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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00402254, IN00400685, and IN00399680. Complaint IN00400685 - Federal/State deficiencies related to the allegations are cited at F656 and F697. Complaint IN00399680 - Federal/State deficiencies related to the allegations are cited at F921, F684, and F812. Complaint IN00402254 - Federal/State deficiencies related to the allegations are cited at F561, F585, F600, F609, F610, F656, F661, F684, F697, F812, F881, and F921. Survey dates: May 4, 5, 8, 9, 10, and 11, 2023 Facility number: 000012 Provider number: 155029 AIM number: 100274900 Census bed type: SNF/NF: 46 Total: 46 Census payor type: Medicaid: 37 Other: 9 Total: 46 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 22, 2023	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit on May 11, 2023. Please accept this plan of correction as the provider's credible allegation of compliance as of June 2, 2023. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
keith davis	senior executive director	06/02/2023

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

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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to have the interdisciplinary team (IDT) determine and document that self administration of medications and treatments were clinically appropriate for 2 of 2 residents randomly observed for self-administration of medications and medications at bedside. (Residents 20 and 45) Findings include: 1. The clinical record for Resident 20 was reviewed on 5/8/23 at 11:04 a.m. His diagnoses included, but were not limited to: schizophrenia, chronic pain, and hypertension. The 4/18/23 Quarterly MDS (Minimum Data Set) assessment indicated he had a BIMS (brief interview for mental status) score of 10, indicating he was moderately cognitively impaired. The physician's orders indicated to administer 500 mg of divalproex 3 times a day for schizophrenia; 650 mg of Tylenol 3 times a day for chronic pain; and 20 mg of Lasix once a day for hypertension. There was no self-administration of medication evaluation in Resident 20's clinical record. An observation of Resident 20 was made and interview was conducted with LPN (Licensed Practical Nurse) 15 on 5/8/23 at 10:53 a.m. Resident 20 was standing in the doorway of his room, holding a medication cup with 4 pills inside,	F 0554	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -Residents 20 and 45 are receiving medications per order. QMA 22 has been educated on Self Administration of Medications. Both residents have been assessed by the IDT for the ability to self administer medications How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving medications has the potential to be affected by this alleged deficient practice. Facility audit to be completed per DNS/designee by 6/2/23 to identify any residents with an order to self administer medications to ensure IDT self administration evaluation is completed (see Attachment A). Educate all nurses/qma's on Self Administration of Medications by 6/2/23 per DNS/designee . DNS/designee to complete weekly medication pass observations (see	06/02/2023

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	asking if he was going to pass out and stating he needed a band-aid. There was no staff member present with him. LPN 15 was standing nearby in front of a medication cart in the hallway. LPN 15 indicated she did not administer the medications inside of the cup Resident 20 was holding to him and would check with QMA (Qualified Medication Aide) 22. LPN 15 walked over to Resident 20 and took the cup of medications from him. LPN 20 walked down the hallway to QMA 22, who was standing in front of another medication cart towards the end of the hall. QMA 22 informed LPN 15 that Resident 20 kept saying he was going to take the medications on his own. LPN 15 and QMA 22 walked back down the hallway into Resident 20's room with the cup of medications and encouraged Resident 20 to take the medications. After leaving Resident 20's room, LPN 15 indicated the medications inside of the cup were Depakote, Lasix, and Tylenol. An interview was conducted with the RNC (Regional Nurse Consultant) on 5/8/23 at 12:07 p.m. He indicated Resident 20 did not have a self-administration of medication evaluation completed and should not be administering his own medications.2. An interview with Resident 45 was conducted on 5/5/23 at 10:30 a.m. in her room. During the interview an observation was made of Resident 45's bedside table. Sitting on her bedside table was a clear medication cup which contained 3 unidentified pills. When asked about the medications in the cup, Resident 45 indicated, when she woke up that morning, the cup with the pills was already sitting on the table. She indicated, she was unsure if the medication in the cup was even hers. Resident 45 indicated, she took more morning medications than what was in the cup and stated she was not going to take them for that reason. This was not the first time		Attachment A). Medication Administration skills validations to be completed with all qma #22 by 6/2/23 per DNS/designee. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Educate all nurses/qma's on Self Administration of Medications by 6/2/23 per DNS/designee . All nurses upon hire will complete medication administration skills validation. IDT will review and complete self administration evaluation on any resident requesting to self administer medications, if indicated order will be obtained and care planned. DNS/designee to complete weekly medication pass observations (See Attachment A). Medication Administration skills validations to be completed with all nurses/qma's by 6/2/23 per DNS/designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the	

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	medications had been left for her to take when she awoke. An interview with Float DNS (Director of Nursing Service) conducted on 5/5/23 at 11 a.m. indicated, Resident 45 did not have a self-administration of medication evaluation completed for the medications which were left at bedside. Medications should not be left at bedside if the resident has not been evaluated for self-administration of medications. A Self-Administration of Medications policy was received from Float DNS on 5/5/23 at 11 a.m. The policy indicated, "If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the "Self-Administration of Medication Assessment" observation. A Physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medications will be included in the self-administration plan...The resident will be assessed for continued self-administration of medications quarterly and with any significant change of condition. The resident's care plan will be updated to include self-administration." 3.1-11		Executive Director. · CQI tool identified as Self Administration of Medications (see Attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.			

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	Based on observation and interview, the facility failed to ensure a resident had the right to reasonable accommodations by having the resident's personal items blocking the only sink in a room from use of the other roommate for 1 of 2 residents reviewed for food. (Resident 39) Findings include: An interview with Resident 39 was conducted on 5/5/23 at 10:54 a.m. Resident 39 indicated, he was unable to wash his hands in his room because his roommate had so many personal items stacked under and around the sink, he was unable to use the sink. An observation of the area around Resident 39's sink was made at the same time as the interview. Resident 39's roommate had a pink basin with a urinal in it under the sink, many bottles of soda under the sink; a large chair with more personal items was positioned in front of the sink; and a laundry basket containing some clothing and his roommate's leg holders from his wheelchair was on the left side of the sink. An environmental tour of the facility was conducted with ED on 5/11/23 at 11:40 a.m. During the tour the following was witnessed: Resident 39's roommate still had the laundry basket with wheelchairs leg supports in it next to the sink, soda pop bottles and pink basin with urinal under the sink and the large chair in front of the sink. The bathroom light fixture did not have its cover and the call light panel between both beds when pressed on, would recess into the wall. An interview with ED conducted at the end of the environmental tour indicated, Resident 39's roommate should not have his personal items stored in a manner which blocks Resident 39 from accessing the sink.	F 0558	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 39 has access to his sink. The light fixture cover in question has been replaced and call light panel is secure. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. Facility inspection per Executive Director to be completed by 6/2/23 to identify any residents without access to their sink, uncovered light fixtures and insecure call light panels. All staff education provided by Executive Director/designee by 6/2/23 on environmental concerns including access to sinks, faulty light fixture covers and faulty call light panels (see Attachment AA). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff Education provided by Executive Director/designee by 6/2/23 on environmental concerns including access to sinks, faulty light fixture covers and faulty call light panels (see Attachment AA).	06/02/2023

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	3.1-3(v)(1)		Maintenance to complete weekly rounds and reported any concerns to the Executive Director. Customer service care companions (IDT members) assigned to each resident will complete room observations and report any concerns to the Executive Director in daily morning meeting. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Accommodation of Needs (see Attachment B) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination.			

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	The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to promote and facilitate resident self-determination through support of a resident's choice to choose a shower over a bed bath and to have his fingernails cleaned and cut routinely for 1 of 3 residents reviewed for ADL's (Activities of Daily Living) (Resident 37) and a resident who wanted to be awakened and placed in his wheelchair so he may eat breakfast in his wheelchair for 1 of 1 residents reviewed for choices (Resident 16).	F 0561	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 37 is receiving showers per preference and nail care is being provided routinely. Resident 16 is being assisted to wheelchair for breakfast per preference. How other residents having the	06/02/2023

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	Findings include: 1. The clinical record for Resident 37 was reviewed on 5/9/23 at 3:37 p.m. Resident 37's diagnoses included, but not limited to, hemiplegia and hemiparesis (difficulty/inability to move left side of body) to the left dominant side, congestive heart failure (CHF), heart attack, and depression. An observation and interview with Resident 37 was conducted on 5/5/23 at 2:42 p.m. Resident 37 indicated, he preferred getting a shower rather than a bed bath. When asked if he received showers over bed baths, he indicated 'no' by turning his head side to side. An observation of Resident 37's fingernails of both hands appeared to be long in length and had dark, black grime packed underneath his fingernails. Resident 37's Admission MDS (Minimum Data Set) dated 12/24/21 indicated, he required extensive assistance of two persons for transfers and was totally dependent on two persons for bathing. Resident 37's Quarterly MDS dated 3/20/23 indicated, he required extensive assistance of two persons for transfers and was totally dependent on one person for bathing. The facility's Preferences for Customary Routine and Activities for Resident 37 and dated 12/21/21 indicated, it was "very important" for him to choose between tub bath, shower, bed bath/sponge bath. It also indicated, the type of bathing he was used to was a shower. Resident 37's care plan dated 12/20/21 indicated he required assistance with ADL's including, but		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. Audit to be completed per DNS/designee by 6/2/23 (see Attachment C) to identify any residents preferences not being met in regards to receiving showers per preference, nail care or getting up timely for breakfast. Education provided to all nursing staff per DNS/designee by 6/2/23 on resident preferences, shower sheets, nail care (see Attachment AA). Nail care skills validations to be completed per DNS/designee by 6/2/23 with all nursing staff. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Education provided to all nursing staff per DNS/designee by 6/2/23 on resident preferences, shower sheets, nailcare (see Attachment AA). IDT to review shower sheets daily to ensure that showers are being completed as scheduled with refusal documented. Customer service care companions (IDT members) assigned to each resident to ensure preferences are being met with any concerns addressed in daily morning meeting. IDT to	

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	not limited to, transfers. An approach was to assist with bathing as needed per resident preference and offer showers two times per week and partial baths in between. A review of Resident 37's POC (point of care) charting for bathing was completed on 5/9/23 for the time period of 3/1/23 to 5/9/23. The POC indicated, during the specified time frame, Resident 37 had received 83 complete bed baths and only 3 showers. An observation of Resident 37 was conducted on 5/9/23 at 4:30 p.m. Resident 37 had just come out of the shower room from having a shower. The underneath of his fingernails were still long and packed with black grime. They did not appear to have cleaned under or clipped. An interview with Resident 37 was conducted on 5/10/23 at 9:50 a.m. When he was asked: if anyone had offered to cut his nails when he had his shower yesterday, he indicated, 'no' by shaking his head side to side; if he liked his fingernails the length they were, he indicated, 'no'; and if the grime under them bothered him, he indicated, 'yes' by shaking his head up and down. An interview with RNC (Regional Nurse Consultant) was conducted on 5/10/23 at 10:09 a.m. RNC indicated, resident's fingernails should be cut and cleaned when necessary and if they pose a potential to cause skin injuries. A Fingernail Care skills validation - CNA (Certified Nursing Assistant) was received on 5/10/23 at 10:31 a.m. from Float Social Services. It indicated, the procedure steps: "6. Fill basin halfway with warm water and have resident check water temperature, 7. Soak resident's hands and pat		ensure resident preferences are indicated on residents profile. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Self Determination (see Attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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	dry...9. Clean under nails with orange stick. 10. Clip fingernails straight across, then file in a curve...15. Document procedure." 2. The clinical record for Resident 16 was reviewed on 5/9/23 at 9:24 a.m. Resident 16's diagnoses included, but not limited to, major depressive disorder, dysphagia (difficulty/inability to swallow), and osteoarthritis. An interview conducted with Resident 16 on 5/5/23 at 11:52 a.m. indicated, he preferred to be out of bed in the morning at 5 a.m. so that when breakfast arrives he can eat while sitting in his wheelchair. He indicated, staff comes in the morning and gets his roommate up and in his wheelchair because he liked to eat breakfast in the dining room , but, Resident 16 did no want to eat in the dining room and wishes to eat in his room. He stated, he has asked staff when they are getting up his roommate for them to get him up as well and "they act like they don't want to do it". Resident 16 indicated, sometimes the staff doesn't get him up at all. An interview conducted with Resident 16 on 5/11/23 at 1:35 p.m. indicated, he has not refused to get up and into his wheelchair for breakfast and still wishes to be up and in his wheelchair prior to breakfast being served. An interview conducted with CNA on 5/9/23 at 9:56 a.m. indicated, she was aware that Resident 16 prefers awakened and up in his wheelchair early in the morning. She indicated, it was the night shift's responsibility to get him up prior to leaving, but they didn't get him up that morning. She was unsure as to why they didn't assist him to his wheelchair that morning. When asked how she knew Resident 16 was to be up and in his			

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	wheelchair prior to night shift leaving she stated, because there was a list taped onto the wall in nursing station with 8 Resident's names on it and his was one of them. An interview with DNS (Director of Nursing Services) conducted on 5/9/23 at 9:30 a.m. indicated, when the facility admits a new resident, an activity member will conduct and interview with the resident for their preferences. After the interview, a care plan for preferences should be completed. DNS indicated, she had not been made aware of Resident 16's preference but then added him to the "Night Shift Get Up's" list of residents who wanted to get up early. The list had 5 resident room numbers listed at the time she added Resident 16 to the list. Resident 16's quarterly MDS (Minimum Data Set) dated 4/4/23 indicated, he was totally dependent on the assistance of two persons for transfers. Resident 16's care plan dated 7/11/19 indicated, he requires assistance with ADLs including, but not limited to, bed mobility, transfers, and eating. The interventions included, to be up as desired in his high back wheelchair with assistance of a mechanical lift and two staff members; and to assist with eating and drinking as needed. Resident 16's current care plan did not include resident preferences. A Preferences for Daily Routine policy was received from the RNC (Regional Nurse Consultant) on 5/9/23 at 10:51 a.m. The policy indicated, "Purpose: To identify and develop a plan of care that reflects a resident's past and current daily customary routines...Activity Director or designee will complete the Preferences for Daily Customary Routines worksheet upon			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	admission of a new resident, quarterly and upon significant change to the resident...The information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences." This Federal tag relates to Complaint IN00402254. 3.1-3(u)(1) 3.1-3(u)(3) 3.1-3(v)(1)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided			

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	upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the physician of a resident's fall for 1 of 1 resident reviewed for accidents. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on 5/4/23 at 12:50 a.m. Her diagnoses included, but were not limited to: dementia, anxiety, and Parkinson's disease. The 2/4/23 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating	F 0580	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - resident 35 has a completed has a completed fall review per IDT with physician notification - cna 21 has been educated on leaving resident unattended at bedside.	06/02/2023

