Findings are cited at R029, R052, R214, R302, R326, R349, and R414.</p> <p>Survey dates: April 26, 27, 28, 2021.</p> <p>Facility number: 013642</p> <p>Residential Census: 42</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on May 6, 2021.</p>	R 0000		
R 0029 Bldg. 00	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation and interview, the facility failed to ensure residents received the care and consideration for their individual needs consistent with dignity and individual service plans for 1 of 3 residents observed for transfer. (Resident B)</p> <p>Finding includes:</p> <p>On 4/26/21 at 8:35 a.m., Resident B was observed lying on their right side on the floor, with the w/c (wheelchair) around the corner of the hallway. LPN 1 was observed to assess Resident B for injuries. CNA 5 and CNA 6 were observed to lift</p>	R 0029	<p>As all residents have the potential to be affected by the deficient practice, corrective action involved in-service to all employees on dignity and resident rights. Nursing department was in-serviced on need for assistive devices such as transfer belts to be used for the safe transfer of residents, and the policy on use of transfer belts.</p> <p>To ensure the same deficient practice does not reoccur, employees will be routinely</p>	05/21/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>Resident B under the arms to a sitting position on the floor, then lift under Resident B's arms, grasped the back waistband of his pants to lift to a standing position, then pivoted to the w/c. Resident B was then pulled backwards in the w/c to their room. CNA 5 and CNA 6 were observed to instruct Resident B to grab the bar in the bathroom. Then CNA 5 and CNA 6 were observed to grab Resident B under the arms and the back of their pants, brought to a standing position with staff bearing much of Resident B's weight. Resident B was transferred to the shower bench and given a shower. On completion of the shower, Resident B was grasped under the arms to stand, pulled up Resident B's pants and brief, and pivoted, utilizing the arm and waistband grasp, to the w/c. Resident B was then transferred from the w/c to the recliner, grasping under the arms and the back of the waistband, and pivoted to the recliner.</p> <p>The staff failed to utilize an assistive device to assist with transfer for resident requiring assistance of 2 for transfers, to lessen the potential strain on residents axilla region (armpit).</p> <p>On 4/26/21 at 11:10 a.m., the record for Resident B was reviewed. Diagnosis included, but were not limited to, dementia with behavioral disturbance, insomnia, hallucinations, Parkinson's disease, restlessness and agitation.</p> <p>The Service Plan, dated 1/28/21-4/28/21, indicated but was not limited to, long term memory- severe impairment, orientation- severe impairment, short term memory- severe impairment, fall potential-high, transferring- total-resident requires routine hands on assistance with transfers and/or changes in position. Bathing-total-resident is</p>		<p>audited for compliance with use of Direct Care Audit tool. Corrective action will be monitored through an audit monthly x 3 months, then quarterly for compliance. The results of these audits will be discussed by the CQI (Continuous Quality Improvement) committee. These systematic changes will be completed by 5/21/21.</p>	

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R 0052 Bldg. 00	<p>dependent on others to provide bath, including shampoo. Dressing- total- resident is dependent on others to do all dressing/undressing. Incontinent of bladder...Incontinent of bowel.</p> <p>On 4/28/21 at 12:44 p.m., CNA 5 indicated when transferring with 2 assist, each gets under one arm, grabs the back of the pant/waistband, and lifts the resident.</p> <p>On 4/28/21 at 12:02 p.m., the Administrator indicated the facility did not have a policy related to the physical transfer from one surface to another.</p> <p>This Residential tag relates to Complaint IN00351663.</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent elopement from a secure dementia unit for 1 of 1 residents reviewed for elopement and failed to prevent physical and verbal abuse for 2 of 4 residents reviewed for abuse. (Resident D, Resident J, Resident K)</p> <p>Findings Include:</p> <p>1. On 4/26/21 at 10:00 a.m., the facility reported incident forms were provided by the Administrator for review. An incident form, dated 4/19/21,</p>	R 0052	As both identified resident and all residents could be affected by deficient practice, corrective action included in-service to all staff beginning 4/19/21 of Elopement Policy and Procedure along with the following: "Every time that you open an exit door or exit gate, when you close it you must stay and hold door long enough that it clicks, and then check it by pushing on it to ensure that it is secured. If a door does not secure, or you observe that a	05/21/2021

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	<p>indicated that "...At 4 p.m. staff was getting residents into the dining room for supper, and resident [Resident D] was not in his room. Building search initiated. Following building search, at 4:10 p.m. Administrator instructed Nursing Director to call 911. staff continued to search outdoor areas, parking lot, adjacent parking lots. 911 instructed nursing director that police had picked up man with that description and were currently in route to take him to [name of hospital]..."</p> <p>On 4/26/21 at 2:22 p.m., the clinical record of Resident D was reviewed and diagnoses included, but were not limited to: Alzheimer's disease and dementia with behavioral disturbance. An admission service plan, dated 4/12/21, stated Resident D "...Does not have a current or history of wandering...frequent poor judgement issues...may resist care often, needs protection and supervision because participant makes unsafe and inappropriate decisions..."</p> <p>A nurse's note, dated 4/19/21 at 6:13 p.m., indicated that "...At 4 p.m. resident [Resident D] had not presented to dining room for evening meal. Staff went to res [resident] room but res was not in room, building search initiated with room to room check. Staff were unable to locate res within 10 minutes. Call placed to 911. Dispatcher stated that res was currently at [name of hospital] ER. Call placed to POA [power of attorney] who was informed of res elopement and currently at [name of hospital] ER. POA called facility from ER asking if res was allowed to return. POA assured that res could return. Received call from SW [social worker] at [name of hospital] who asked if res was to return and that per physician recommendation would return</p>		<p>door is not alarming or functioning properly, you must contact the administrator immediately and that someone must remain at the door to supervise until it is repaired." Corrective action also included having the doors and gates inspected by outside vendor for proper functioning.</p> <p>Corrective action regarding abuse involved a full investigation at the time of the incident which resulted in the termination of the employee on 2/25/21. All employees were in-serviced immediately beginning 2/23/21 on Residents rights and Resident Abuse and Neglect Policy.</p> <p>To ensure the same deficient practice does not reoccur, employees will be required to attend in-services on Resident Rights and resident abuse and reporting policies, in addition to Elopement Policy and Procedures upon hire and quarterly. The Maintenance Director will continue to conduct monthly checks of gates/call lights/exit doors/motion sensors per facility policy.</p> <p>The corrective action will be monitored by reviewing in-service records and monthly alarm checks monthly at CQI meeting. These systematic changes were completed 5/11/21.</p>	

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	<p>via ambulance instead of with POA..."</p> <p>On 4/26/21 at 2:41 p.m., Resident D was observed attempting to exit at the front of the unit. The unit entrance was locked and an alarm sounded as Resident D attempted to open the door. Staff responded and redirected the resident.</p> <p>On 4/26/21 at 3:45 p.m., the timeline for the investigation was provided by the Administrator. The timeline indicated that on 4/19/21 at 4:45 p.m., the " ...Officer returned call to facility that picked up resident. Stated that the resident had been trying to get a ride to the Marathon gas station. The man he asked for a ride realized that the resident was disoriented and called 911 and stayed with the resident until police arrived. Police arrived to resident at 3:36 p.m. and transported to [name of hospital] ..."</p> <p>During an interview on 4/26/21 at 3:11 p.m., the Administrator indicated that Resident D exited through the east side doors that opened into a gated area. On 4/19/21 staff had assisted Resident D's family out of the east side door after a visit around lunch time and the Administrator believed that the gate did not latch properly at that time. Resident D was observed to be in his room at around 2:00 p.m. when he had been asked to come down for a movie and declined. Staff could not find him when getting ready to take him to dinner at around 4:00 p.m., they searched all resident rooms, outside around the facility, and then called 911. When 911 was called, they discovered that the police had picked him up and taken him to the local emergency room. The east side door was not latched all the way when they checked it and was not alarming. The gate that is outside of the side door was unlatched as well.</p>			

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	<p>After the incident, the maintenance man checked the door and did file it down a bit. It had magnets and they have to be lined up just right in order for it to latch securely and it is in working order.</p> <p>During an interview on 4/27/21 at 11:26 a.m., HHA (home health aide) 1 indicated that she was on the back hall assisting with dinner at the time that Resident D eloped from the facility. HHA 1 indicated that staff could not locate Resident D in the facility and searched about 10 minutes. HHA 1 suggested that they check the east side door, as the east side door and gate had weak sensors. HHA 1 indicated that 911 was called and the resident was located. HHA indicated that on a windy day the alarm would go off constantly for the gate but has been corrected since. A lawn care company had been at the facility the day before Resident D eloped and could have possibly left the gate unlatched. HHA 1 indicated the east exit door was touchy and sometimes if you pushed on it, it would alarm and sometimes it would not alarm. HHA 1 stated that the door and gate have been repaired.</p> <p>During an interview on 4/27/21 at 2:19 p.m., QMA (qualified medication aide) 1 indicated that on 4/19/21, Resident D had been given his medications at 12:21 p.m. in his room, and had refused to go to the dining for room lunch. After lunch, Resident D came to the front nurse's station and was talking to QMA 1 and the receptionist. QMA 1 and the receptionist went to lunch about 1:10 p.m. and Resident D walked towards his room. At dinner time, QMA 1 went down to get Resident D from his room. Resident D was not in his room, so QMA 1 and a CNA completed room to room checks. They could not locate the resident. QMA 1 went to the side door and when</p>			

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	<p>she got to the door it was not latched and the outside gate was open. The door and gate were not sounding an alarm. A staff member called 911 at that time. QMA 1 indicated that staff have had inservices on the door and gate locks. QMA 1 stated that, at the time of the elopement, the side door did not have a handle on it, so there was no way to pull it closed tightly if the magnets did not engage. The wind would allow the door to fail to latch completely before the handle was installed, the handle allowed it to be pulled tightly.</p> <p>On 4/27/21 at 2:27 p.m., the east side door was observed with QMA 1. A handle was observed on the side door that allowed it to be pulled tight. QMA 1 pushed on the door and the alarm sounded. The side yard and exit gate were observed at that time. The gate was locked and a key pad alarm was in place to both the door and gate. The side door made an audible sound when it closed. The exterior gate lead into the corner of the front parking lot of the facility. QMA 1 indicated that staff must listen for the audible sound the door made to ensure the door is completely closed. QMA 1 indicated that staff have all been trained on the exit doors and gate.</p> <p>During an interview on 4/27/21 at 2:35 p.m., HHA (home health aide) 2 indicated that on 4/19/21, Resident D was observed in the front TV room at about 1 or 2 p.m. HHA 2 was not caring for Resident D at that time. HHA 2 indicated she heard over the walkie talkie that Resident D could not be located. The side door was not alarming at that time and the side gate was not latched. HHA 2 identified the east side door that Resident D had exited through.</p> <p>During an interview on 4/28/21 at 10:55 a.m., the</p>			

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	<p>receptionist indicated that she had taken a family member out the back entrance of the facility after a visit with Resident D on the morning of 4/19/21. The receptionist indicated that staff were worried that Resident D would try to follow his visitor out the door, so she escorted the visitor out the back door of the facility. After exiting the back door, the family member was walked around the facility in the enclosed yard area and taken out the gate that is outside of the east side door. The receptionist stated that the gate was secured and closed after the family member exited through it. The receptionist entered back into the facility through the east side door and the door was closed and secure at that time.</p> <p>A policy, dated October, 2014, and titled "Elopement Prevention" was provided by the Administrator on 4/26/21 at 3:36 p.m. The policy stated "...Environmental safeguards to prevent elopement include: keyed entry and egress...alarmed exterior windows..." The policy also indicated that a "...preventative maintenance program will be in place to ensure proper functioning of system...elopement drills will be held monthly..."</p> <p>An undated policy, titled "Door/Gate Lock and Alarms Policy" was provided and indicated that "...Electronic equipment including alarms or magnetic locks may be installed on specific doors in the community to alert staff when a door is opened by a resident... door locks and alarms should be tested weekly..."</p> <p>A policy, dated October 2014, and titled "Elopement-Missing Resident" was provided and stated that "...All reasonable efforts will be made to monitor a Resident's whereabouts. Diligent</p>			

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	<p>effort will be made to locate a Resident who elopes from the premises..."</p> <p>2. On 4/26/21 at 11:20 a.m., Resident J was observed wandering in the assisted dining room. He was non responsive to simple questions or gestures, and nonverbal.</p> <p>On 4/26/21 at 10:00, the Administrator provided facility reported incidents for review.</p> <p>On 4/26/21 at 2:10 p.m., the record for Resident J was reviewed. Diagnosis included, but were not limited to: Alzheimer's disease and diverticulosis.</p> <p>The service plan dated 2/5/21 indicated minimal wandering issues, independent with ambulation, moderate fall risk, extensive assist with bathing, and incontinent of bladder.</p> <p>On 4/27/21 at 2:08 p.m., the Administrator provided the investigation of the reported incident dated 2/23/21. The investigation indicated, but was not limited to, ...received a cell phone call from Agency CNA 1 with concerns that happened last week when working...she stated that the night she and CNA 2 worked alone (upon investigation was 2/18/21) she had real issues with how she treated and talked to the residents. ...When they went to get Resident J ready for bed she just walked up to him and pulled his shirt off him from behind and that Resident J grabbed her arm and ended up bruising her, she said she yelled at him but didn't recall if she cursed at him... since she hadn't worked with us before she wasn't sure who to talk to and that she was going to say something when she came in the next shift but that management wasn't there...she was telling staff about it and they were the ones that had her to call me (Administrator)...Administrator spoke with night</p>			