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	she was cognitively intact. The 4/18/23 Annual MDS assessment indicated she required extensive assistance of 2 persons for bed mobility and transfers and extensive assistance of 1 person for dressing. The ADL care plan, last reviewed/revised 5/2/23, indicated she required assistance with ADLs including bed mobility, transfers, eating and toileting. Approaches were to provide care in pairs, starting 7/28/23; to assist with bed mobility as needed; to assist with dressing/grooming/hygiene as needed; and to assist with transfers as needed. The fall care plan, last reviewed/revised 5/2/23, indicated she was at risk for falls due to Parkinson's disease, debility, hypertension, a history of falls, arthritis, cognition, neuropathy, age, incontinence, medications, requiring assistance for mobility, and altered awareness of immediate physical environment. The goal was for fall risk factors to be reduced in an attempt to avoid significant fall related injury. An interview was conducted with Resident 35 on 5/4/23 at 12:55 p.m. She indicated CNA 21 left her on the edge of her bed and she fell yesterday. An interview as conducted with CNA 21 on 5/10/23 at 2:38 p.m. She indicated she'd worked at the facility for 2 years as a CNA. Resident 35 required a lot of assistance with ADLs. She was recently taken off of her Parkinson's medications. She required only one person to assist her with dressing, but 2 people to assist her with getting up. When she assisted Resident 35 with dressing, Resident 35 was usually sitting on the edge of her bed with her feet on the floor while CNA 21		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents with fall risk have the potential to be affected by this alleged deficient practice - audit of falls in the past 90 days completed per dns by 6/2/23 to ensure IDT documentation complete with physician notification -Education provided to all nursing staff on fall management policy per dns/designee by 6/2/23. (see Attachment AA). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Education provided to all nursing staff on fall management policy per dns/designee by 6/2/23. (see Attachment AA). - IDT to review all falls to ensure that physician notification was completed	

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	dressed her and put her bra on. Resident 35 had fallen before. Last week, CNA 21 left the room to get a nurse and Resident 35 fell while she was gone. CNA 21 left Resident 35 sitting up on the edge of the bed with her feet on the ground. CNA 21 left the room to get another staff member to help her transfer Resident 21 into her chair. "I was gone 2 seconds to get the nurse." When CNA 21 returned, Resident 35 was on the floor by the side of her bed. Resident 35 was not hollering out afterwards and didn't complaint of any pain, but had a "scratched up knee." Three staff members, CNA 21 included, along with QMA (Qualified Medication Aide) 22, and the FDNS (Float Director of Nursing Services,) assisted her off the floor and into her chair. CNA 21 did not recall exactly what day the fall occurred, but "definitely last week." Resident 35's clinical record did not indicate she had a fall the previous week. There was no fall event, fall assessment, IDT (Interdisciplinary Team) note, or progress note referencing a fall the previous week or notification of a fall to Resident 35's physician. An interview was conducted with the FDNS on 5/10/23 at 3:42 p.m. She indicated CNA 21 came and got her one day last week and informed her she needed help getting Resident 35 off the floor. She went into Resident 35's room where she saw Resident 35 on the floor. She did not have any injuries or any complaints of pain. A QMA was already present in the room doing vitals. A charge nurse was also present, but she was unsure who it was. There should be a post fall assessment in Resident 35's clinical record. She didn't do one herself, because the other nursing staff handled it, but she did not follow up to make sure. Resident 35 was able to bend and sit up afterwards and did		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Notification of Changes (see Attachment D) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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	not have any skin tears or any other apparent injury. The 5/10/23 event from the clinical record read, "Obtain x-ray of lumbar and right knee (pain lower pain and pain/swelling knee). Diclofenac Gel 1% 2 gm right knee QID [4 times daily....]Resident seen by MD. New orders received: Obtain x-ray of lumbar and right knee...Pharmacy and Mobilex made aware." The 5/11/23, 2:17 a.m. nurse's note read, "resident had complaints of pain and resident stated " NURSE NURSE NURSE" very loudly for duration of shift disturbing other residents during night hours. resident requested Tylenol and voltaren cream to be rubbed on her this writer fulfilled tasks resident stated "your doing it wrong put more on now" no new orders at this time call light within reach." An interview was conducted with the RNC (Regional Nurse Consultant) on 5/11/23 at 10:05 a.m. He indicated Resident 35 did not have a post fall assessment or an IDT review of the fall or any verification of physician notification. He indicated there was currently an order for an x-ray, but their radiology provider wouldn't do it STAT [immediately] and hadn't come in yet. They offered to send Resident 35 out for the x-ray, but she declined. The 5/11/23, 8:47 a.m. nurse's note read, "Spoke with resident as the X-ray tech [technician] had to reschedule the imaging and offered to send the resident to the Hospital for immediate imaging and the resident declined saying " No they are coming I want it done here". Will cont [continue] to follow up."			

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	An interview was conducted with Resident 35 on 5/11/23 at 10:45 a.m. She indicated CNA 21 left her on the edge of the bed after getting her bra on. CNA 21 didn't have everything she needed, so she left. "I was saying wait. I'm going to fall. She shut the door, and I fell by the time she got back" The Fall Management policy was provided by the RNC on 5/11/23 at 9:07 a.m. It read, "It is the policy of [name of facility] to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls....Post fall...3. The physician will be contacted immediately, if there are injuries, and orders will be obtained. If there are no injuries, notify the physician during normal business hours. 4. The family will be notified immediately by the charge nurse of falls with injury. If there are no injuries, notify the family during day or evening hours (if a fall occurred during the middle of the night, wait until morning) 5. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be competed in full in order to identify possible root causes of the fall and provide immediate interventions. 6. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls. The fall event will be reviewed by the team. IDT note will be written. The care plan will be reviewed and updated, as necessary. Hot Charting will be initiated post fall." 3.1-5(a)(1)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to			

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	voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of			

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	independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to			

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	be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on interview and record review, the facility failed to address grievances for 1 of 1 residents reviewed for grievances. (Resident D) Findings include: The clinical record for Resident D was reviewed on 5/8/23 at 1:00 p.m. The diagnoses for Resident D included, but were not limited to, type 2 diabetes mellitus, cirrhosis, seizures, and ascities. A nursing progress note dated 1/23/23 indicated "Writer received call from [Resident D's Representative] who c/o [complaints of] res. [resident] c/o not being changed for 3 1/2 hrs [hours]. Writer informed caller that aides are actively in res. room changing res. while speaking with caller. Writer attempted to explain to caller that res. is in facility for therapy and to increase functionality, so res. expelling feces and urine into her brief would be regression since res. arrived to facility using a bed pan. Caller cont. [continued] to be irate and refused to listen to writer, stating that she would be contacting director..."	F 0585	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Resident D and resident 4 have discharged from the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents have the potential to be affected by this alleged deficient practice - resident QIS questions completed by 6/2/23 per assigned customer service care companions to identify any	06/02/2023

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	A Social Services Director note dated 1/23/23 "The writer was approached by one of the aides in the hallway. The aide reported she was with the resident at an appointment on this date and one of the staff members informed her that the resident was criticizing the facility and the staff. The writer met with the resident to discuss her concerns. Resident reported she does not like the facility and she would like to transfer to another facility. The writer asked what facility would she like to transfer to, and she reported she was not sure and that she would let the writer know. The resident was educated on the grievance process and was provided with grievances. SS [Social Services] will continue to provide monitor and provide support as needed." The resident's clinical record did not include follow up on any care grievances the resident had reported to the social services. An interview was conducted with Regional Nurse Consultant on 5/8/23 at 1:45 p.m. He indicated he was unable to provide any grievance forms for Resident D. An interview was conducted with Resident D's Representative on 5/8/23 at 2:30 p.m. She indicated she was unhappy with the care and treatment that was provided to Resident D during her stay. She had reported the concerns to the Executive Director by phone multiple times that included: skin treatments, mannerism of the staff, missing personal items, food served, and staff assistance with care needs and nothing was done. An interview was conducted with Executive Director (ED) on 5/8/23 at 3:40 p.m. He indicated he did not have any grievances for Resident D. He		resident concerns with grievances to be completed on grievances voiced - all staff educated by the Senior Executive Director by 6/2/23 on grievance policy and addressing resident concerns (see Attachment AA) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - all staff educated by the Senior Executive Director by 6/2/23 on grievance policy and addressing resident concerns (see Attachment AA) - customer service care companions (IDT members) to follow up daily if a resident has voiced a concern and concerns will be documented on grievance forms - concerns and grievances to be reviewed daily in morning meeting with plan for resolution identified and documentation completed How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;	

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	did have multiple conversations via phone texing with Resident D's Representative. He had returned to the facility at times to observe the resident due to some of the discussions he had with Resident D's Representative. For example: She was worried Resident D might fall, so he returned to the facility to check on the resident. The ED indicated he had recently replaced his cell phone, so he could not confirm what texts he had received from Resident D's Representative that were concerns. He did recall that she had mentioned concerns with customer service issues with the staff. He probably should have filled out grievance forms regarding the concerns she had mentioned, but he had not. A "Resident Concerns and Grievances" policy was provided by the Regional Nurse Consultant on 5/9/23 at 11:46 a.m. It indicated "...Policy: Resident, representative or family concerns/grievances occurring during the resident's stay shall be responded to promptly and without fear of reprisal or discrimination. Each resident has the right to: file grievances orally or in writing; file a grievance anonymously, and to obtain a written decision regarding his or her grievance...The Executive Director/Grievance Official shall review all complaints and agree with the actions taken towards resolution. Responses to resident, representative and/or family shall be made as soon as possible and preferably immediately. Actions take to resolve the complaint shall be made within 72 hours from the time the Concern/Grievances form was received unless there is a compelling reasons for delay. Actions taken must prevent further potential violations of any resident rights. Actions taken include contacting the resident, representative and/or family with an explanation of the steps the facility will take to resolve the complain and to ensure		· Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Grievances (see Attachment E) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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	their satisfaction...Actions taken must be documented....Procedure...If a concern/grievance of any kind is noted, the Concern/Grievance Form is used. The person receiving the concern completes Section I. The following information is placed on the form by the individual completing the record. Date incident occurred, Time incident occurred, Date concern/grievance was received, Name of person receiving the concern/grievance, Department receiving the concern/grievance, Detailed accounting of concern/grievance, Date the complaint form was completed. The concern/Grievance Form is then referred to the Department Leader for review and actions taken. Actions taken will be recorded in Section II by the Department Leader. Section III of the form is to be completed by the employee designated to ensure satisfaction with the resolution of complaints...The Executive Director/Grievance Official will then complete Section IV....The Executive Director/Grievance Official will sign off on all completed concern/grievance forms, ensuring resident and or family satisfaction. The Executive Director/Grievance Official is responsible for overseeing process, receiving and tracking grievances through the conclusion, lead any investigations as necessary, maintain the confidentiality of all information associated with grievances, issue written grievance decisions to the resident...All concern forms are to be maintained on-site for a minimum of three years." This Federal tag relates to Complaint IN00402254. 3.1-7(a)(2)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

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COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interviews and record review, the facility failed to protect the resident ' s right to be free from verbal abuse by a staff member for 1 of 4 residents reviewed for abuse (Resident 17). Findings include: The clinical record for Resident 17 was reviewed on 5/10/23 at 8:57 a.m. The Resident's diagnosis included, but were not limited to, rheumatoid arthritis and diabetes. A care plan, initiated 7/7/21, indicated he needed assistance with bed mobility, eating, transfers, and toilet use. The goal was that he had a desire to improve his current function. The approaches included, but were not limited to, transfer using a mechanical lift and 2 staff members, initiated 7/27/21, assist with med mobility as needed, initiated 7/7/21, and assist with eating and drinking as needed, initiated 7/7/21. A care plan, initiated 9/29/21, indicated he displayed behaviors such as yelling at the staff and calling them inappropriate names during care.	F 0600	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident 17 has been followed by Social Service Director with no psychosocial distress noted and participating in activities per baseline. · CNA 4 no longer works at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents have the potential to be affected by the alleged deficient practice. · Care Companions to complete resident QIS questions with assigned residents to identify any resident concerns. · Senior Executive Director to in-service DNS on abuse policy by	06/02/2023

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	The goal was for him to be easily redirected when yelling or using inappropriate language. The interventions that were initiated 9/29/21 included, but were not limited to, allow resident to express his feelings and validate his feelings, offer redirection, and allow him time and space when he is unruly during care. An Annual MDS (Minimum Data Set) Assessment, completed 4/18/23, indicated Resident 17 was cognitively intact. A Behavior Event, dated 5/4/23 at 6:45 a.m. by LPN 3, indicated that Resident 17 was observed to be screaming with aide. The Behavior Event had been Invalidated by the DNS on 5/5/23 at 12:33 p.m. The Invalidation Note indicated it was not a new or worsening behavior and that the resident was care planned for these outbursts. During an interview on 5/10/23 at 8:57 a.m., LPN (Licensed Practical Nurse) 3 indicated she had come in and given a statement about an incident that happened during the night shift on Wednesday of last week. LPN 3 had heard yelling coming from a room down the hallway. LPN 3 went to investigate and witnessed CNA (Certified Nursing Assistant) 4 and Resident 17 "going back and forth" with each other. Resident 17 was calling CNA 4 a "b**** " and CNA 4 had called Resident 17 a "crippled m****** f*****". LPN 3 had intervened and calmed CNA 4 and Resident 17 down. Then CNA 5 came up the hallway and started yelling that CNA 4 was her daughter. LPN 3 reported the incident to the DNS (Director of Nursing Services) and the ED (Executive Director) on the morning of 5/4/23. The incident happened around 5:00 a.m., and LPN 3 had reported the incident about 7:30 or 8:00 a.m. She had reached out to the DNS for clarification about the incident.		6/1/23. · All staff to be in-service on abuse policy per Senior Executive Director by 6/2/23. See attachment AA What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · Senior executive Director to in-service DNS on abuse policy by 6/2/23 · All staff to be in-service on abuse policy per Senior executive Director by 6/2/23. See attachment AA · IDT will review behavior events daily and complete resident interview prior to invalidating, if behavior communication is indicated IDT to complete and educate staff as indicated. · Assigned Care Companions will check with assigned residents daily to ensure no concerns. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Abuse 600 (see attachment F) will be	

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	She had left a message for the ED. She had given her written statement to the DNS. During an interview on 5/10/23 at 9:11 a.m., Resident 17 indicated there was a young lady who was mean to him last week. The young lady was always grouchy and would throw his things. She had said all kinds of mean things to him last week, but he couldn't remember exactly what had been said. During an interview on 5/10/23 at 9:20 a.m., the RNC (Regional Nurse Consultant) indicated there had been no reportable incidents submitted in the last week which involved Resident 17. On 5/10/23 at 9:50 a.m., the ED, DNS, Float DNS, Float ED, and RNC were interviewed, and all indicated they had no knowledge of CNA 4 cursing at or calling Resident 17 names. The ED indicated he knew about an interaction between two employees, CNA 4 and CNA 5 being in an argument in the hallway. The DNS indicated she had received a call from LPN 3 on that morning, but it was about CNA 4 and CNA 5 screaming at each other while CNA 4 was providing care to Resident 17's roommate. The Float ED indicated he had been informed of an incident of 2 staff members using foul language in the hallway during the morning meeting on 5/4/23. The ED, DNS, Float ED, and RNC indicated they did not have a written statement from LPN 3 about CNA 4 cursing at Resident 17, and that if the Resident 17 had been cursed at and called names by CNA 4, it would have been verbal abuse. During an interview on 5/10/23 at 1:52 p.m., LPN 8 indicated she had worked at the facility on the night shift that started on 5/3/23 and ended the morning on 5/4/23. LPN 8 had been in orientation		completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; 6/2/23	

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	with LPN 3. LPN 8 was sitting at the nurses' station with LPN 3 when they heard yelling and went to investigate. When LPN 8 got to the room she witnessed CNA 4 and Resident 17 "going back and forth" with each other. Resident 17 had called CNA 3 a "b****" and wanted some ice and CNA 4 had called Resident 17 a "b****" and told him to get up and get the ice himself. CNA 4 had been providing care for Resident 17's roommate and yelling back and forth with Resident 17 while doing the care. LPN 3 had " broken them up" and gotten Resident 17 some ice. Resident 17 had calmed down. LPN 8 did not recall another staff member coming to the room and yelling. LPN 8 and LPN 3 had returned to the nurses' station. Immediately upon returning to the nurses' station, LPN 3 indicated she was going to let the DNS know about what had happened. LPN 8 had watched LPN 3 text someone. LPN 8 did not see the text message but assumed LPN 3 was reporting the "verbal abuse". CNA 4 had not been removed from the facility. LPN 8 was unsure of exactly what time the incident had occurred, but knew it was not at the end of the shift. At around 6:00 a.m., CNA 4 came to the nurses' station and informed LPN 3 that she was leaving for the day. During an interview on 5/10/23 at 3:50 p.m., the DNS indicated the Behavior Event had been invalidated because there was already a care plan for Resident 17's behaviors with the staff. A behavior communication note should have been completed. The DNS had educated LPN 3 about the behavior communication note last weekend. On 5/4/23 at 2:15 p.m., the Float ED provided the Abuse Prohibition, Reporting, and Investigation policy, last revised January 2023, which read "...It is the policy of ...to provide each resident with an environment that is free from abuse...Definitions/			

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	Examples of Abuse... Verbal Abuse- the use of oral, written, and/ or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability...Prevention ...Supervisory personnel are responsible to monitor, through observation and counseling as needed, staff/ resident interactions, and the provision of care and services to residents ...Investigation ... The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director Of Nursing Services ...Resident Abuse- Staff member, volunteer, or visitor ...Any individual who witnesses abuse, or has suspicions of abuse, shall immediately notify the charge nurse of the unit, which the resident resides and to the Executive Director ...Any Staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed ... The Executive Director and/ or Director of nursing will be immediately notified of the report and the initiation of the investigation ...An incident report will be initiated within 2 hours of the allegation ... The investigation will include: Facts and observations by involved employees. Facts and observations by witnessing employees. Facts and observations by witnessing non-employees. Facts and observations by other employees who work with the alleged staff member ..." This Federal tag relates to Complaint IN00402254. 3.1-27(b)			

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to assure timely reporting of witnessed verbal abuse of a resident for 1 of 4 residents reviewed for abuse (Resident 17). Findings include:	F 0609	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident 17 has been followed by Social Service Director with no psychosocial distress	06/02/2023

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	1. The clinical record for Resident 17 was reviewed on 5/10/23 at 8:57 a.m. The Resident's diagnosis included, but were not limited to, rheumatoid arthritis and diabetes. An Annual MDS (Minimum Data Set) Assessment, completed 4/18/23, indicated Resident 17 was cognitively intact. A Behavior Event, dated 5/4/23 at 6:45 a.m. by LPN 3, indicated that Resident 17 was observed to be screaming with aide. The Behavior Event had been Invalidated by the DNS on 5/5/23 at 12:33 p.m. The Invalidation Note indicated it was not a new or worsening behavior and that the resident was care planned for these outbursts. During an interview on 5/10/23 at 8:57 a.m., LPN (Licensed Practical Nurse) 3 indicated she had come in and given a statement about an incident that happened during the night shift on Wednesday of last week. LPN 3 had heard yelling coming from a room down the hallway. LPN 3 went to investigate and witnessed CNA (Certified Nursing Assistant) 4 and Resident 17 "going back and forth" with each other. Resident 17 was calling CNA 4 a "b**** " and CNA 4 had called Resident 17 a "crippled m****** f*****". LPN 3 had intervened and calmed CNA 4 and Resident 17 down. Then CNA 5 came up the hallway and started yelling that CNA 4 was her daughter. LPN 3 reported the incident to the DNS (Director of Nursing Services) and the ED (Executive Director) on the morning of 5/4/23. The incident happened around 5:00 a.m., and LPN 3 had reported the incident about 7:30 or 8:00 a.m. She had reached out to the DNS for clarification about the incident. She had left a message for the ED. She had given her written statement to the DNS.		noted and participating in activities per baseline. · CNA 4 no longer works at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents have the potential to be affected by the alleged deficient practice. · Senior executive Director to in-service DNS on abuse policy by 6/2/23 related to timely reporting. See attachment AA · All staff to be in-service on abuse policy per Senior Executive Director by 6/2/23. See attachment AA What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · Senior Executive Director to in-service /DNS on abuse policy by 6/2/23 related to timely reporting. See Attachment AA · All staff to be in-service on abuse policy per Senior Executive Director by 6/2/23. See attachment AA How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;	

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	During an interview on 5/10/23 at 9:11 a.m., Resident 17 indicated there was a young lady who was mean to him last week. The young lady was always grouchy and would throw his things. She had said all kinds of mean things to him last week, but he couldn't remember exactly what had been said. During an interview on 5/10/23 at 9:20 a.m., the RNC (Regional Nurse Consultant) indicated there had been no reportable incidents submitted in the last week which involved Resident 17. On 5/10/23 at 9:50 a.m., the ED, DNS, Float DNS, Float ED, and RNC were interviewed, and all indicated they had no knowledge of CNA 4 cursing at or calling Resident 17 names. The ED indicated he knew about an interaction between two employees, CNA 4 and CNA 5 being in an argument in the hallway. The DNS indicated she had received a call from LPN 3 on that morning, but it was about CNA 4 and CNA 5 screaming at each other while CNA 4 was providing care to Resident 17's roommate. The Float ED indicated he had been informed of an incident of 2 staff members using foul language in the hallway during the morning meeting on 5/4/23. The ED, DNS, Float ED, and RNC indicated they did not have a written statement from LPN 3 about CNA 4 cursing at Resident 17, and that if the Resident 17 had been cursed at and called names by CNA 4, it would have been verbal abuse. During an interview on 5/10/23 at 1:52 p.m., LPN 8 indicated she had worked at the facility on the night shift that started on 5/3/23 and ended the morning on 5/4/23. LPN 8 had been in orientation with LPN 3. LPN 8 was sitting at the nurses' station with LPN 3 when they heard yelling and		· Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as abuse 610 (see attachment G)will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; 6/2/23	

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	went to investigate. When LPN 8 got to the room she witnessed CNA 4 and Resident 17 "going back and forth" with each other. Resident 17 had called CNA 3 a "b****" and wanted some ice and CNA 4 had called Resident 17 a "b****" and told him to get up and get the ice himself. CNA 4 had been providing care for Resident 17's roommate and yelling back and forth with Resident 17 while doing the care. LPN 3 had " broken them up" and gotten Resident 17 some ice. Resident 17 had calmed down. LPN 8 did not recall another staff member coming to the room and yelling. LPN 8 and LPN 3 had returned to the nurses' station. Immediately upon returning to the nurses' station, LPN 3 indicated she was going to let the DNS know about what had happened. LPN 8 had watched LPN 3 text someone. LPN 8 did not see the text message but assumed LPN 3 was reporting the "verbal abuse". CNA 4 had not been removed from the facility. LPN 8 was unsure of exactly what time the incident had occurred, but knew it was not at the end of the shift. At around 6:00 a.m., CNA 4 came to the nurses' station and informed LPN 3 that she was leaving for the day. During an interview on 5/10/23 at 3:50 p.m., the DNS indicated the Behavior Event had been invalidated because there was already a care plan for Resident 17's behaviors with the staff. A behavior communication note should have been completed. The DNS had educated LPN 3 about the behavior communication note last weekend. On 5/11/23 at 9:55 a.m., the Float ED provided an incident reported to Indiana Department of Health which indicated the incident date and time was 5/10/23 at 9:50 a.m. Resident 17 had indicated that CNA 4 was always saying mean things to him and that she always throws things. It was reported by a nurse that the staff member was arguing in the			

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	room with a resident and using foul language. During an interview on 5/11/23 at 10:00 a.m., the Float ED and RVPO (Regional Vice President of Operations) indicated the actual date and time of the incident should have been 5/4/23 and the incident report would be amended with the correct date. On 5/4/23 at 2:15 p.m., the Float ED provided the Abuse Prohibition, Reporting, and Investigation policy, last revised January 2023, which read "...It is the policy of ...to provide each resident with an environment that is free from abuse...Definitions/ Examples of Abuse... Verbal Abuse- the use of oral, written, and/ or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability...Prevention ...Supervisory personnel are responsible to monitor, through observation and counseling as needed, staff/ resident interactions, and the provision of care and services to residents ...Investigation ... The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director Of Nursing Services ...Resident Abuse- Staff member, volunteer, or visitor ...Any individual who witnesses abuse, or has suspicions of abuse, shall immediately notify the charge nurse of the unit, which the resident resides and to the Executive Director ...Any Staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed ... The Executive			

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	Director and/ or Director of nursing will be immediately notified of the report and the initiation of the investigation ...An incident report will be initiated within 2 hours of the allegation ... The investigation will include: Facts and observations by involved employees. Facts and observations by witnessing employees. Facts and observations by witnessing non-employees. Facts and observations by other employees who work with the alleged staff member ..." This Federal tag relates to Complaint IN00402254. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to identify an alleged perpetrator of an abuse allegation to protect residents during the	F 0610	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	06/02/2023

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	investigation; to interview other staff members as part of the investigation; to ensure that a resident was protected against further potential abuse or mistreatment during the investigation of verbal abuse; and that an allegation of verbal abuse was thoroughly investigated for 3 of 4 resident's reviewed for abuse (Residents 17, 35, and Anonymous Resident) Findings include: 1. The clinical record for Resident 35 was reviewed on 5/4/23 at 12:50 a.m. Her diagnoses included, but were not limited to: dementia, anxiety, and Parkinson's disease. The 2/4/23 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. An interview was conducted with Resident 35 on 5/4/23 at 12:55 p.m. She indicated there were 2 staff members with the same first name that worked at the facility. One was a CNA (Certified Nursing Assistant) and the other one sat behind the desk. She was verbally abused by the one who sat behind the desk. She told her to shut up "all the time," as recently as yesterday. The above allegation was reported to the FED (Float Executive Director) immediately after the interview. On 5/5/23 at 1:34 p.m., the ED (Executive Director) provided a copy of the 5/4/23 incident report for Resident 35's allegation of verbal abuse. The report indicated CNA 21 was suspended pending investigation. CNA 21 was not the staff member Resident 35 indicated as having verbally abused		· Resident 35 and 17 have been followed by Social Service Director with no psychosocial distress noted and participating in activities per baseline. · CNA 4 no longer works at the facility. · CNA 5 no longer works at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents have the potential to be affected by the alleged deficient practice. · Senior Executive Director to in-service DNS on abuse policy by 6/2/23 related to thoroughly identifying the alleged and thoroughly investigating all allegations of abuse. See attachment AA · All staff to be in-service on abuse policy per Senior Executive Director by 6/2/23. See attachment AA What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · Senior Executive Director to in-service DNS on abuse policy by 6/2/23 related to thoroughly identifying the alleged and thoroughly investigating all allegations of abuse.	

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	her. CNA 21 was the staff member with the same first name as the staff member Resident 35 indicated as having verbally abused her. The report indicated resident and staff interviews were to be conducted. An interview was conducted with the ED on 5/5/23 at 1:34 p.m. He indicated he spoke with Resident 35 this morning. CNA 21 was suspended as a result of Resident 35's allegation of verbal abuse. The ED was going to look into whether or not there was another staff member with the same first name as CNA 21. An interview was conducted with the FED on 5/5/23 at 1:55 p.m. He indicated he was unsure if there were 2 staff members with the same first name as the one Resident 35 alleged in her allegation of verbal abuse. He was unsure who interviewed Resident 35 about her allegation. CNA 21 was assigned to care for Resident 35 the day prior to her allegation, so that was why she was suspended pending investigation. An interview was conducted with the ED on 5/5/23 at 3:50 p.m. He indicated he was uncertain who actually interviewed Resident 35 about her allegation of verbal abuse, but would find out. There was not another staff member with the same first name as CNA 21. An interview was conducted in person at the facility with CNA 21, who was currently working, on 5/10/23 at 2:38 p.m. She indicated she'd worked at the facility as a CNA for 2 years. She was suspended on 5/4/23 while working. She was in the dining room, serving lunch, when she was pulled and informed by the DNS (Director of Nursing Services) and the RNC (Regional Nurse Consultant)		· All staff to be in-service on abuse policy per Senior Executive Director by 6/2/23. · All abuse investigations will be reviewed Regional Social Enrichment Consultant x 6 months to ensure a thorough investigation is completed per policy How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as abuse 610 (see attachment H) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; 6/2/23	

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	that a resident made an allegation of verbal abuse against her. She'd been a CNA for 30 years and had never had "anything on my license." CNA 21 was "shocked and hurt" at the allegation, as she had a good rapport with Resident 35. She tried to go above and beyond to make Resident 35 happy. CNA 21 would let Resident 35 use her personal cell phone to talk to her sister. She "would never" tell Resident 35 to shut up. There was an agency staff member with the same first name as hers, who regularly worked at the facility as a nurse. The progress notes from Resident 35's electronic health record included 52 nurse's notes written by LPN 24, who shared the same first name as CNA 21. The notes were dated between 2/1/23 and 5/4/23 when Resident 35 made the allegation of verbal abuse. An interview was conducted with LPN 24 via telephone on 5/11/23 at 10:14 a.m. She indicated she worked on and off at the facility in the float pool as needed. She last worked at the facility on 4/30/23, and she'd been there a lot starting in November or December, 2022. While working at the facility, she cared for Resident 35 regularly. Resident 35 would "call the desk a lot," question her medications or start yelling. She tried to help her as much as she could. If you talked to her, she would calm down. She'd never been frustrated with Resident 35 and never told her to shut-up. Prior to this interview, no one from the facility had called her, asked her for a statement, questioned her about any residents, or notified her not to come into the facility. An interview was conducted with the FED, ED, and RVPO (Regional Vice President of Operations) on 5/10/23 at 3:06 p.m. The RVPO indicated the facility had their own float staffing pool. The FED			

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	indicated it was possible there was another staff member who worked at the facility with the same first name as CNA 21. The ED indicated CNA 21 worked at the facility all the time and took care of Resident 35, so "nothing triggered" as far as suspending LPN 24 pending Resident 35's allegation of verbal abuse. An interview was conducted with the ED on 5/11/23 at 9:48 a.m. He indicated the investigation into Resident 35's allegation of verbal abuse was completed and let CNA 21 come back to work after its' completion. He interviewed Resident 35 about her allegation on 5/4/23 and would look for documentation of the interview. Resident 35 informed him during the interview that someone with the same first name as CNA 21 and LPN 24 told her to shut up and was "pretty sure she said [first name of CNA 21 and LPN 24] behind the desk." He was unsure if anyone assessed Resident 35 for harm. No one informed LPN 24 or her agency that LPN 24 was suspended pending investigation. They would normally call and suspend an alleged perpetrator, but due to the confusion with the 2 staff members with the same first name, they didn't suspend LPN 24. He also may not have interviewed any staff members who regularly worked with Resident 35, LPN 24, CNA 21, or any staff at all about Resident 35's allegation of verbal abuse. The ED provided a copy of the investigative file into Resident 35's 5/4/23 allegation of verbal abuse. It did not include interviews with LPN 24, CNA 21, or any other staff member. It included an interview with Resident 35 that read, "Res [Resident] reported info [information] yesterday May 4 2023." The documented interview with Resident 35 did not include any other information.			