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	<p>shift CNA 3...heard CNA 2 be rude and tell people to sit down and not in a nice tone...CNA 2 is rough with people - she rolls them over like "whoosh" and never gives her showers..he has to do all the showers when he works with her because she doesn't do them...</p> <p>On 4/27/21 at 2:48 p.m., the employee record for CNA 2 was reviewed. The record contained Corrective Counseling form, dated 2/25/21, position title QMA, department - resident care services, Termination. An allegation of verbal abuse and rough care towards residents was reported to the administrator on 2/23/21. The employee was place on suspension pending investigation into the matter immediately. Associate denied any accusations, but upon conclusion of the investigation, it was found that CNA 2 frequently sleeps on the job exhibits poor approach with dementia residents including not pre-explaining care and providing rushed care. These actions violate our standards of conduct and violates the Resident's Rights to dignified care. ...signed per the supervisor on DNS on 2/28/21.</p> <p>3. On 4/26/21 at 10:00 a.m., the Administrator provided facility reported incidents for review.</p> <p>On 4/27/21 at 10:30 a.m., the Record for Resident K was reviewed. Diagnoses included, but were not limited to: dementia with behaviors, anxiety, and insomnia.</p> <p>The service plan indicated, but was not limited to: extensive wandering issues, total dependent on staff member (s) for all mobility/ambulation needs or requires hands on assistance on routine basis, moderate fall potential, total dependence for</p>			

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	<p>bathing, incontinence of bladder and bowel with total dependence for toileting.</p> <p>On 4/27/21 at 2:08 p.m., the Administrator provided the investigation of the reported incident dated 2/23/21. The investigation indicated, but was not limited to, ...received a cell phone call from Agency CNA 1 with concerns that happened last week when working...she stated that the night she and CNA 2 worked alone (upon investigation was 2/18/21) she had real issues with how she treated and talked to the residents. ...when taking care of Resident K, that when CNA 2 was rolling her over and said "shut up" when she started yelling out for her daddy like she does. Said that she ripped the brief off her and was very quick and abrupt with care... since she hadn't worked with us before she wasn't sure who to talk to and that she was going to say something when she came in the next shift but that management wasn't there...she was telling staff about it and they were the ones that had her to call me (Administrator)...Administrator and HSD (Health Services Director) spoke with CNA 4...CNA 2 sometimes has an attitude with resident's...she's short, like telling a resident "just go lay down again, I just put you to bed" or "oh my god, why are you up again"...Administrator spoke with night shift CNA 3...heard CNA 2 be rude and tell people to sit down and not in a nice tone...CNA 2 is rough with people - she rolls them over like "whoosh" and never gives her showers..he has to do all the showers when he works with her because she doesn't do them...</p> <p>On 4/27/21 at 2:48 p.m., the employee record for CNA 2 was reviewed. The record contained Corrective Counseling form, dated 2/25/21, position title QMA, department - resident care</p>			

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	<p>services, Termination. An allegation of verbal abuse and rough care towards residents was reported to the administrator on 2/23/21. The employee was place on suspension pending investigation into the matter immediately. Associate denied any accusations, but upon conclusion of the investigation, it was found that CNA 2 frequently sleeps on the job exhibits poor approach with dementia residents including not pre-explaining care and providing rushed care. These actions violate our standards of conduct and violates the Resident's Rights to dignified care. ...signed per the supervisor on DNS on 2/28/21.</p> <p>On 4/27/21 at 3:20 p.m., the Administrator provided the current facility policy, Abuse and Neglect, issued April 12, 2018. The Policy included, but was not limited to, "all staff members and residents will be educated about abuse and neglect in the assisted living setting, including definitions, prevention and reporting. ...failure to follow the policy and procedures as set forth will be considered a serious violation of one's employee responsibilities and will result in disciplinary action up to and including discharge...neglect is a pattern of conduct or inaction by a person or entity with a duty to care for or provide goods and services that maintain physical or mental health of a vulnerable adult, or that avoids or prevents physical or mental harm. It also includes an act or omission that demonstrates a serious disregard of consequences of to a degree that presents a clear and present danger to the vulnerable adult's health, welfare, or safety."</p> <p>This Residential tag relates to Complaint IN00351663.</p>			

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R 0214 Bldg. 00	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency</p> <p>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to evaluate the resident after multiple falls and injuries for 1 of 2 residents who had a decline in ambulation and transferring. The service plan had not been revised or new interventions implemented after a resident who had been able to ambulate and transfer independently now required 1-2 persons for transferring and was unable to ambulate. (Resident E)</p> <p>Findings include:</p> <p>On 4/26/21 at 8:45 a.m., Resident E was observed to be sleeping in a recliner in the back day room with her feet elevated. Her bilateral feet were edematous.</p> <p>On 4/26/21 at 11:37 a.m., Resident E was observed to be staring out of the window in the dining room during the lunch meal. Upon passing the resident, staff would remind the resident to eat, and the staff would feed the resident a bite of food. Eventually, the resident was fed by the staff. LPN 1 indicated the resident was fed her meals by the staff.</p> <p>On 4/27/21 at 8:50 a.m., Resident E was observed to be sitting in a wheelchair in the back dining room. Staff was observed to be feeding the</p>	R 0214	<p>As all residents had the potential to be affected, Corrective action included reviewing and updating the service plans (if necessary) of all residents occurring for active residents.</p> <p>To ensure that the same deficient practice does not reoccur, the service plans will be audited for compliance using resident health record audit tool.</p> <p>Corrective action will be monitored through audit monthly x 3 months, and then quarterly for compliance. The results of these audits will be discussed by the CQI (Continuous Quality Improvement) committee. These systematic changes were completed 5/21/21.</p>	05/21/2021

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	<p>resident. After eating, Resident E was transported into the back day room and transferred with assist of 1 person to a recliner.</p> <p>On 4/28/21 at 5:05 a.m. Agency CNA 3 and CNA 7 were observed to perform pericare (washing of the genitals and anal areas) on Resident E. The resident had been incontinent of urine. Agency CNA 3 indicated the night shift staff would check the residents every 2 hours and perform pericare when she was incontinent.</p> <p>The clinical record for Resident E was reviewed on 4/26/21 at 10:54 a.m. Diagnosis included, but was not limited to, dementia with behaviors.</p> <p>A "Service Plan Detail," dated 2/1/21-5/1/21, included, but was not limited to, the following: Long term memory: severe impairment. Orientation: severe impairment. Short term memory: severe impairment. Fall potential: high. Ambulation: independent. Transferring: independent-resident does not require assistance with transferring. Bathing: extensive - resident requires hands on assistance with participation by the resident to complete task. Grooming/Personal Hygiene: total - resident is dependent on others to provide all grooming/personal hygiene needs. Dressing: total - resident is dependent on others to do all dressing/undressing. Meal Consumption: total - resident must be fed by mouth by another person... Resident is on a regular diet. Incontinent of bladder...Incontinent of bowel.</p> <p>During an interview on 4/26/21 at 9:28 a.m.,</p>			