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	The file included employee coaching and counseling forms for CNA 21, CNA 5, and CNA 4 and documented interviews with 24 other residents. On 5/11/23 at 11:19 a.m., the ED provided his documented interview with Resident 35. There was no date on the interview. On 5/11/23 at 11:49 a.m., the ED provided the 5/9/23 follow up incident report to the IDOH (Indiana Department of Health.) It read, "Investigation completed. Employee was brought back and received coaching and counseling on customer service." 2. The clinical record for Resident 17 was reviewed on 5/10/23 at 8:57 a.m. The Resident's diagnosis included, but were not limited to, rheumatoid arthritis and diabetes. An Annual MDS (Minimum Data Set) Assessment, completed 4/18/23, indicated Resident 17 was cognitively intact. A Behavior Event, dated 5/4/23 at 6:45 a.m. by LPN 3, indicated that Resident 17 was observed to be screaming with aide. The Behavior Event had been Invalidated by the DNS on 5/5/23 at 12:33 p.m. The Invalidation Note indicated it was not a new or worsening behavior and that the resident was care planned for these outbursts. During an interview on 5/04/23 at 12:11 p.m., the Float ED (Executive Director) indicated he had received a report in morning meeting about an incident between an aide and a resident and it would be reported. During an interview on 5/10/23 at 8:57 a.m., LPN (Licensed Practical Nurse) 3 indicated she had come in and given a statement about an incident			

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	that happened during the night shift on Wednesday of last week. LPN 3 had heard yelling coming from a room down the hallway. LPN 3 went to investigate and witnessed CNA (Certified Nursing Assistant) 4 and Resident 17 "going back and forth" with each other. Resident 17 was calling CNA 4 a "b**** " and CNA 4 had called Resident 17 a "crippled m****** f*****". LPN 3 had intervened and calmed CNA 4 and Resident 17 down. Then CNA 5 came up the hallway and started yelling that CNA 4 was her daughter. LPN 3 reported the incident to the DNS (Director of Nursing Services) and the ED (Executive Director) on the morning of 5/4/23. The incident happened around 5:00 a.m., and LPN 3 had reported the incident about 7:30 or 8:00 a.m. She had left a message for the ED on his phone and had given her written statement to the DNS. During an interview on 5/10/23 at 9:11 a.m., Resident 17 indicated there was a lady who was mean to him last week and had said mean things to him. He could not remember exactly what was said because it had been a few days. During an interview on 5/10/23 at 9:50 a.m., the DNS indicated she had received a call from LPN 3 the morning of 5/4/23. The call had been about two C.N.A.'s "screaming" outside of Resident 17's room. During an interview on 5/10/23 at 9:50 a.m., the Float ED indicated he was made aware of an incident of 2 staff members using foul language in the hallway during the morning meeting on 5/4/23. On 5/10/23 at 10:28 a.m., the DNS provided the timecard for CNA 4 which indicated she had started work at the facility on 5/3/23 at 11:35 p.m. and clocked out from work at the facility at 6:37			

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	a.m. on 5/4/23. On 5/10/23 at 12:24 p.m., the DNS provided a copy of the completed investigation file of the incident of CNA 4 and CNA 5 yelling in the hallway. The investigation file included a statement given to the ED by CNA 5 which indicated CNA 5 stated there were words exchanged between staff but that no words were involving a resident. The investigation file did not contain an Alleged Abuse Interview form for Resident 17. The investigation file did not contain any other staff interviews. During an interview on 5/10/23 at 1:52 p.m., LPN 8 indicated she had worked at the facility on the night shift that started on 5/3/23 and ended the morning on 5/4/23. LPN 8 was sitting at the nurses' station with LPN 3 when they heard yelling and went to investigate. When LPN 8 got to the room she witnessed CNA 4 and Resident 17 "going back and forth" with each other. Resident 17 had called CNA 3 a "b****" and wanted some ice and CNA 4 had called Resident 17 a "b****" and told him to get up and get the ice himself. LPN 8 was unsure of exactly what time the incident had occurred, but knew it was not at the end of the shift. At around 6:00 a.m., CNA 4 came to the nurses' station and informed LPN 3 that she was leaving for the day. LPN 8 had not been questioned about the incident between Resident 17 and CNA 4 by any staff member of the facility. During an interview on 5/10/23 at 3:50 p.m., the DNS indicated the Behavior Event had been invalidated because there was already a care plan for Resident 17's behaviors with the staff. A behavior communication note should have been completed. The DNS had spoken LPN 3 about the behavior communication note last weekend.			

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	3. On 5/5/23 at 1:35 p.m., the ED provided a copy of the incident report about an AR (Anonymous Resident) allegation of abuse submitted to the Indiana Department of Health on 5/4/23. The incident report read "...Brief Description of the Incident...Description added 5/4/23 Resident reported that he/she overhead[sic] a resident yelling out at a staff member. Resident reports that staff member responded, 'you won't talk to me that way.' Resident also reports that interaction took place over several minutes. Reporting resident wished to remain anonymous..." On 5/8/23 at 10:10 a.m., the RVPO provided a copy of the updated incident report submitted to the Indiana Department of Health on 5/5/23 which read "...Follow up added--5/5/23 Clarification of verbiage for resident report: Resident reported being startled by light being turned on the room and stated, 'D***, who turned the light on?" Resident then stated that CNA 5 said, 'You can't cuss at me', then 'went off' on her and was 'yelling at her', which went on for several minutes..." On 5/10/23 at 4:12 p.m., the Float ED provided a copy of the completed investigation file for the AR allegation of verbal abuse. The completed investigation file contained an incident report, dated 5/4/23 at 12:01 p.m. The staff involved was CNA 5. The incident report read "...Brief Description of the Incident...Description added 5/4/23 Resident reported that he/she overhead[sic] a resident yelling out at a staff member. Resident reports that staff member responded, 'you won't talk to me that way.' Resident also reports that interaction took place over several minutes. Reporting resident wished to remain anonymous"...Follow up added--5/5/23 Clarification of verbiage for resident report:			

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	Resident reported being startled by light being turned on the room and stated, 'D***, who turned the light on?" Resident then stated that CNA 5 said, 'You can't cuss at me', then 'went off' on her and was 'yelling at her', which went on for several minutes... Follow up added--5/10/23 Investigation complete. Through investigation it was determined that staff member was arguing with other staff. Investigation revealed that while a staff members was coming out of a resident's room they were right outside of the room where a resident may have overheard an exchange Staff were in serviced on resident rights and professional behavior." The file also included a statement given to the ED by CNA 5 which indicated CNA 5 stated there were words exchanged between staff but that no words were involving a resident, and two Employee Coaching and Counseling form, one signed by CNA 4, and one signed by CNA 5. During an interview on 5/10/23 at 4:20 p.m., the ED indicate that he had believed the AR report of alleged verbal abuse was regarding the same incident as the incident between the 2 staff members yelling in the hallway on 5/4/23. He had not interviewed any other staff who may have been there. He had not spoken with either of the LPN's who had worked the night shift on 5/3/23. The ED was responsible for the abuse investigations at the facility. On 5/4/23 at 2:15 p.m., the Float ED provided the Abuse Prohibition, Reporting, and Investigation policy, last revised January 2023, which read "...It is the policy of ...to provide each resident with an environment that is free from abuse...Definitions/ Examples of Abuse... Verbal Abuse- the use of oral, written, and/ or gestured language that willfully includes disparaging and derogatory			

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	terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability...Prevention ...Supervisory personnel are responsible to monitor, through observation and counseling as needed, staff/ resident interactions, and the provision of care and services to residents ...Investigation ... The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director Of Nursing Services ...Resident Abuse- Staff member, volunteer, or visitor ...Any individual who witnesses abuse, or has suspicions of abuse, shall immediately notify the charge nurse of the unit, which the resident resides and to the Executive Director ...Any Staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed ... The Executive Director and/ or Director of nursing will be immediately notified of the report and the initiation of the investigation ...An incident report will be initiated within 2 hours of the allegation ... The investigation will include: Facts and observations by involved employees. Facts and observations by witnessing employees. Facts and observations by witnessing non-employees. Facts and observations by other employees who work with the alleged staff member ..." This Federal tag relates to Complaint IN00402254. 3.1-28(d)			
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan			

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive			

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	care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for a resident on hospice services to include care and services the facility and hospice will provide for 1 of 1 residents reviewed for hospice (Resident 1); and a resident with risk factors in skin alteration to include individualized interventions for 1 of 1 residents reviewed for skin conditions (Resident 37). Findings include: 1. The clinical record for Resident 1 was reviewed on 5/8/23 at 9:40 a.m. Resident 1's diagnoses included, but not limited to, senile degeneration of the brain, hemiplegia (inability or difficulty moving a side of the body) affecting right side, stage III pressure ulcer to right buttock, non-pressure ulcer to left lower leg with fat layer exposed, and protein-calorie malnutrition. Resident 1's significant change MDS (Minimum Data Set) dated 3/13/23 indicated, Resident 1 had severe cognitive impairment; was totally dependent on the assistance of two persons for transfers, toileting and bathing; required extensive assistance of two persons for bed mobility; and extensive assistance of one person for eating. A physician's order dated 3/8/23 indicated, to call the hospice company for Resident 1 for questions	F 0656	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - resident 37 has an individualized care plan in place to reflect ordered treatments - resident 1 has a plan of care identifying days hospice will provide services and medications. Hospice care plan in place. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents receiving hospice services have the potential to be affected by this alleged deficient practice - audit of residents on hospice completed per Social Services Director by	06/02/2023

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	and/or a change in condition. Resident 1's care plan dated 3/8/23 and last revised on 3/14/23 indicated, Resident 1 required hospice related to senile degeneration of brain. The interventions dated 3/8/23 included, but not limited to, administer pain medication as ordered and to notify hospice of unrelieved or worsening pain; the name and phone number of her hospice; assess for signs of pain, both verbal and non verbal; hospice aide visits: nursing facility will provide scheduled hospice care in the event hospice unable to make visit; hospice licensed nurse visits: nursing facility will provide scheduled hospice care in the event hospice unable to make visit; hospice social worker visits: nursing facility will provide scheduled hospice care in the event hospice unable to make visit; and hospice to provide medication to nursing facility related to hospice diagnosis. The care plan did not indicate how many or which days hospice providers were to visit, what services they were to provide; the specific medications to be provided. An IDT (interdisciplinary team) note in Resident 1's chart indicated, on 5/5/23 at 4:21 p.m. a significant change assessment was added related to Resident 1's weight loss over the last 180 days. The IDT note did not indicate if the hospice had been notified of the significant weight loss. An interview conducted on 5/8/23 at 10:29 a.m. with QMA (Qualified Medication Assistant) 22 indicated, she was unaware of when Resident 1's hospice company was supposed to come in nor what services they provide to her. An interview with Float Social Services conducted on 5/8/23 at 11:54 a.m. indicated, the coordination		6/2/23 to ensure that hospice care plan is present - audit of skin treatments per dns/designee to be completed by 6/2/23 to ensure care plan in place for skin impairment with treatment as ordered - IDT education provided per Regional RAI specialist by 6/2/23 on hospice care plans and skin care plans. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - IDT education provided per Regional RAI specialist by 6/2/23 on hospice care plans and skin care plans. - IDT to review orders daily in clinical meeting with new orders care planned as indicated including hospice How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.	

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	of care between the facility and the hospice providers was usually the social services director with an IDT component. She indicated, the last social services person left at the beginning of April. Since then, the facility has had other social service members assisting but believes the facility liaison for the resident would be nursing staff since their wasn't a permanent replacement as of yet. A review of Resident 1's hospice binder was performed on 5/8/23 at 12:01 p.m. The binder did not contain a hospice care plan. A Hospice policy was received from Regional Vice President of Operations (RVPO) on 5/8/23 at 10:58 a.m. The policy indicated, "It is the policy of this facility that when a resident elects the hospice benefit that the contracted hospice company and facility will coordinate to establish both a person centered plan of care reflecting the physical, spiritual, mental and psychosocial needs of the resident as well as a pattern of communication between the hospice company, healthcare professionals, facility staff and resident/representative...The plan of care will include: a. Resident choices/preferences b. Pain/discomfort management c. Care and services (including medications and supplies) that the facility and hospice will provide in order to be responsive to the resident's needs and desire for hospice care. d. A revision of other care plans to ensure consistency with the hospice care plan of care and individual's needs and preferences... Facility staff will contact the hospice company with any significant change in the resident's condition...The Social Services Director or designee will act as the Hospice Coordinator		· CQI tool identified as Plans of Care (see Attachment I) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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	which will be responsible for the following functions: a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process... b. Communicating with hospice representatives and other healthcare providers... c. Ensuring that the facility communicates with the hospice medical director, the patient's attending physician, and other reactivation...to coordinate the hospice care with the medical care provided by other physicians. d. Obtaining the following information from the hospice: i. The most recent hospice plan of care specific to each patient... vi. Hospice medication information specific to each patient." 2. The clinical record for Resident 37 was reviewed on 5/9/23 at 3:37 p.m. Resident 37's diagnoses included, but not limited to, hemiplegia affecting dominant left side, congestive heart failure, stroke, moderate protein-calorie malnutrition, major depressive disorder, and anxiety. Resident 37's quarterly MDS dated 3/20/23 indicated, he required extensive assistance of two persons for transfers and was totally dependent on one person for bathing. A physician's order dated 1/18/22 indicated, to apply Eucerin cream mixed with Vaseline to face and hands related to dry skin twice a day and as needed. An observation of Resident 37 was conducted on 5/5/23 at 2:35 p.m. Resident 37 was sitting outside in the front courtyard. Resident 37 was scratching			

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his right arm and the skin on his face, head, neck and arms was dry, white, and flaky. When asked if his skin was bothering him, he nodded up and down indicating 'yes'. When asked if he was in pain, he again nodded his head up and down and then began to cry.

Resident 37's care plan was provided by DNS (Director of Nursing) on 5/10/23 at 10:26 a.m. The care plan included, but not limited to, a risk for skin breakdown due to: slightly limited sensory perception, skin occasionally moist, chair fast, very limited mobility, stroke with left sided weakness and history of protein calorie malnutrition. Interventions included, but not limited to house barrier cream at bedside - use as directed. Resident 37's care plan did not address the individualized approach of applying the mixture of Eucerin and Vaseline twice daily to assist in the prevention of skin breakdown nor did it include a care plan related to his excessively dry skin.

An interview with MDSC (Minimum Data Set Coordinator) was conducted on 5/10/23 at 10:31 a.m. MDSC indicated, she had not included in Resident 37's care plan for his risk for impaired skin integrity the intervention of the twice daily use of two different moisturizers (Eucerin and Vaseline, to be mixed together) because she believed since the use of these two moisturizers were marked on the MAR (medication administration record), they did not need to be included in the care plan.

An IDT (Interdisciplinary team) Comprehensive Care Plan policy was received on 5/10/23 at 10:42 a.m. from MDSC. The policy indicated, "It is the policy of the facility that each resident will have a comprehensive person-centered care plan

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	developed based on comprehensive assessment. The care plan will include measurable goals and resident specific intervention based on resident needs and preferences to promote the resident's highest level of functioning...as well as care and services provided to maintain or restore health and well-being, improve functional level or relieve symptoms." This Federal tag relates to Complaint IN00402254 and IN00400685. 3.1-35(b)(1)			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist			

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	the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility to ensure discharge summaries that included recap of resident's stay for 2 of 3 residents reviewed for discharge. (Resident D and Resident 4) Findings include: 1. The clinical record for Resident 4 was reviewed on 5/9/23 at 10:00 a.m. The diagnosis for Resident 4 included, but was not limited to, absence of left knee. A progress note dated 4/11/23 indicated Resident 4 had discharged. A discharge summary dated 4/7/23 indicated the resident went home with daughter. The summary did not include a recap of the resident's stay. An interview was conducted on 5/9/23 at 3:01 p.m. He indicated he was unable to locate a discharge summary for Resident 4 that included a recap of her stay. 2. The clinical record for Resident D was reviewed on 5/8/23 at 1:00 p.m. The diagnosis for Resident D included, but was not limited to, type 2 diabetes mellitus. A progress note dated 3/29/23 indicated Resident D had discharged home and discharge instructions had been explained to the resident	F 0661	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - resident D and resident 4 has been safely discharged from the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents being discharged from the facility have the potential tobe affected by this alleged deficient practice - education provided to all nurses on discharge summary documentation per dns/designee by 6/2/23. See attachment AA What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	06/02/2023

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	and signed. The discharge summary dated 3/29/23 did not include a recap of the resident's stay. An interview was conducted with Regional Nurse Consultant on 5/9/23 at 11:46 a.m. He indicated the discharge summary should have a recap narrative of the resident's stay. Resident's D discharge summary does not include the recap narrative. This Federal tag relates to Complaint IN00402254. 3.1-36(a)(1)		- education provided to all nurses on discharge summary documentation per dns/designee by 6/2/23 (see Attachment AA) - IDT to review all discharge summaries in daily clinical meeting to ensure documentation has been completed - - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Discharge Summary (see Attachment J) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			

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	Based on observation, interview, and record review, the facility failed to provide materials for written communication to 1 of 1 resident reviewed for communication and sensory services. (Resident 23) Findings include: The clinical record for Resident 23 was reviewed on 5/4/23 at 2:30 p.m. His diagnoses included, but were not limited to, aphasia. The 2/28/23 Quarterly MDS (Minimum Data Set) assessment indicated he had a BIMS (brief interview for mental status) score of 15 indicating he was cognitively intact. He had unclear speech; difficulty communicating some words or finishing thoughts; and understood others with clear comprehension. The 6/6/18 care plan, last reviewed/revised 3/12/23, indicated he had difficulty making himself understood related to his speech being garbled and unclear. The goal was for his needs to be met daily. Approaches were to encourage him to use a communication board when expressing himself and to provide materials for written communication to enhance communication. An observation and interview was conducted with Resident 23 in his room on 5/4/23 at 2:58 p.m. He was lying in bed and made a writing motion with his right hand, indicating he wanted to write something down during the interview. There was a permanent red marker and erasable white board on the bedside table next to him. The whiteboard had red permanent markings on it in the middle of the board. There was no eraser material or other writing materials on the table. LPN (Licensed Practical Nurse) 23 was retrieved from the nurses	F 0676	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - resident 23's white communication board has been replaced with writing and erase materials provided and in reach How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - residents requiring the use of a communication board/device have the potential to be affected by this alleged deficient practice - audit of residents requiring the use of a communication board/device completed per dns/designee by 6/2/23 - education provided to all staff per Senior Executive Director by 6/2/23 regarding Communication for residents with Communication deficits. (see Attachment AA) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - education provided to	06/02/2023

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	station to assist. LPN 23 looked through the top drawer of a side table for writing materials, but was unable to locate any, so she left the room to retrieve some. LPN 23 returned with a black erasable marker, handed it to Resident 23 and left the room. Resident 23 used the black erasable marker to begin writing on the whiteboard to the left of the red permanent markings that were already on the board. An observation and interview with Resident 23 was made in his room on 5/8/23 at 11:39 a.m. He was sitting in a Broda chair in his room. His bedside table was in front of him with a black erasable marker and 2 erasable whiteboards on it. One of the whiteboards was completely covered with red permanent markings. The other board was the same board he used during the 5/4/23, 2:58 p.m. observation that had red permanent markings in the middle of the board. There was no eraser material or other writing material on his bedside table. Resident 23 indicated the whiteboards and other writing materials were not always available for use. An interview and observation was made with Resident 23 on 5/8/23 at 2:08 p.m. He was sitting in his Broda chair in his room. His bedside table was in front of him with the same black erasable marker and 2 erasable whiteboards with red permanent markings. There was no eraser material or other writing materials on his bedside table. Resident 23 smiled and indicated he wanted a new erasable whiteboard with no markings on it and an eraser. He pointed to the paper towel dispenser on the wall that was out of reach to him and indicated staff used paper towel to erase his board, but did not provide paper towel within reach for him to use. There was no paper towel on his bedside table.		all staff per Senior Executive Director by 6/2/23 regarding Communication for residents with Communication deficits (see Attachment AA) - assign customer service care companion to check daily that communication supplies are in working order and in reach of the resident - resident profile to be updated to include resident communication supplies are present and in working order and within reach of resident How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Communication (see Attachment) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	An observation of Resident 23 was made with the FSS (Float Social Services) on 5/8/23 at 2:14 p.m. Resident 23 informed the FSS he wanted a new/different whiteboard and an eraser. The Communication Barriers/Interpreter Services policy was provided by the FSS on 5/8/23 at 3:05 p.m. It read, "It is the policy of [name of facility] to assist residents in facilitating communication for those with communication barriers. Procedure: 1. Resident's communication, including language and comprehension abilities, will be assessed upon admission. 2. ...These methods will be added to the plan of care; and may include methods such as communication books/boards..." 3.1-38(a)(2)(E)		By what date the systemic changes will be completed; · Completion date: 6/2/23	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to routinely obtain pulse and to hold a medication when pulse was below 65, as ordered by the physician; to follow up on an Optometrist's recommendation timely; and complete a post fall assessment and review for 1 of 1 resident reviewed for accidents, 1 of 1 resident reviewed for vision, and 1 of 5 residents	F 0684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - resident 30 is receiving assessment and medication as ordered -	06/02/2023

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	reviewed for unnecessary medications (Residents 30, 35, and 37). Findings include: 1. The clinical record for Resident 30 was reviewed on 5/5/23 at 11:18 a.m. The Resident's diagnosis included, but was not limited to, hypertension and moderate protein- calorie malnutrition. A care plan, initiated 10/27/22, indicated he was at risk for ineffective tissue perfusion related to his hypertension. The goal was for him to maintain adequate tissue perfusion as evidenced by blood pressure within normal limits for resident. The interventions that were initiated 10/27/22 included, but were not limited to, administer medications as ordered and monitor vital signs. A physician's order, dated 2/1/23, indicated he was to receive metoprolol succinate (heart medication) extended released tablet 25 mg (milligram) twice a day and to hold the medication if his systolic blood pressure was less than 110 or his heart rate was less than 65. The April and May 2023 MAR (Medication Administration Record) were reviewed, and no pulse rates were documented as obtained prior to giving the metoprolol. The April and May vital signs report indicated that Resident 30's heart rate was documents as below 65 on the following days: 4/15, 4/16, 4/18, 4/21, 4/29, 4/30, and 5/3/23. The metoprolol had not been held on any of those dates. During an interview on 5/8/23 at 3:50 p.m., the RNC (Regional Nurse Consultant) indicated the		resident 37 optometry recommendations are completed - resident 35 fall has been reviewed per IDT How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents have the potential to be affected by this alleged deficient practice - audit completed by dns/designee by 6/2/23 to identify residents with medication parameters, falls in last 90 days and residents with ancillary recommendations in the past 90 days to ensure that follow up was completed. - education provided per dns/designee by 6/2/23 on administering medications as ordered, documenting pulse, ancillary recommendations and fall management policy. (see Attachment AA) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	

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COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

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	Resident 30's heart rate should have been obtained prior to each administration of the metoprolol and that the medication should have been held for a heart rate less than 65. 2. The clinical record for Resident 37 was reviewed on 5/9/23 at 3:37 p.m. Resident 37's diagnoses included, but not limited to, hemiplegia affecting dominant left side, congestive heart failure, stroke, moderate protein-calorie malnutrition, major depressive disorder, and anxiety. A copy of Resident 37's Optometrist's report dated 1/13/23 indicated, the plan included, but not limited to, consult with primary care physician regarding surgical recommendation, recommend social services consult with family regarding need for cataract surgery, follow up in 4 to 5 months, referral for Ophthalmology consult, and a new medication order for artificial tears gel to be applied in both eyes at bedtime. A Social Services note dated 2/6/2023 at 10:39 a.m. indicated, "Resident was seen by the eye doctor on 1/13/23. Recommendations: Artificial tears Gel, apply one drop in both eyes at bedtime. A referral was made for Ophthalmology for cataract surgery". Since that time, no social services notes indicated, Resident 37's family/representative had been made aware of the recommendation for cataract surgery, the referral to Ophthalmology nor was the order for artificial tear drops placed in his orders. An interview with Float Social Services conducted on 5/10/23 at 11:44 a.m. indicated, she was unaware if Resident 37's referral, recommendation for surgery, or the new medication order had been followed- up on. She indicated, the previous Social Services person was still at the facility at		- education provided per dns/designee by 6/2/23 on administering medications as orderd, documenting pulse, ancillary recommendations and fall management policy (see Attachment AA) - IDT to review EMAR documentation daily in clinical meeting to ensure no omissions of pulse/bp per orders - Social Services to follow up with ancillary providers post resident appointments and bring recommendations forward to the IDT team in clinical meeting to be properly addressed. - IDT to review all falls on the next business day to ensure root cause determination, preventative interventions are implemented, care plans updated and physician orders are followed How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held	

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	that time and would need to look into it. A Float Social Services note dated 5/10/2023 at 1:32 p.m. indicated, the writer spoke with Resident 37's daughter on that date regarding eye doctor's recommendation for cataract surgery. The daughter of Resident 37 stated that her dad had one cataract surgery and that she had wanted him to wait to have the other eye surgery performed however, now she was interested in the referral being made. An interview with Float social Services conducted on 5/10/23 at 3:28 p.m. indicated, the referral to Ophthalmology should have been followed up on sooner. An interview with RNC (Regional Nurse Consultant) conducted on 5/11/23 at 11:27 a.m. indicated, Resident 37's new artificial tears medication order had not been addressed as of yet. RNC indicated, usually when a resident uses ancillary services they return with the report in hand however, if they do not come back to the facility with any paperwork from the appointment, the process should entail the social worker to forward onto nursing any new orders from the ancillary services.3. The clinical record for Resident 35 was reviewed on 5/4/23 at 12:50 a.m. Her diagnoses included, but were not limited to: dementia, anxiety, and Parkinson's disease. The 2/4/23 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. The 4/18/23 Annual MDS assessment indicated she required extensive assistance of 2 persons for bed mobility and transfers and extensive		monthly, and is overseen by the Executive Director. · CQI tool identified as Quality of Care (see Attachment L) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 6/2/23	

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	assistance of 1 person for dressing. The ADL care plan, last reviewed/revised 5/2/23, indicated she required assistance with ADLs including bed mobility, transfers, eating and toileting. Approaches were to provide care in pairs, starting 7/28/23; to assist with bed mobility as needed; to assist with dressing/grooming/hygiene as needed; and to assist with transfers as needed. The fall care plan, last reviewed/revised 5/2/23, indicated she was at risk for falls due to Parkinson's disease, debility, hypertension, a history of falls, arthritis, cognition, neuropathy, age, incontinence, medications, requiring assistance for mobility, and altered awareness of immediate physical environment. The goal was for fall risk factors to be reduced in an attempt to avoid significant fall related injury. An interview was conducted with Resident 35 on 5/4/23 at 12:55 p.m. She indicated CNA 21 left her on the edge of her bed and she fell yesterday. An interview as conducted with CNA 21 on 5/10/23 at 2:38 p.m. She indicated she'd worked at the facility for 2 years as a CNA. Resident 35 required a lot of assistance with ADLs. She was recently taken off of her Parkinson's medications. She required only one person to assist her with dressing, but 2 people to assist her with getting up. When she assisted Resident 35 with dressing, Resident 35 was usually sitting on the edge of her bed with her feet on the floor while CNA 21 dressed her and put her bra on. Resident 35 had fallen before. Last week, CNA 21 left the room to get a nurse and Resident 35 fell while she was gone. CNA 21 left Resident 35 sitting up on the edge of the bed with her feet on the ground. CNA			