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R 0273 Bldg. 00	<p>Confidential Interview 1 indicated Resident E had declined in the past month. The resident used to be able to ambulate with assist of 1 but now requires 2 persons for transfers and ambulation. States resident's had a bruise around her mouth recently and her bilateral lower extremities have been edematous.</p> <p>During an interview on 4/26/21 at 10:30 a.m., LPN 1 indicated Resident E had been declining. The resident used to ambulate around the facility everyday with assist of 1 person, but now she was unable to ambulate or feed herself. The resident had a few weeks ago a bruise around her mouth and the staff did not know what caused it. Also, the resident's bilateral lower extremities had been swelling for the past couple of weeks. The facility had obtained a x-ray which was negative.</p> <p>The facility lacked documentation the service plan had been updated since the resident declined.</p> <p>The current facility policy, "Resident Service Plans." dated 4/12/18, provided by the Administrator on 4/28/21 at 8:45 a.m., included, but was not limited to, "As the Resident's condition changes, resulting in a change in care needs, the service plan should be updated to reflect those changes."</p> <p>This Residential tag relates to Complaint IN00351663.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p>			

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	<p>Based on observation, interview, and record review, the facility failed to maintain safe food storage and handling standards for 1 of 1 kitchen observations. An open food item was not dated and hand hygiene was not performed correctly during meal preparation and serving. (Cook 2, Food Services Manager)</p> <p>Findings Include:</p> <p>1. On 4/26/21 at 8:20 a.m., the facility kitchen was observed. The walk in refrigerator was observed with a bowl of prepared mashed potatoes on the shelf. The mashed potatoes were covered with clear plastic wrap and lacked a date indicating when they had been prepared.</p> <p>At that time, the Food Services Manager indicated that the mashed potatoes should have a date on the plastic wrap indicating when they had been prepared. The Food Services Manager then wrote a date on the plastic wrap and placed the mashed potatoes back into the refrigerator.</p> <p>2. On 4/26/21 at 10:28 a.m., the puree food process was observed in the kitchen. Cook 2 was observed preparing pureed meat. Cook 2 obtained a pan from the oven with an oven mitt, removed the foil cover from the pan with her bare hand, and scooped out gravy into a metal container with a spoon. Cook 2 then replaced the foil with her bare hand, placed the pan back into the oven with the oven mitt, closed the oven door with her bare hand, and carried the metal container with gravy with her bare hands to the area where she was preparing the meat. Cook 2 then completed handwashing at the sink for 6 seconds under the running water. Cook 2 then poured the gravy into the puree meat mixture and started the food</p>	R 0273	<p>As all residents have potential to be affected by the deficient practice, corrective action included in-service all staff on hand hygiene and infection control with meal service and in-service with dietary employees specific to dietary policy including dating food, covering foods, safe food storage, and infection control standards in food service areas. To ensure that the same deficient practice does not reoccur, the dietary department will be audited through use of Dietary Audit as well as scheduled site visits by Dietician.</p> <p>The corrective actions will be monitored through an audit monthly x 3 months, then quarterly for compliance. The results of these audits will be discussed by the CQI committee. These systematic changes were completed by 5/21/21.</p>	05/21/2021

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R 0302 Bldg. 00	<p>between tasks and after touching anything that is considered dirty.</p> <p>A policy, dated April 12, 2018, and titled "Hand Hygiene" was provided by the Administrator on 4/28/21 at 8:45 a.m. The policy indicated that handwashing is "...the single most effective barrier to microbial transfer..." and that handwashing technique is "...dependent upon exposure but at least 20 seconds..."</p> <p>A policy, dated August 11, 2017, and titled "AR Dietary Services" was provided. The policy indicated that "...The facility will comply with all applicable regulations relating to food service for food purchasing, storage, preparation, sanitation, safety and health as set forth by state, county, and local health departments..."</p> <p>410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.</p> <p>Based on observation, interview, and record review, the facility failed to ensure OTC (over-the-counter) medications were labeled for 1 of 2 observations of the medication carts. The medications were not labeled with the residents or physician's name on them and discontinued medications remained in the medication cart. (Resident M, Resident N, Resident B, Resident C, Resident O, Resident P, Resident E, Resident A, Resident U, Resident Q, Resident R, Resident S, Resident T)</p>	R 0302	As all residents have the potential to be affected by the deficient practice, corrective action included applying labels to all current OTC medications on site to include resident name, physician name, expiration date, name of drug, and strength. In addition, all nurses were in-serviced on the requirement for any OTC medication to be labeled with necessary information. To ensure that the same deficient	05/21/2021

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	<p>Findings include:</p> <p>During an observation of the back hall medication cart on 4/27/21 from 2:11 p.m. through 2:45 p.m., the following was observed:</p> <p>1. Resident M had an open bottle of One-A-Day vitamins. The lid had "A.M." and "P.M." written on it with a marker, no resident's name or physician's name was on the product. QMA 1 indicated the medication belong to Resident M.</p> <p>The clinical record for Resident M was reviewed on 4/28/21 at 8:15 a.m. A physician's order, start date 3/29/21, indicated the resident was to take 1 tablet by mouth bid (twice a day.)</p> <p>2. Resident N had an open bottle of Calcium 600 mg (milligrams) + Vitamin D3 10 mcg (micrograms) with the resident's last name written on the bottle, an open bottle of stool softener with stimulant laxative 8.6-50 mg tablets with "AM" and "PM" written on bottle, and an open container of Aspirin 81 mg (milligrams) no resident's or physician's names on product. QMA 1 indicated the Aspirin belonged to Resident N.</p> <p>The clinical record for Resident N was reviewed on 4/28/21 at 8:25 a.m. Resident N had a physician's order for Calcium+D Petite 1 tablet by mouth three times a day, start date 6/30/20, Senna-S (a stool softener/stimulant laxative) 8.6/50 mg 1 tablet by mouth one time a day in the morning and 2 tablets at bedtime, start date 6/30/20, and Aspirin EC 81 mg 1 tablet by mouth one time a day, start date 6/30/20.</p> <p>3. Resident B had an opened bottle of Aspirin 81</p>		<p>practice does not reoccur, the OTC medications will be audited through the use of the medication management audit.</p> <p>The corrective actions will be monitored through an audit monthly x3 months, then quarterly for compliance. The results of these audits will be discussed by the CQI committee. These systematic changes were completed by 5/21/21.</p>	