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	21 left the room to get another staff member to help her transfer Resident 21 into her chair. "I was gone 2 seconds to get the nurse." When CNA 21 returned, Resident 35 was on the floor by the side of her bed. Resident 35 was not hollering out afterwards and didn't complaint of any pain, but had a "scratched up knee." Three staff members, CNA 21 included, along with QMA (Qualified Medication Aide) 22, and the FDNS (Float Director of Nursing Services,) assisted her off the floor and into her chair. CNA 21 did not recall exactly what day the fall occurred, but "definitely last week." Resident 35's clinical record did not indicate she had a fall the previous week. There was no fall event, fall assessment, IDT (Interdisciplinary Team) note, or progress note referencing a fall the previous week. An interview was conducted with the FDNS on 5/10/23 at 3:42 p.m. She indicated CNA 21 came and got her one day last week and informed her she needed help getting Resident 35 off the floor. She went into Resident 35's room where she saw Resident 35 on the floor. She did not have any injuries or any complaints of pain. A QMA was already present in the room doing vitals. A charge nurse was also present, but she was unsure who it was. There should be a post fall assessment in Resident 35's clinical record. She didn't do one herself, because the other nursing staff handled it, but she did not follow up to make sure. Resident 35 was able to bend and sit up afterwards and did not have any skin tears or any other apparent injury. The 5/10/23 event from the clinical record read, "Obtain x-ray of lumbar and right knee (pain lower pain and pain/swelling knee). Diclofenac Gel 1% 2			

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	gm right knee QID [4 times daily....]Resident seen by MD. New orders received: Obtain x-ray of lumbar and right knee...Pharmacy and Mobilex made aware." The 5/11/23, 2:17 a.m. nurse's note read, "resident had complaints of pain and resident stated " NURSE NURSE NURSE" very loudly for duration of shift disturbing other residents during night hours. resident requested Tylenol and voltaren cream to be rubbed on her this writer fulfilled tasks resident stated "your doing it wrong put more on now" no new orders at this time call light within reach." An interview was conducted with the RNC (Regional Nurse Consultant) on 5/11/23 at 10:05 a.m. He indicated Resident 35 did not have a post fall assessment or an IDT review of the fall or any verification of physician notification. He indicated there was currently an order for an x-ray, but their radiology provider wouldn't do it STAT [immediately] and hadn't come in yet. They offered to send Resident 35 out for the x-ray, but she declined. The 5/11/23, 8:47 a.m. nurse's note read, "Spoke with resident as the X-ray tech [technician] had to reschedule the imaging and offered to send the resident to the Hospital for immediate imaging and the resident declined saying " No they are coming I want it done here". Will cont [continue] to follow up." The Fall Management policy was provided by the RNC on 5/11/23 at 9:07 a.m. It read, "It is the policy of [name of facility] to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls....Post fall...3. The physician will be			

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	contacted immediately, if there are injuries, and orders will be obtained. If there are no injuries, notify the physician during normal business hours. 4. The family will be notified immediately by the charge nurse of falls with injury. If there are no injuries, notify the family during day or evening hours (if a fall occurred during the middle of the night, wait until morning) 5. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be competed in full in order to identify possible root causes of the fall and provide immediate interventions. 6. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls. The fall event will be reviewed by the team. IDT note will be written. The care plan will be reviewed and updated, as necessary. Hot Charting will be initiated post fall." This Federal tag relates to Complaints IN00402254 and IN00399680. 3.1-37(b)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the			

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	resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to timely address dietary recommendations for a resident with weight loss for 1 of 2 residents reviewed for nutrition (Resident 30). Findings include: The clinical record for Resident 30 was reviewed on 5/5/23 at 11:18 a.m. The Resident's diagnosis included, but was not limited to, hypertension and moderate protein- calorie malnutrition. A Significant Change of Status MDS (Minimum Data Set) Assessment, completed 12/11/22, indicated Resident 30 had severe cognitive impairment. An IDT (Interdisciplinary Team) Progress note, dated 3/15/23, indicated he was being reviewed for weight loss. His weight was down 11 pounds in 1 week. The recommendation was to start Ensure Plus (dietary supplement) 240 ml (milliliter) daily. The clinical record did not contain a physician's order to start Ensure Plus. A Significant Change of Status MDS Assessment, completed 3/22/23, indicated he had severe	F 0692	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - resident 30's Dietary Recommendations are in place How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents with Dietary Recommendations have the potential to be affected by this alleged deficient practice - audit completed by dns/designee by 6/2/23 to ensure that all Dietary Recommendations are in place - education provided by Senior Executive Director by 6/2/23 on weight management policy (see Attachment AA)	06/02/2023

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	cognitive impairment. He needed supervision of 1 staff member for eating, and he had experienced a significant weight loss. His weight was 194 pounds. An IDT progress note, dated 4/10/23, indicated Resident 30's weight was 192 pounds. The new recommendation was to ensure the previous recommendation for Ensure Plus 240 ml was initiated to add calories and protein. A physician's order, dated 4/11/23, indicated to give 237 ml of Ensure Plus daily. A care plan, last updated 4/23/23, indicated he was at risk for altered nutritional status and had a significant weight loss in 30 days. The goal was for him to regain weight back to his desired weight range of 205 pounds + or - 5 pounds. The interventions included, but were not limited to, administer supplements as ordered, initiated 3/15/23. During an interview on 5/9/23 at 3:30 p.m., the DNS (Director of Nursing Services) indicated the nutritional supplement should have been implemented after it was recommended in March 2023. On 5/9/23 at 10:33 a.m., the Regional Vice President of Operations provided the Resident Weight Monitoring policy, last revised 12/2022, which read "...Any significant unexplained weight loss is considered a change in condition and must be addressed by the Interdisciplinary Care Plan Team..." 3.1-46(a)(1)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - education provided by Senior Executive Director by 6/2/23 on weight management policy (see Attachment AA) - assigned IDT to complete dietary recommendations within 3 business days post receiving said recommendations - dietary recommendations to be checked and reviewed weekly in NAR (Nutritionally at Risk) weekly meeting. To ensure residents are receiving supplements as prescribed How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Nutrition (see Attachment M) will	

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			be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	
F 0697 SS=E Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to timely address residents' pain; assess residents' pain that included effectiveness of as needed pain medications; and ensure nonpharmacological interventions were provided to address a residents pain for 1 of 2 residents reviewed for pain, 1 of 1 resident reviewed for rehabilitation and restorative services, and 1 of 1 residents reviewed for hospice per facility policy. (Residents D, F, 1, and 37) Findings include: 1. The clinical record for Resident F was reviewed on 5/8/23 at 11:46 a.m. Her diagnoses included, but were not limited to: coronary artery disease, congestive heart failure, and chronic kidney disease. She was admitted to the facility on 12/19/22 and discharged to the hospital on	F 0697	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; residents F,D,1 and 37 have had pain assessments completed including location of pain, intensity of pain and effectiveness of pain medications. Care plans have been updated with non pharmacological interventions How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be	06/02/2023

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	1/20/23. The 12/28/22 pain care plan indicated she was at risk for pain. The goal was for her to be free from adverse effects of pain. Approaches were to administer medications as ordered; assist with positioning to comfort; notify MD if pain is unrelieved and/or worsening; and to offer non-pharmacological interventions such as quiet environment, rest, shower, back rub, and reposition. The physician's orders indicated for her to have PT (physical therapy) treatment 5 times a week for 8 weeks, starting 12/21/22. They indicated "Roxicodone (oxycodone) - Schedule II tablet; 15 mg; amt: 15 mg; oral Special Instructions: Indication: pain Every 4 Hours PRN," effective 12/19/22. There were no other pain medications ordered for her. An interview was conducted with the TD (Therapy Director) on 5/9/23 at 3:16 p.m. She reviewed Resident F's therapy notes and indicated Resident F received all 3 disciplines of therapy while residing at the facility. She was on PT 5 times a week from 12/21/22 to 1/5/23. She started out with the ability to walk 10 feet, then discharged requiring a Hoyer lift. She recalled she was regressing and not doing better. She was complaining of pain in her lower back with a compression fracture in November, 2022. She recalled discussing pain management with physical therapy, but Resident F wasn't really interested in that, such as modalities, different ways to move around the room. The 12/29/22 note referenced education of exercises bedside, but she refused to get out of bed. Resident F was consistently complaining of pain at a level of 8 on a scale of 1 to 10. The pain never changed during		taken; - all residents experiencing pain have the potential to be affected by this alleged deficient practice - audit of pain assessments to be completed by dns/designee by 6/2/23 to identify any residents experiencing pain to ensure concern has been addressed. - education provided to all nurses per dns/designee by 6/2/23 on pain assessments noting location, intensity, documenting effectiveness of pain medications and non pharmacological interventions. (see Attachment AA) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - education provided to all nurses per dns/designee by 6/2/23 on pain assessments noting location, intensity, documenting effectiveness of pain medications and non pharmacological interventions. (see Attachment AA) - IDT to review orders daily and the facility activity report to identify any residents experiencing pain and any new pain medication orders to indicate	

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	her therapy treatment. There was education regarding getting out of bed to decrease pain, but she refused. The 1/2/23 physical therapy note indicated, "Low back pain 9/10 limiting functional mobility task." The 1/3/23 occupational therapy note read, "continued to c/o [complain of] back pain throughout treatment session." The 1/4/23 physical therapy note read, "Low back pain 9/10 limiting all functional mobility tasks. Pt [Patient] unable to sit on the EOB [edge of bed] d/t [due to] c/o low back pain." The 12/21/22, 4:14 p.m. nurse's note indicated she complained of back and stomach pain. The 12/27/22, 2:07 p.m. nurse's note indicated she complained of back, stomach and leg pain. There was no information in the clinical record, including the nurse's notes, medication administration records, and treatment administration records to indicate the facility addressed the above referenced complaints of pain. An interview was conducted with the DNS (Director of Nursing Services) on 5/10/23 at 3:50 p.m. She reviewed Resident F's clinical record and indicated she did not see any other pain medications ordered other than the oxycodone. She was going to look into whether the facility addressed the complaints of pain referenced in the 12/21/22 at 4:14 p.m. nurse's note, 12/27/22 at 2:07 p.m. nurse's note, 1/4/23 physical therapy note, 1/2/23 physical therapy note, and 1/3/23 occupational therapy note and whether anyone		a need for IDT pain assessment and non pharmacological interventions - IDT pain assessments to be completed on all new admissions, quarterly and with any significant change. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Pain Management (see Attachment N)will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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	notified the physician of her unrelieved pain. An interview was conducted with the RNC (Regional Nurse Consultant) on 5/11/23 at 9:42 a.m. He indicated there was no verification of any pain interventions for the above 5 dates.2. The clinical record for Resident D was reviewed on 5/8/23 at 1:00 p.m. The diagnoses for Resident D included, but were not limited to, type 2 diabetes mellitus, cirrhosis, seizures, and ascities. A pain care plan dated 1/11/23 indicated Resident D was at risk for pain. Interventions were the following: "...Observe for adverse side effects of pain medication including, but not limited to over sedation, constipation, skin rash, nausea/vomiting, loss of appetite, change in mental status, stomach upset. Document abnormal findings and notify MD [medical provider], Assist with positioning to comfort,...Document effectiveness of prn [as needed] medications,...Administer meds as ordered,...Observe for non verbal signs of pain: changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture,...Offer nonpharmacological interventions such as quiet environment, rest, shower, back rub, reposition..." A physician order dated 1/11/23 indicated Resident D was to receive 20 milligrams of baclofen three times a day for muscle spasms. A physician order dated 1/11/23 indicated staff was to monitor for effectiveness of routine pain medication every shift and complete pain assessment if not effective. The January 2023 Medication (MAR) indicated			

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	Resident D's pain was controlled with routine pain medication from 1/11/23 through 1/31/23 every shift. A nursing vitals assessment note dated 1/12/23 indicated Resident D was experiencing pain in her lower extremities. The resident's clinical record did not include a pain assessment of the resident's pain on 1/12/23, that included intensity of pain utilizing a pain scale and how the resident's pain was addressed. A nursing progress note dated 1/25/23 "resident crying from pain in bilateral legs/feet stating level of pain 10/10. no prn medication available. On-call services contacted. new order for Biofreeze TID [three times a day] as needed per NP [Nurse Practitioner]. Resident made aware. Thin layer of Biofreeze applied to BLE [bilateral lower extremities] and will continue to monitor effectiveness." A pain assessment was completed on 1/25/23. It indicated the resident had complaints of "excruciating pain in BLE." The medical provider notified an ordered biofreeze three times a day. A physician order dated 1/25/23 indicated Resident D was to receive biofreeze three times a day to lower extremities for pain as needed. The order was discontinued on 2/22/23. The clinical record did not indicate if the biofreeze was effective and/or if nonpharmacological interventions were provided on 1/25/23. A physician order dated 2/1/23 indicated Resident D was to receive lidocaine patches to bilateral extremities daily.			

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A nursing progress note dated 2/17/23 indicated, "Resident complaining of BLE pain, resident crying requesting for pain medication. On call notified new order for Tylenol 650 mg, on call made aware of allergies to percocet and lortab, resident states she has no reaction to Tylenol, on call states cont [continue] with Tylenol."

A physician order 2/17/23 indicated Resident D was to receive 325 milligrams of Tylenol every 6 hours for pain as needed. The order was discontinued on 2/19/23.

A pain assessment dated 2/22/23 indicated Resident D had complaints of pain in bilateral lower extremities.

A physician order dated 2/22/23 indicated Resident D was to receive biofreeze to lower extremities for pain four times a day.

A physician order dated 2/22/23 indicated Resident D was to receive 300 milligrams of neurotin daily.

The February 2023 MAR indicated Resident D's pain was controlled with routine pain medication from 2/1/23 through 2/28/23 every shift.

The resident's clinical record did not include the pain intensity of the resident's pain, if the Tylenol was effective, and/or if nonpharmacological interventions were provided on 2/17/23 and 2/22/23.

A nursing progress note for Resident D dated 3/16/23 indicated "resident had complaints of pain requested pain med when given acetaminophen resident stated " i want a muscle relaxer or pain pill

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	not this " writer educated resident about current orders resident told writer to " get out" no new orders call light within reach." A nursing progress notes for Resident D dated 3/19/23 indicated "resident requested pain pill resident stated " i have a as needed pain pill " writer informed resident that the pill she has that is as needed is for after seizure activity writer offered prn acetaminophen . resident stated " that's not gone do nothin " no new orders call light within reach." The March 2023 MAR indicated Resident D's pain was controlled with routine pain medication 3/1/23 through 3/28/23 every shift. The resident's clinical record did not include a pain assessment that had been conducted on 3/16/23 nor 3/19/23 that included pain intensity, how the resident's pain was addressed and/or if nonpharmacological interventions were provided. An interview was conducted with Regional Nurse Consultant on 5/9/23 at 12:17 p.m. He indicated the staff will assess a resident's pain and document a yes or a no if the resident's pain was controlled with their routine pain medication. If the resident responds with a no the pain medication was not controlling his or her pain then the staff will do a pain assessment. He was unable to provide pain assessments and nonpharmacological interventions provided to Resident D to address her pain.3. The clinical record for Resident 1 was reviewed on 5/8/23 at 9:40 a.m. Resident 1's diagnoses included, but not limited to, senile degeneration of the brain, hemiplegia affecting right side (inability/difficulty with moving a side of the body), protein-calorie malnutrition, convulsions, stage III pressure			

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	wound to right buttock, non-pressure wound to left lower leg with fatty layer exposed, and congestive heart failure. A physician's order indicated, Resident 1 was placed on hospice services on 3/8/23. Resident 1's care plan dated 3/8/23 indicated, she required hospice related to senile degeneration of brain with a goal to experience death with dignity and physical comfort. Interventions included, but not limited to, administer pain medication as ordered and to notify the physician and hospice of unrelieved or worsening pain. Physician's orders dated 3/8/23 indicated, for Resident 1 to receive 30 mg of morphine extended release every 12 hours and receive 10 mg (milligrams) of morphine concentrate every 2 hours as needed for dyspnea (rapid breathing) and anxiety. Resident 1 also had an order for acetaminophen 650 mg every 4 hours as needed for mild pain/fever. A physician's order dated 3/7/23 indicated, to monitor Resident 1 for effectiveness of routine pain medication every shift and indicate yes or no. If, no, complete pain assessment and notify physician and/or hospice. A review of Resident 1's March, April and May 2023 MARs (medication administration record) conducted on 5/8/23 at 10:08 a.m. indicated, Resident 1 did not receive the scheduled 30 mg of morphine as ordered on the following dates and times: April 15th - 8 a.m. dose April 17th - 8 a.m. dose April 24th- 8 a.m. dose April 27th - 8 a.m. dose			

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	May 7th - 8 a.m. dose A hospice nurse's note dated 3/21/23 indicated, Resident 1 reports mild pain and asked QMA (Qualified Medication Assistant) to administer as needed morphine. The review of the March MAR indicated, Resident 1 did not receive the as needed pain medication on 3/21/23. A hospice nurse's note dated 3/31/23 indicated, Resident 1 finally sleepy per QMA. Resident 1 having increased pain. A review of Resident 1's treatment administration record (TAR) for April and May indicated, her routine medication was not effective on the following dates and times: April 1st - day shift; under "yes/no" it indicated, "120" April 17th - evening shift; under "yes/no" it indicated, "120" April 24th - day shift April 25th - evening shift April 26th - day shift April 26th - evening shift May 2nd - day shift A review of Resident 1's April and May 2023 MARs (medication administration record) conducted on 5/8/23 at 10:08 a.m. indicated, she had not received any as needed medications on the days it was documented that her routine medications were not effective. An IDT (Interdisciplinary team) pain interview dated 5/5/23 indicated, Resident 1 had pain and/or was hurting in the last 5 days; frequently experienced pain/hurting over the last 5 days; her pain limited her day-to-day activities; and rated the intensity of her worst pain over the last 5 days			

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	as severe. The clinical record for Resident 1 did not indicate the pain's intensity during any of the medication administrations as per policy. 4. The clinical record for Resident 37 was reviewed on 5/9/23 at 3:37 p.m. Resident 37's diagnoses included, but not limited to, hemiplegia affecting dominant left side, congestive heart failure, stroke, moderate protein-calorie malnutrition, major depressive disorder, and anxiety. A physician's order dated 4/15/22 indicated, for Resident 37 to receive 650 mg of acetaminophen twice a day routinely and as needed for up to 3 times a day for muscle wasting and atrophy. A physician's order dated 3/13/23 indicated, to monitor Resident 37 for effectiveness of routine pain medication every shift and indicate yes or no. If, no, complete pain assessment and notify physician and/or hospice. A review of Resident 37's April and May 2023 TAR indicated, his routine pain medication was not effective on the following dates and times: April 4th - day shift April 17th - night shift April 23rd - night shift; under "yes/no" it indicated, "120" May 2nd - day shift The clinical record for Resident 37 did not indicate the pain's intensity during any of the medication administrations as per policy. A pain management policy was provided by the Regional Vice President Director of Operations on			

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	5/8/23 at 10:58 a.m. It indicated "...Policy: It is the policy of [name of facility] to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management....Residents are assessed for pain upon admission, weekly and during medication administration...The following will be used when assessing pain. * Nursing Admission Observation * Weekly summary * IDT Pain Interview or PAINAD (Pain Assessment in Advanced Dementia Scale) * Ongoing nursing assessments can also be documented in matrix progress notes or matrix vitals... Interviewable Resident - Pain medications will be prescribed and given based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10) or Wong-Baker FACES scale...Non-interviewable Resident- Pain medications will be prescribed and given based upon nursing assessment of the following: * NON-VERBAL SOUNDS... * VOCAL COMPLAINTS OF PAIN... * FACIAL EXPRESSIONS... * PROTECTIVE BODY MOVEMENTS OR POSTURES * WONG-BAKER FACES Scale... Residents receiving routine pain medications should be assessed each shift by the charge nurse during rounds and/or medication pass...Additional information including, but not limited to reasons for administration, and effectiveness of pain medication will be documented on the Electronic Medication Administration Record (EMAR)...The licensed nurse will monitor the efficacy of the analgesia and keep the physician informed of any indicators of drug or dosage change as it relates to the			

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	resident's pain management." This Federal tag relates to Complaint IN00402254 and IN00400685. 3.1-37(a)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, interview, and record review, the facility failed to ensure a resident with PTSD (Post Traumatic Stress Disorder) received appropriated treatment, in coordination with psychiatric services, to mitigate triggers of past trauma for 1 of 1 resident reviewed for mood and behavior (Resident 43). Finding include: The clinical record for Resident 43 was reviewed on 5/4/23 at 11:39 a.m. The Resident's diagnosis included, but were not limited to, severe major depressive disorder without psychotic features, anxiety disorder, panic disorder, and PTSD. An Admission MDS (Minimum Data Set) Assessment, completed 2/18/23, indicated she was cognitively intact. PHQ-9 (Patient Health Questionnaire) score was 17, which indicated moderately severe depression, and she had no	F 0699	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - resident 43 care plan reflects triggers and interventions, interventions have been added to resident profile and staff have been educated regarding triggers and interventions - IDT has consulted PNP (Psyche Nurse Practitioner) to help develop a plan of care including triggers and interventions How other residents having the potential to be affected by the same deficient practice will be	06/02/2023

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	behaviors. A Notice of PASRR (Preadmission Screening and Resident Review) Level II Outcome Notice, dated 2/24/23, indicated Resident 43 needed rehabilitative services, support counseling from nursing facility staff, education regarding medications and side effects, and mental health services to help with symptoms of anxiety and depression. A care plan, initiated 2/27/23, indicated Resident 43 had experienced trauma due to lack of family support and was at risk for experiencing re-traumatization, feeling unsafe/ untrusting, and/or distressed. The goal was to eliminate or mitigate (reduce) triggers that may cause re-traumatization. The approaches, initiated 2/27/23, were to provide behavioral health services through the facility provider, encourage per support and socialization, encourage Resident 43 and her representatives to give input in developing and reviewing the plan of care, ensure she had a sense of emotional and physical safety, establish and encourage open communication between staff and resident. A care plan, initiated 2/27/23, indicated Resident 43 was at risk for signs and symptoms of anxiety such as worried facial expressions, repetitive movements, shortness of breath, nausea, sweating, tremors, irritability, insomnia and reporting anxiety due to her diagnosis of anxiety. The goal was for her to no have increased signs and symptoms of anxiety. The approaches, initiated 2/27/23, were to encourage activities of interest, encourage family support and involvement, encourage her to verbalize fears and anxiety, offer validation and reassurance, maintain a calm environment, move her to a quiet area as		identified and what corrective action(s) will be taken; - all residents with PTSD have the potential to be affected by this alleged deficient practice - audit of residents with a diagnosis of PTSD completed by dns/designee by 6/2/23 to ensure resident needs are being met and Trauma Informed Care policy is followed - all staff educated by Senior Executive Director by 6/2/23 on Trauma Informed Care policy (see Attachment AA) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - all staff educated per Senior Executive Director by 6/2/23 on Trauma Informed Care policy (see Attachment AA) - The director of social services will receive annual and as needed education on the trauma informed policy. All residents will be	

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	needed, administer medications as ordered by physician, and psychiatric services as appropriate. A Psychiatry Initial Consult, dated 3/16/23, indicated the history of her present illness included an admission to an acute care hospital on 2/11/23 for pneumonia. She was initially calm during the consultation but became tearful while discussing her past. She was alert and oriented to person, place, time, and events. She reported being homeless and losing everything upon moving to the area. She had no family support. She had a history of experiencing depression, anxiety, panic attacks as recently as yesterday. She reported a history of PTSD from being physically and sexually abused and from her mother's untimely death when she was 14 years old. She reported increased symptoms of depression and anxiety. The facility staff report ongoing complaints of anxiety and increased episodes of crying and tearfulness, and trouble participating in therapy after her a.m. medications. She had never smoked cigarettes, used alcohol, or taken recreational drugs. Her mood was anxious, crying, depressed mood, tearful, and labile (rapid, often exaggerated changes in mood, where strong emotions or feelings occur). Her anxiety symptoms were excessive worry, anxiety and fearfulness. Clonazepam (anti-anxiety medication) 0.5 mg (milligram) every 8 hours as needed was prescribed to treat anxiety. The follow up was to adjust medications and have nursing continue to give supportive care, monitor target behaviors and record, and to report any new or worsening behaviors. A Psychiatric Progress Note, dated 3/30/23, indicated Resident 43 reported ongoing anxiety and panic attacks and that clonazepam had been		assessed for potential trauma upon admission , annually and upon significant change. Residents who answer positively to a trauma screen or who have a diagnosis that could indicate trauma will be referred to behavioral health for a trauma assessment. The trauma assessment will include person centered triggers and interventions to avoid or mitigate risks for re-traumatization which will be incorporated into the plan of care. Staff will be educated regarding triggers and interventions in the plan of care. - Any resident newly diagnosed with PTSD will be reviewed by IDT and have psyche referral completed and care plan completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Trauma (see Attachment O) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.	

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	effective. Staff reports no new or worsening behaviors, and that mood has been stable. The plan was to continue current medication regimen. On 5/5/23 at 2:50 p.m., the Float SSD (Social Service Director) provided a Resident Concern/ Grievance Form, dated 4/5/23 at 2:53 p.m., which indicated Resident 43 had a concern about not receiving her medications on time, not being woken up for her scheduled pain medications, and not receiving her anti-anxiety medication every 8 hours as scheduled. The action taken for the grievance was that it was explained to Resident 43 that her clonazepam (anti-anxiety medication) was scheduled on an as needed basis and would not be offered to her if she did not request it. The times of the scheduled medications were changes so that they would not be given at shift changes, and that a care plan had been created for her to be woken up for her medications, per her preference. A physician's order, dated 4/26/23, indicated to change clonazepam .5 mg to 1 tablet every bedtime as needed for anxiety. A physician's order dated 5/4/23, indicated to change clonazepam .5 mg to 1 tablet every 12 hours as needed for anxiety. A care plan, initiated 5/5/23, Resident 43 had episodes of verbal aggression toward staff related to recent changes in medications. The goal was for her to allow staff to reassure and/or redirect resident during discussions of medication changes. The approaches, initiated 8/10/22, included to allow her to voice concerns as needed, reassure her that provider will assess medications and adjust as needed, and consult physician, nurse practitioner, or psychiatric services as needed.		· If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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	During an interview on 5/4/23, Resident 43 indicated she had bad anxiety, depression, and PTSD from things that had happened to her in her life. She became upset because she felt she had to "justify" her need for medications. She had frequent panic attacks and the physician had changed her anxiety medication without talking to her. She didn't understand why the medication change was done, but the psychiatric nurse practitioner had straightened the problem out when Resident 43 asked about it. Resident 43 began to cry and indicated a had a nurse that told her she was taking too much medication. The nurse tried to explain that she was being Resident 43's advocate, but it didn't seem that way to Resident 43. Resident 43 felt "judged" by the nurses because she would set the alarm on her phone in order to ask for her anxiety pills when they were due to be given. he nurses would make comments to her like "oh, it must be 9 o'clock, she's coming for her meds". Resident 43 felt that the nurses were judging her and couldn't understand that she really needed the medications, she wasn't just taking them for no reason. During an interview on 5/8/23 at 10:56 a.m., CNA (Certified Nursing Assistant) 7 indicated she was aware Resident 43 had a history of trauma. CNA 7 did not know any specific approaches that were to be used for Resident 43. During an interview on 5/8/23 at 1:50 p.m. CNA 6 indicated she had no knowledge of any resident who had a history of trauma. During an interview on 5/8/23 at 5:35 p.m., CNA 5 indicated that Resident 43 may have a trauma			

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	history because of her behaviors. CNA 5 had been instructed by LPN (Licensed Practical Nurse) 3 to provide care for Resident 43 in pairs due to Resident 43 "getting into it" with LPN 3 last week. During an interview on 5/9/23 at 2:50 p.m., the DNS (Director of Nursing Services) indicated that Resident 43 often became upset about her medications. She was a "clock watcher" when it came to taking her medications and would set an alarm to take them. Resident 43 would "snap off" at the nurse about her medications and tell the nurses she didn't like all the questions about her medications. Resident 43 had become very upset when the nurse practitioner had decreased her clonazepam to one time daily at bedtime. The nurse practitioner had decreased the clonazepam because it could interact with another medications Resident 43 took routinely. The Psychiatric Nurse Practitioner had seen Resident 43 and the clonazepam was increased to every 12 hours as needed, which had calmed Resident 43 down a little. During an interview on 5/9/23 at 2:59 p.m., the RNC (Regional Nurse Consultant) indicated that when Resident 43 was admitted the staff had attempted to talk with her about things which could trigger Resident 43's anxiety or depression related to her PTSD. Resident 43 had not been forthcoming with any triggers. During an interview on 5/10/23 at 8:57 a.m., LPN 3 indicated that Resident 43 had "gone off" on every single nurse in the building, including her. Resident 43 was like "clockwork", she would come up to the front and ask for her medications and would get very upset if she didn't get it. Resident 43 had called her everything "but a child of God".			