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	<p>mg with only the resident's name written on the bottle.</p> <p>The clinical record for Resident B was reviewed on 4/28/21 at 8:33 a.m. Resident B had a physician's order for Aspirin 81 mg 1 tablet by mouth one time a day for prophylaxis, start date 6/30/20.</p> <p>4. Resident C had an opened bottle of Acetaminophen 500 mg with only the resident's name written on the bottle.</p> <p>The clinical record for Resident C was reviewed on 4/28/21 at 8:40 a.m. Resident C had a physician's order for Acetaminophen 325 mg 2 tablets every 4 hours prn (as needed) for pain or elevated temperature, start date 4/6/21 and did not have an order for Acetaminophen 500 mg.</p> <p>5. Resident O had an opened bottle of Acetaminophen 500 mg with no resident or physician's name on the bottle. QMA 1 indicated the medication belonged to Resident O.</p> <p>The clinical record for Resident O was reviewed on 4/28/21 at 8:46 a.m. Resident O had a physician's order for Acetaminophen 500 mg (milligrams) 2 caplets by mouth one time a day in the evening for pain, start date 9/15/20.</p> <p>6. Resident P had an opened bottle of Bayer Aspirin 325 mg with no resident or physician's name, with the open date of 7/17/20, and an opened bottle of Aspirin 81 mg with only the resident's name and open date of 7/2020. QMA 1 indicated the Bayer Aspirin belonged to Resident P.</p>			

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	<p>The clinical record for Resident P was reviewed on 4/28/21 at 8:52 a.m.. Resident P had a physician's order start date 6/18/20, for Aspirin 81 mg which was discontinued on 7/28/20. The resident had never had an order for Bayer Aspirin 325 mg.</p> <p>7. Resident E had an opened bottle of Lutein (a vitamin) 6 mg with the resident's name and opened date of 12/15/20 on the bottle and a bottle of Vitamin D3 2000 IU (international units) with the resident's name and open date of 12/15/20 on the bottle.</p> <p>The clinical record for Resident E was reviewed on 4/28/21 at 9:00 a.m. Resident E had a physician's order for Lutein 6 mg 1 tablet by mouth one time a day, start date 6/30/20, and Vitamin D3 every tablet by mouth one time a day, start date 6/30/20.</p> <p>8. Resident A had an opened bottle of Multivitamins with only the resident's name on it and an open date of 12/20.</p> <p>The clinical record for Resident A was reviewed on 4/28/21 at 9:06 a.m. Resident A had a physician's order, start date 6/30/20, for Certavite tablet 1 by mouth one time a day.</p> <p>9. On 4/27/21 at 2:47 p.m., QMA 1 indicated she was unaware that over-the-counter medication required the resident's name, physician's name, name of the medication, strength of the medications, or expiration date on the medication.</p> <p>During an observation of the front hall medication cart on 4/27/21 from 2:48 p.m. through 3:15 p.m., the following was observed:</p>			

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	<p>10. Resident U had an opened bottle of Sodium Chloride Ophthalmic (used to decrease swelling of the cornea) 5% drops with only the resident's name written on the box, an opened bottle of Tylenol 500 mg with "tabs (tablets) 2 bid (twice a day)" written on the bottle, and an opened bottle of Bayer Aspirin 325 mg (milligrams) with only the resident's first name written on it. LPN 2 indicated the resident had been out of the facility for the past "couple of weeks" and was receiving care in a rehabilitation center. LPN 2 indicated the resident would probably be returning to the facility but was unsure of how soon it would be. She indicated she thought the facility was holding the resident's bed.</p> <p>The clinical record for Resident U was reviewed on 4/28/21 at 9:25 a.m. Resident U did not have a physician's order for Sodium Chloride Ophthalmic drops, but had an order for Artificial Tears Ophthalmic 1.4% 1 drop in each eye four times a day as needed for dry eyes, start date 11/5/20, Bayer Aspirin 325 mg 1 tablet by mouth daily, start date 10/6/20, and Acetaminophen 500 mg 2 caplets every 8 hours for pain, start date 10/5/20.</p> <p>The manufacturer's recommendation indicated Artificial Tears should be discarded 3 months after opening.</p> <p>11. Resident Q had an opened bottle of Vitamin D3 1000 IU (international units) with only the resident's name on the bottle and an opened bottle of Calcium 600 mg (milligrams) with no resident or physician's name on the bottle. LPN 2 indicated the Calcium belonged to Resident Q.</p> <p>The clinical record for Resident Q was reviewed</p>			

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	<p>on 4/28/21 at 9:34 a.m. Resident Q had a physician's order for Calcium 600 mg take once daily, start date 4/9/21, and Vitamin D3 2000 IU by mouth daily, start date 4/9/21</p> <p>12. Resident R had an opened bottle of Acetaminophen 650 mg tabs 2 written on the bottle as well as the resident's first name and last initial, an opened bottle of Vitamin B-Complex (a supplement) with the resident's name and open date wrote on the bottle, an opened bottle of Vitamin C 500 mg with no resident or physician's name on the bottle, I-caps (a supplement) with the resident's first name and an open date of 3/30/21, and an opened bottle of Vitamin D3 2000 IU (international units) with the resident's name and open date of 10/11/20 on the bottle. LPN 2 indicated the Vitamin C belonged to Resident R.</p> <p>The clinical record for Resident R was reviewed on 4/28/21 at 9:39 a.m. Resident R had a physician's order for Acetaminophen ER 650 mg 2 caplets by mouth three times a day, start date 3/22/21, Vitamin B-100 Complex 1 capsule by mouth one time a day, Vitamin C 500 mg 1 tablet by mouth one time a day, start date 7/2/20, Vitamin D3 1000 IU 1 tablet by mouth one time a day, start date 7/2/20, I-caps Lutein-Omega-3 - 1 capsule by mouth one time a day, start date 2/18/20,</p> <p>13. Resident S had an opened bottle of Magnesium (a supplement) 500 mg (milligram) with the resident's last name on the bottle and an open bottles of Vitamin D3 1000 IU and Vitamin B12 1000 mcg with no resident or physician's names on either bottles. LPN 2 indicated the Vitamin D3 and Vitamin B12 belonged to Resident S.</p>			

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	<p>The clinical record for Resident S was reviewed on 4/28/21 at 9:47 a.m. Resident S had a physician's order for Magnesium 400 mg by mouth daily, start date 4/7/21, Vitamin D 25 mcg by mouth daily, start date 4/7/21, and Vitamin B12 1000 mcg by mouth daily, start date 4/7/21</p> <p>14. Resident T had an opened container of Acetaminophen 500 mg with only his name on the bottle and an opened bottle of "Men's Vitafusion Multivitamin" with the resident's first name and "AM." written on the bottle.</p> <p>The clinical record for Resident T was reviewed on 4/28/21 at 9:59 a.m. Resident T had a physician's order for Acetaminophen 500 mg 2 caplets by mouth 2 times a day, start date 6/30/20, and Tab-a-Vite 1 tablet by mouth daily, start date 6/30/20</p> <p>On 4/27/21 at 3:17 p.m., LPN 2 indicated the facility pharmacist had just been to the facility last week to check the resident's medications and did not indicate the resident's over-the-counter medications needed to be labeled. LPN 2 thought the over-the-counter medications should be labeled but was unaware of how the medications were to be labeled.</p> <p>On 4/27/21 at 4:10 p.m., the Administrator indicated the facility had never labeled the resident's over-the-counter medications. The facility's new consultant had brought it to their attention just recently. She did not think the facility had a policy on over-the-counter medications.</p> <p>On 4/28/21 at 10:20 a.m., LPN 1 indicated</p>			

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R 0326 Bldg. 00	<p>Resident P did not have an order for Bayer Aspirin 325 mg and the Aspirin 81 mg had been discontinued and should have been removed from the medication cart. The Acetaminophen for Resident C was for 325 mg and not 500 mg and she would be informing the family to bring in the correct dose.</p> <p>On 4/28/21 at 10:45 a.m., LPN 4 indicated the Sodium Chloride Ophthalmic drops were never ordered for Resident U and should have been discarded. Medications for residents are kept by the facility if the resident has a bed hold with the facility.</p> <p>The current facility policy, "Medication, Non-Contract," dated 4/12/18, provided by the Administrator on 4/28/21 at 9:10 a.m., included, but was not limited to, "Each container of medication that is centrally stored by the Community will carry the following information:"The contents of each container must be labeled in accordance with established policies... Medications not ordered by the resident's primary care provider, or unacceptable for other reasons, are returned to the responsible party. In the event, said medication order is discontinued or the resident expires, the remaining supply of these medications are not returned to the family or responsible party, but are disposed of using the medication disposal procedure used by the facility.</p> <p>This Residential tag relates to Complaint IN00351663.</p> <p>410 IAC 16.2-5-7.1(a) Activities Programs - Deficiency (a) The facility shall provide activities programs appropriate to the abilities and</p>			

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	<p>interests of the residents being served.</p> <p>Based on record review, observation, and interview, the facility failed to provide activities programs for 3 of 3 days of the survey appropriate to the interests of the residents for 3 of 3 days of observations. Activities were not provided to residents in the back day room. (Resident D, Resident E, Resident J, Resident L, Resident M, Resident O, Resident V, Resident W, Resident X, Resident Y, Resident Z)</p> <p>Findings include:</p> <p>1. On 4/26/21 at 8:36 a.m., Resident E was observed sleeping in a recliner in the back day room. A program was playing on the television. No staff was present in the back day room.</p> <p>2. On 4/26/21 at 10:33 a.m., Resident E and Resident L were observed in the back day room. Resident E was sleeping in a recliner. Resident L was sitting in a chair with her rollator next to her. The television was on. The Activity Assistant was observed to enter the back day room and change the program on the television and leave the room. Resident J, Resident M, Resident O, Resident V, Resident X, Resident Y, and Resident Z were also observed in the back day room. Resident V was sleeping in her broda chair, Resident P, Resident X, Resident Y, and Resident Z were sitting in chairs looking around or dozing. Resident D was observed walking in the back day room and hall aimlessly.</p> <p>3. On 4/26/21 at 2:10 p.m., Resident E, Resident L, Resident V, and Resident X were also observed sitting in the back day room. The residents were either sleeping or looking aimlessly</p>	R 0326	<p>As all residents have the potential to be affected by the deficient practice, corrective action included in-service to all staff on need for programming and activities in supportive living. Staff in-serviced on location of supportive activity calendar and on activities that can be provided as well as where the supplies are located.</p> <p>To ensure that the same deficient practice does not reoccur, the activities will be audited for compliance.</p> <p>The corrective actions will be monitored through an audit monthly x 3 months, then quarterly for compliance. The results of these audits will be discussed by the CQI committee. These systematic changes were completed by 5/21/21.</p>	05/21/2021			

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	<p>around the room. The television was on and no staff was present in the day room.</p> <p>The Activity Calendar was posted in the hall outside of the back day room. Activities for 4/26/21, were as followed:</p> <p>9:00 a.m.: Inspirations 9:30 a.m.: Chair Yoga 10:00 a.m.: Coffee and Chronicles 10:30 a.m.: Balloon Bop 1:00 p.m.: Letters of support 2:00 p.m.: Movie Matinee 5:30 p.m.: Loving Hand Crocheting 6:30 p.m.: Evening Cafe</p> <p>4. On 4/27/21 at 9:45 a.m., the Dietary Manager indicated she provided exercises in the dining room every morning for the residents to help the staff with activities.</p> <p>5. On 4/27/21 at 10:00 a.m., Resident E, Resident L, Resident J, Resident O, and Resident W were observed sitting in the back day room. Resident E and Resident L were observed sleeping in chairs, Resident O was observed removing her shoes. Resident J was observed to be walking and sitting in the back hall as well as walking in the back day room with no shoes on. Resident X was sitting in a wheelchair outside the entrance door to the back day room. No staff was in the room with the residents.</p> <p>6. On 4/27/21 at 11:23 a.m., the Activity Assistant entered the back day room and changed the television program. QMA 1 indicated the staff would try to provide activities for the residents but were often short of staff and today the CNAs were still getting residents out of bed and it was</p>			

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	<p>almost lunch time.</p> <p>7. On 4/27/21 at 1:10 p.m., Resident E, Resident L, Resident M, Resident O, Resident P, and Resident X were observed sitting in the back day room. All of the residents were sleeping. The television was playing with the same program as was playing at 11:23 a.m. No staff was observed in the room with the residents. The Activity Assistant was observed providing manicures to residents in the main dining room.</p> <p>8. On 4/27/21 at 2:10 p.m., Resident E, Resident L, Resident M, Resident O, Resident X, and Resident Y were observed sleeping in the back day room. Resident W was observed sitting in a broda chair with his legs hanging off the sides of the chair. Resident D was observed walking in the back day room and attempting to move a sofa which was next to the back window area. The television was playing.</p> <p>The Activity Calendar was posted in the hall outside of the back day room. Activities for 4/27/21, were as followed:</p> <p>9:00 a.m.: Inspirations 9:30 a.m.: Fitness Tunes 10:00 a.m.: Coffee and Chronicles 1:00 p.m.: Manicures 2:00 p.m.: What's Cooking in the Kitchen 3:00 p.m.: Bingo 5:30 p.m.: Adult Coloring 6:30 p.m.: Evening Cafe</p> <p>9. On 4/28/21 at 9:00 a.m., the Activity Assistant (Act Asst) was observed to place a video into the television in the front day room for devotions.</p>			

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	<p>10. On 4/28/21 at 10:08 a.m., the Activity Assistant was observed to enter the back day room, turn the television to a different program, and place sensory mats across Resident O, Resident E, Resident X, Resident W, Resident N, and Resident V before exiting the room. The residents were sleeping and the Activity Assistant did not attempt to wake the residents or assist them with the sensory mats.</p> <p>11. On 4/28/21 at 10:35 a.m., Resident E, Resident L, Resident V, Resident O, and Resident W were observed sleeping in the back day room. The television was on but no staff was observed in the back day room.</p> <p>12. On 4/28/21 at 1:15 p.m., Resident E, Resident L, Resident W, Resident O, and Resident V were observed sleeping in the back day room. The television was on and no staff was in the room.</p> <p>The Activity Calendar was posted in the hall outside of the back day room. Activities for 4/28/21, were as followed: 9:00 a.m.: Inspirations 9:30 a.m.: Chair Yoga 10:00 a.m.: Coffee and Chronicles 10:30 a.m.: Beauty Parlor 1:00 p.m.: Choir 3:00 p.m.: Getting to Know You 6:30 p.m.: Evening Cafe</p> <p>13. The clinical record for Resident E was reviewed on 4/26/21 at 10:54 a.m. Diagnosis included, but was not limited to, dementia with behaviors.</p> <p>A "Service Plan Detail," dated 2/1/21-5/1/21, included, but was not limited to, the following:</p>			

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	<p>Resident will maintain and/or maximize current level of functioning with activities. Level of Assistance - Activities: Extensive. Resident requires daily reminders and physical assistance for activities. The Service Plan lacked documentation of the resident's interests.</p> <p>14. The clinical record for Resident L was reviewed on 4/28/21 at 8:00 a.m. Diagnosis included, but was not limited to, depressive disorder.</p> <p>A "Service Plan Detail," dated 1/29/21-4/29/21, included, but was not limited to, the following: Resident will maintain and/or maximize current level of functioning with activities. Level of Assistance - Activities: Extensive. Resident requires daily reminders and physical assistance for activities. The Service Plan lacked documentation of the resident's interests.</p> <p>On 4/26/21 at 10:30 a.m., LPN 1 indicated the residents in the back hall of the facility did not receive activities. She indicated the Activity Director (AD) had not worked for a long time and the facility had not had any activity assistants until last week. The staff would try to provide activities but they could only do so much as the facility was short on staff. Stated even when AD had worked she would place either place a video of an "Alan Jackson Gospel Music" or "funeral" music into the recorder and it would play all day. Indicated when the AD worked, she would not arrive until 8:30 or 9:00 a.m., put a video in the television for the residents in the back day room, participate in the morning meeting for 1.5 to 1.75 hours, and then sit in her office the rest of the day</p>			

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	<p>with the blinds closed.</p> <p>On 4/28/21 at 10:12 a.m., the Activity Assistant indicated she had just recently started working at the facility and the Activity Director was off on vacation at this time. She indicated she did not have activity participation forms for the residents. The residents in the back day room are lower functioning and the activities were provided more for the residents in the front of the facility. She did not offer manicures to the female resident in the back day room yesterday. She would need to question the Activity Director regarding doing any activities with the residents on the back area of the facility.</p> <p>On 4/28/21 at 12:10 p.m., the Administrator indicated the Activity Director had been off work quite a lot recently. The AD did not do a very good job with activities especially for the residents in the back area of the facility and the facility was lacking in activities. The Activity Director did not time-manage very well and the activity calendar was the same each month. The Activity Director had 2 closets full of items to use for activities but had never used them for the residents. The Activity Assistant had just started last week and had never been employed in an activity department in the past.</p> <p>The current facility policy, "Programming," dated 4/2018, provided by the Administrator on 4/28/21 at 12:21 p.m., included, but was not limited to, "Activities for residents will: Support the skills and abilities of resident in order to promote or maintain their highest level of independence or functioning; Accommodate individual differences by providing a variety of types of activities and levels of</p>			

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R 0349 Bldg. 00	<p>involvement; and Offer residents a variety of weekly activities that are physical; cognitive, intellectual, or creative; productive; sensory; reflective or contemplative; involve nature or the natural world; and weather permitting outdoor activity."</p> <p>"Residents will be encouraged but not forced to participate in activity programs offered by the facility. If a resident is unable to choose an activity for him/herself, staff will encourage participation and assist when necessary."</p> <p>"There will be a written schedule of activities that meets the following criteria: The schedule will include group activities for all residents or small groups of residents. If a resident requires an individual schedule of activities, that schedule will be a part of the individualized service plan. In addition to the required scheduled activities, there will be unscheduled staff and resident interaction throughout the day that fosters an environment that promotes socialization opportunities for residents."</p> <p>This Residential tag relates to Complaint IN00351663.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p>			

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	<p>Based on observation, interview, and record review, the facility failed to maintain a complete and accurate clinical record following two separate falls for 1 of 3 residents reviewed for falls. (Resident H)</p> <p>Finding Includes:</p> <p>On 4/26/21 at 10:00 a.m., the facility reported incident forms were provided by the Administrator for review. An incident report, dated 3/30/21, indicated that on 3/29/21 Resident H was rubbing her left thigh and complaining of pain. The physician was notified and orders for an x-ray were obtained. The x-ray showed a "...sub-acute FX [fracture] of left trochanter..." Resident H was sent to the hospital for treatment. The incident form indicated that "...Investigation initiated into how FX may have occurred..."</p> <p>On 4/27/21 at 9:46 a.m., the clinical record of Resident H was reviewed and diagnoses included, but were not limited to: vascular dementia, cerebrovascular accident, and history of falls. An admission service plan, dated 3/6/21, indicated that Resident H was a high fall potential and "...resident will maintain and/or maximize current level of functioning with fall potential..."</p> <p>A nurse's note, dated 3/29/21 at 10:01 a.m., indicated that "...Resident yelled out in pain in L hip, Norco given at 9:30 am for pain. Unable to bear weight on L leg. 2 assist on transfer from bed to w/c [wheelchair]. Called [physician name] regarding L hip pain, received N/O [new order] x-ray left hip..."</p> <p>A nurse's note dated 3/30/21 at 3:22 p.m., indicated that "...During the investigation into how</p>	R 0349	<p>As all residents have the potential to be affected by the deficient practice, corrective action included termination of the nurse found to be in violation of facility policy, and in-service to the nursing staff on 3/30/21 of the requirements of the facility incident reporting policy.</p> <p>To ensure that the same deficient practice does not reoccur, the nursing staff will be in-serviced quarterly on fall management policy and procedures.</p> <p>Corrective action will be monitored by reviewing in-service records at monthly CQI meetings. These systematic changes were completed 5/21/21.</p>	05/21/2021

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	<p>the resident could have FX'd [fractured] her L Greater Trochanter it was discovered the res [resident] had fallen on 3/27/21 and on 3/28/21..."</p> <p>There was no documentation of any reports of pain or falls on 3/27/21 or 3/28/21 in the clinical record. The clinical record lacked any documentation of a fall assessment or vital signs on 3/27/21 or 3/28/21.</p> <p>The investigation of the reported incident, dated 3/29/21 at 5:00 p.m., was provided by the Administrator on 4/27/21 at 10:50 a.m. The investigation indicated that on 3/27/21 at 2:00 p.m., "...Per report from Nurse on duty 3/27/21 res was observed on floor in hallway outside of Rooms 36 & 37. Nurse reports that she checked res [resident] for injury and none were noted. Per investigation this res was observed on floor by caregiver and Nurse who assisted res from floor into a wc [wheelchair]. Caregiver reported that it did not appear that res had hit her head..." The incident report included action taken as "...Res assessed for injury w [with] v/s [vital signs] taken per statement of nurse on duty..."</p> <p>The clinical record lacked documentation for the fall on 3/27/21.</p> <p>The investigation of the reported incident, dated 3/29/21 at 5:00 p.m., was provided by the Administrator on 4/27/21. The investigation indicated that on 3/28/21 at 9:00 a.m., "...Per rec'd [received] report from witnesses: Res was observed on the floor at the end of her bed with bed linens around her laying on her left side. Staff assisted res onto back and then res was assessed by nurse and then res assisted x 2 staff off of the floor and into a YWCA [wheelchair]. The incident</p>			

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	<p>form stated "...Per nurse on duty vs [vital signs] taken but not documented...Per nurse on duty assessed for injury with none noted..."</p> <p>The clinical record lacked documentation for the fall on 3/28/21.</p> <p>During an interview on 4/27/21 at 10:50 a.m., the Administrator indicated that LPN 3 was working on 3/27/21 and 3/28/21 when Resident H fell. LPN 3 did not document those falls or complete an incident report and was subsequently terminated due to not documenting appropriately.</p> <p>During an interview on 4/27/21 at 11:22 a.m., HHA [home health aide] 1 indicated that she did not recall both falls, but does remember that the residents were finishing dinner at around 5:30 p.m. on 3/27/21 and she found Resident H on the floor in the hallway. HHA 1 and LPN 3 assisted the resident to a standing position and Resident H kept saying "ouch." HHA 1 indicated that LPN 3 never assessed Resident H, she just stood her up and seated her into a wheelchair. HHA 1 left after her shift around 6:00 p.m.</p> <p>During an interview on 4/27/21 at 11:50 a.m., the Administrator indicated that she was not aware of Resident H having any falls at all until she was completing an investigation surrounding the residents hip fracture on 3/29/21. The administrator indicated that she was questioning staff about how Resident H could have suffered a fracture and discovered that the resident had suffered two falls over the weekend (prior two days). The nurse had not documented any falls for those incidents and was subsequently terminated.</p> <p>During an interview on 4/27/21 at 2:30 p.m., QMA</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>I indicated that if a resident experiences a fall, she would call the nurse immediately. The nurse would then complete an assessment and determine if there were any injuries. An ambulance would be called if necessary, and the family and physician would be notified. Staff would report the fall to the next shift as well. The nurse would then document in the clinical notes what happened and what was done.</p> <p>During an interview on 4/27/21 at 2:39 p.m., LPN 2 indicated that if a resident falls, a full assessment would be completed on the resident. The physician and family would be called and she would notify the Director of Nursing or the Administrator. The fall would be documented in the nurse's notes and an incident report would be completed immediately.</p> <p>A policy, dated October 2014, and titled "Accidents, Incidents, and Unusual Occurrences" was provided on 4/27/21 at 3:20 p.m. The policy stated that "...It is the policy of this community that all accidents and/or incidents will be responded to and investigated promptly...Incident reports must be completed within the same shift during which the incident occurred..."</p> <p>A policy, dated April 12, 2018, and titled "Fall Management" was provided on 4/28/21 at 8:45 a.m. The policy stated that "...Appropriate care and medical intervention will be provided as indicated when a resident sustains a fall...Licensed nurse will evaluate resident for injury and determine if emergency medical services (911) should be summoned..."</p> <p>A policy, dated April 12, 2018, and titled "Change of Condition" was provided on 4/28/21 at 8:45 a.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2021
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R 0414 Bldg. 00	<p>The policy stated that "...The licensed nurse will ensure that appropriate evaluation and follow-up take place and will be responsible for notifying the resident's family or responsible party and physician, if appropriate. The licensed nurse will also determine if the change is potentially life threatening, significant but not life threatening, requires temporary monitoring and alert charting, or does not require further follow up..."</p> <p>This Residential tag relates to Complaint IN00351663.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure infection control standards were met during observations of resident care for 2 of 3 residents. Staff did not perform hand hygiene when changing gloves and performing incontinence care. (Resident B, Resident J)</p> <p>Findings Include:</p> <p>1. On 4/26/21 during observation of Resident B from 8:35 a.m. to 9:16 a.m., CNA 5 was observed to wash her hands and apply gloves, CNA 6 applied gloves, with no hand hygiene observed, assisted Resident B to disrobe, stood the resident with extensive assist of 2, and transferred the resident to the shower bench. CNA 5 was observed to utilize a cloth to wash Resident B's upper torso and arms. CNA 5 discarded the used cloth to the floor and obtained another cloth to wash Resident B's lower legs. CNA 6 was</p>	R 0414	<p>Corrective action included conducting a return demonstration hand washing in-service with all facility employees and discussing the facility handwashing policy. To ensure that the same deficient practice does not occur the Management Team will conduct random observations of employee handwashing. The corrective actions will be monitored through observation and audit of a minimum of 10 employee's handwashing weekly x 4 weeks, then monthly for compliance. These audits will be discussed by the CQI committee. These systematic changes will be completed by 5/21/21.</p>	05/21/2021

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	<p>observed to wash Resident B's left side, arm and leg and discard the used cloth to the floor, discarded her gloves to the trash, opened a plastic bag and laid it on the floor, applied new gloves with no hand hygiene, and assisted CNA 5 to finish the shower. CNA 5 and CNA 6 discarded the towels to the floor after drying the resident. CNA 6 picked up the linens from the floor and bagged them in plastic bag. CNA 5 and CNA 6 removed their gloves and washed their hands.</p> <p>2. On 4/27/21 at 11:24 a.m., Agency CNA 2 was observed to perform personal care for Resident J. Agency CNA 2 utilized wipes to clean BM from Resident J's buttocks and thighs while Resident remained standing, applied clean brief with no glove removal or hand hygiene observed, and assisted LPN 2 to pull Resident J's pants up, then removed her gloves. No hand hygiene was observed. Agency CNA 2 then tied the soiled bag containing the soiled brief and wipes. Agency CNA 2 then applied new gloves, no hand hygiene was observed, and bagged the linens and clothing in the shared bathroom. Agency CNA 2 then removed her gloves and washed her hands, turned off the water faucet, then dried her hands with paper toweling. She then double bagged the linens and clothing, washed her hands thoroughly, took the bags to the soiled barrels and utilized hand sanitizer.</p> <p>On 4/28/21 at 11:48 a.m., CNA 6 indicated she was to do hand hygiene during care, when entering a resident's room, in between residents, before the meal and after the meal. When discarding used/soiled linens, they were to be bagged and not placed on the floor.</p> <p>On 4/28/21 at 8:45 a.m., the Administrator</p>			

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	<p>provided the current facility policy, Hand Hygiene, issued April 12, 2018. The Policy indicated, but was not limited to, "hand hygiene practices will promote resident safety and prevent infections. All employees shall wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment...an alcohol based hand rub may be used in between residents. In addition, staff shall wash their hands and any other skin or flush mucous membranes with water immediately or as soon as feasible following contact of such body area with blood or other potentially infectious materials..."</p> <p>This Residential tag relates to Complaint IN00351663.</p>				