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	LPN 3 had asked Resident 43 why she was getting a new medication for anxiety and depression and Resident 43 had told LPN 3 that she sure knew how to make a "m***** f***** feel bad". Resident 43 wanted to take her anti-anxiety medication at the same time as her narcotic pain medication. LPN 3 had educated Resident 43 that taking the medications together could sedate Resident 43, but Resident 43 still wanted the medications as close together as possible. During an interview on 5/10/23 at 3:35 p.m., the DNS indicated she was aware Resident 43 had the behavior of cursing at the staff and that there should be a care plan addressing that behavior. During an interview on 5/11/23 at 9:29 a.m., the PNP (Psychiatric Nurse Practitioner) indicated that the facility had not consulted with her about any things that may trigger Resident 43 or about Resident 43's plan of care. The PNP indicated that a trigger at the moment for Resident 43 was the upcoming Mother's Day. Resident 43 had expressed increased anxiety related to Mother's Day coming since she had unexpectantly lost her mother at a young age. On 5/9/23 at 1:16 p.m., the Float SSD provided the Trauma Informed Care policy, last revised October 2022, which read "... It is the policy of this facility to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident...For the resident to feel safe in their environment and trust caregivers despite past trauma. Trauma survivors can include...survivors of physical- sexual- or mental abuse, other violent			

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	crimes, a history of ...homelessness, or who have suffered traumatic loss of a loved one...Trauma-informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of traumas. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization... Behavioral health services will assist with resident and Interdisciplinary Team in developing a plan of care which will be added to the medical record. This plan of care will incorporate individual experiences, customary routines, and cultural preferences of the individual's needs..."			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) had worked 8 hours in the facility. This had a potential to effect 44 of 44 residents on 10/1/22, 46 of 46	F 0727	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	06/02/2023

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	residents on 10/2/22, 44 of 44 residents on 10/16/22, 43 of 43 residents on 10/22, 43 of 43 residents on 10/23/22, 43 of 43 residents on 11/12/22 and 44 of 44 residents on 12/17/22. Findings include: The PBJ Staffing Data Report that was generated from October 1, 2022 - December 31, 2022 indicated the following days the facility did not have an RN working 8 hours in the building: 10/1/22, 10/2/22, 10/8/22, 10/16/22, 10/22/22, 10/23/22, 11/12/22 and 12/17/22. An interview was conducted with the Float Director of Nursing Services (FDNS) on 5/9/23 at 3:30 p.m. She indicated an RN had not worked an 8 hour shift in the facility on the following days: 10/1/22, 10/2/22, 10/16/22, 10/22/23, 10/23/22, 11/12/22 and 12/17/22.		practice; - the facility has obtained RN coverage for 8 consecutive hours a day / 7 days a week. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents have the potential to be affected by this alleged deficient practice - the daily staffing is reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place - all staff educated by 6/2/23 by the Senior Executive Director on the rn coverage of 8 consecutive hours and 7 days a week What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - The daily staffing is reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place	

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			- If RN coverage is needed, the facility will contact staffing agencies and the in-company staffing group to obtain the required RN coverage - The Executive Director and Director of Nursing are continuing to recruit and hire RN's both full and part time - all staff educated by the Senior executive Director by 6/2/23 on the requirement of 8 hours of rn coverage daily for 7 days a week How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · To ensure compliance the Executive Director/Director of Nursing will review the staffing schedule showing RN coverage monthly for 6 months and report any identified concerns during monthly QAPI meetings and follow QAPI recommendations. If RN coverage has not been achieved as required an action plan will be	

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			developed and review will continue until RN coverage has been achieved 7 days a week for 8 consecutive hours. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 6/2/23	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with	F 0812	**What corrective action(s) will be accomplished for those residents found to have been**	06/02/2023

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	professional standards for food service safety by the dishwasher not reaching an adequate wash temperature causing residents to eat off of Styrofoam and using plastic utensils, not utilizing hair restraints properly, having a personal item on a spice shelf, not disposing of food items by the use by date, not labeling and dating food with proper dating, not ensuring stored items are wrapped tightly and not exposed to the air for 43 of 46 residents who consume food served from the kitchen. (Facility) Findings include: An initial kitchen tour was conducted on 5/4/23 at 9:49 a.m. with DM (Dietary Manager). During the tour, the following was observed: 1. The kitchen's dishwasher was not reaching temperature. An interview with DM during the tour indicated, the dishwasher has been down for a about a week because it was not reaching the needed temperature for the wash cycle. So, the resident's are being served meals using Styrofoam plates, bowls, and cups. They are also using plastic silverware at meals. 2. An observation of KS (Kitchen Staff) 1 and 2 during the tour indicated, they both had facial hair in excess of 1/4 inch in length that was not covered by a hair restraint. 3. An opened and half consumed bottle of Calypso Ocean Blue Lemonade was sitting on the same shelf as the spices. DM indicated, she wasn't sure who the drink belonged to in the kitchen. 4. Bulk cereals stored under a prep table had the following "use by" dates on the stickers on each		**affected by deficient practice:** · All un-labeled, un-dated and/or outdated food items were discarded · All food/beverage items not stored in a sanitary manner were discarded · Booster heater for dishwasher approved and purchased · KS 1 and 2 provided 1 on 1 education re: use of beard nets · KS 1 and 2 were provided beard nets **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:** · All residents on an oral diet have the potential to be affected by the alleged deficient practice · All Culinary staff will be in-serviced by the Culinary Manager/Designee on the Culinary Food Storage Policy by 6/2/23 (see Attachment P) · All Culinary staff will be in-serviced by the Culinary Manager/Designee on the Personal Hygiene Policy by 6/2/23 (see Attachment P) · Booster heater for dish machine will be installed and operable by 6/2/23 · Short Sanitation Audit will be completed by the Regional Dietitian/Designee. Corrective action will be taken as	

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	container: Fruit Loops 5/3/23, Raison Bran cereal 5/1/23, Frosted Flakes 5/4/23, and Rice Crispies 5/1/23. 5. The lid to the bulk container of bread crumbs in the dry storage room was left open to air. 6. In the walk-in Fridge: - Two trays of Styrofoam serving bowels containing precut watermelon pieces (one tray was stacked on top of the second tray) had no labels nor was dated; 15 of the watermelon bowls under the top tray did not not have lids and were open to air with the potential to touch the bottom of the top tray. - An opened box of egg patties was left open to air as the plastic inside the box was left open. - A plastic bag of cut Zucchini had no label or opened date, - An opened box of cinnamon roll dough was left open to air as the plastic bag inside was left open. - A plastic bag of sausage was dated with a use by date of 4/30/23. - A plastic bag of chicken patties was dated with a use by date of 4/12/23. An interview with DM conducted during the kitchen tour indicated, all food should not be left open to air and labeled and dated with use by dates or dates opened. An interview with ED (Executive Director) conducted on 5/11/23 at 10:15 a.m. indicated, the facility's dishwasher had broke on 12/12/22 and served residents on Styrofoam and plastic until the week of 1/15/23. At that time a 'new' dishwasher was installed. The 'new' dishwasher stopped meeting the required wash temperatures on 4/20/23 and since 4/20/23, the residents have been served on Styrofoam and with plastic		needed-**was completed 5/30/23** **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:** · All Culinary staff will be in-serviced by the Culinary Manager/Designee on the Culinary Personal Hygiene and the Food Storage Policy by 6/2/23 (see Attachment P) · Culinary Manager/Designee will round daily using the **AM walk-through checklist**. Items of concern identified will be addressed immediately. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place:** ·POC QAPI **Tool Short Sanitation** will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	utensils since then. The dishwasher was still broken down at the end of the survey period. A Culinary Personal Hygiene policy was received on 5/11/23 at 12:11 p.m. from RNC (Regional Nurse Consultant). The policy indicated, "Personal Cleanliness a. All employees working in the culinary department must wear a clean hair restraint which effectively covers all hair. A ball cap, chef beanie or similar may be worn over a proper hair restraint. Culinary employees with facial hair must also wear a beard restraint...d. Personal items would not be stored on food preparation equipment or in food storage areas." A Food Storage policy was received on 5/11/23 at 12:11 p.m. from RNC. The policy indicated, "Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing...Leftover prepared foods and processed meats...are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared, and marked to indicated the date by which the food shall be consume or discarded...Dry Storage...Containers with covers must be used for storing cereals, cereal products, flour, sugar, pasta...when removed from their original container. These containers should be labeled and dated on both the container and the lid...All foods shall be covered or wrapped tightly, labeled, and dated." This Federal tag relates to Complaints IN00399680 and IN00402254. 3.1-21 (i)(3)		**By what date the systemic changes will be completed:** 6/2/23	
F 0851 SS=C Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing			

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	information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).			

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	§483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to accurately submit the data for license personnel that worked in the facility from October 2022 through December 2022 to CMS (The Centers for Medicare & Medicaid Services) for the Payroll Based Journal Daily Nurse Staffing (PBJ) report. This had a potential to effect 46 of 46 residents that reside in the facility. Findings include: The PBJ Staffing Data Report that was generated from October 1, 2022 - December 31, 2022 indicated the following days the facility did not have license personal working in the building: 10/16/22, 10/23/22, 11/6/22, 11/12/22, 11/13/22, 11/19/22, 11/26/22, 12/4/22, 12/17/22 and 12/18/22. An interview was conducted with the Float Director of Nursing Services (FDNS) on 5/9/23 at 3:30 p.m. She indicated the license personnel staffing was reported incorrectly from October	F 0851	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - the alleged deficient practice does not have the potential to affect residents - all staff educated by the senior executive director on pbj hours/timesheets and submission	06/02/2023

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	2022 through December 2022 for the PBJ report. There was license personnel that had worked in the building on 10/16/22, 10/23/22, 11/6/22, 11/12/22, 11/13/22, 11/19/22, 11/26/22, 12/4/22, 12/17/22 and 12/18/22. The FDNS provided a nursing schedule and timesheets. The license personnel worked schedule that included timesheets was provided by the FDNS on 5/9/23 at 3:28 p.m. It indicated the following days license personnel had worked in the facility: 10/16/22 - 1 License Practical Nurse (LPN) worked on 1st shift, 1 LPN worked on 2nd shift and 1 LPN worked on 3rd shift, 10/23/22 -1 LPN worked on 1st shift, 1 LPN worked on 2nd shift and 1 LPN worked on 3rd shift, 11/6/23 - 1 RN worked on 1st shift 1 LPN worked on 2nd shift and 1 LPN worked on 3rd shift, 11/12/22 - 1 LPN worked on 1st and 2nd shift (double), 1 LPN worked 3rd shift, 11/13/22 - 1 Registered Nurse (RN) worked on 1st shift, 1 LPN worked on 2nd shift and 1 LPN worked on 3rd shift, 11/19/22 - 1 LPN worked on 1st and 2nd shift (double) and 1 LPN worked on 3rd shift, 11/26/22 - 1 LPN worked on 1st, 1 LPN worked on 2nd shift, and 1 LPN worked 3rd shift, 12/4/22 - 1 LPN worked on 1st shift, 1 LPN worked on 2nd shift, and 1 RN worked on 3rd shift, 12/17/22 - 1 LPN worked on 1st shift, 1 LPN worked on 2nd shift, and 1 LPN worked on 3rd shift, and 12/18/22 - 1 LPN worked on 1st shift, 1 LPN worked on 2nd shift, and 1 LPN worked on 3rd shift		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - The BOM/designee will review employee and agency timesheets/logs once daily 5x per week to verify that worked hours are reported through Kronos. -all staff educated by the senior executive director on pbj hours/timesheets and submission. See attachment aa How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · BOM/designee will report on any identified concerns during monthly QAPI meeting and follow recommendations until facility has gone 6 months with 100% compliance · If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	155029	A. BUILDING 00 B. WING	05/11/2023

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			By what date the systemic changes will be completed; · Completion date: 6/2/23	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that 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			

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	be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (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 a medication was not administered after being dropped onto a	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	06/02/2023

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	medication cart, hand hygiene was done prior to donning gloves, and that gloves were donned prior to administering insulin for 3 of 5 residents randomly observed for medication administration (Resident 16, 33, and 197) Findings include: 1. On 5/8/23 at 9:29 a.m., QMA (Qualified Medication Aide) 22 was observed administering medications to Resident 16. QMA 22 obtained his medication cards from the drawer of the medication cart. She then began to remove the medications from the card into a plastic medication cup. As she did this, one of the medications fell onto a piece of paper which was sitting on top of the medication cart. QMA 22 obtained a plastic spoon from the medication cart and used the spoon to pick up the pill that had fallen onto the medication cart and placed it in the plastic medication cup with the other medications. She took the plastic medications cup into the resident and administered all of the medications to Resident 16. During an interview on 5/8/23 at 9:45 a.m., QMA 22 indicated she had not disposed of the pill that had fallen on the medication cart because it had fallen on the piece of paper, not directly on the cart. 2. On 5/9/23 at 11:53 a.m., RN (Registered Nurse) 31 was observed performing a blood sugar check for Resident 197. She obtained the needed items from the medication cart and took them into Resident 197's room. RN 31 then donned a pair of gloves. She did not do hand hygiene prior to donning the gloves. She obtained the blood sugar and removed her gloves. She then did hand hygiene using alcohol-based hand gel and		practice; - Residents 16, 197 and 33 have shown no signs and symptoms of infection - QMA 22 has been educated on Infection Control practices with Medication Administration - RN 31 has completed Glucometer skills validation in addition to receiving education on Infection Control practices How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents receiving medication, insulin, and glucometer checks have the potential to be affected by this alleged deficient practice. - education provided to all nursing staff per dns/designee by 6/2/23 on Infection control practices (see Attachment AA) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - education provided to all nursing staff per dns/designee by 6/2/23	

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	returned to the medication cart. She obtained an insulin pen from the medication cart and set the pen for the prescribed amount of insulin. RN 31 then went back into Resident 197's room with the insulin pen. She administered the prescribed amount of insulin into Resident 197's right arm. She did not do hand hygiene or don gloves prior to administering the insulin. RN 31 then left the room and performed hand hygiene with alcohol-based hand gel. 3. On 5/9/23 at 12:05 p.m., RN 31 was observed performing a blood sugar check for Resident 33. She obtained the needed items from the medication cart and took them into Resident 33's room. RN 31 then donned a pair of gloves. She did not do hand hygiene prior to donning the gloves. She obtained the blood sugar and removed her gloves. RN 31 then did hand hygiene using alcohol-based hand gel as she left the room. During an interview on 5/9/23 at 12:10 p.m., RN 31 indicated she normally did hand hygiene prior to donning gloves and that she normally wore gloves while administering an insulin injections. On 5/9/23 at 3:27 p.m., the RNC (Regional Nurse Consultant) provided the Hand Hygiene Policy, last revised 12/2021, that read "...Hand hygiene- a general term that applies to hand washing, antiseptic hand wash and alcohol-based hand rub...Indications for Hand-rubbing...Before and after removing gloves..." On 5/9/23 at 3:27 p.m., RNC provided the Insulin Pen Administration Nursing Skills Competency, last reviewed 10/2019, which read "...3. Gather needed supplies. 4. Perform hand hygiene... 6. Put on gloves..."		on Infection Control practices (see Attachment AA) - all nurses/qma's have completed medication administration skills validations - all nurses have completed skills validations for glucometers - assigned IDT to complete weekly observations of Medication pass, glucometers and insulin How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Infection Control (see Attachment Q) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed;	

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	On 5/9/23 at 3:27 p.m., the RNC provided the Medication Pass Procedure, last reviewed 12/2016, which read "...17. Wasted or dropped medication destroyed properly and documented per policy..." 3.1-18(b)		· Completion date: 6/2/23	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to ensure a resident had an infection that met the criteria for antibiotic usage prior to providing an antibiotic for 1 of 6 residents reviewed for unnecessary medications. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on 5/9/23 at 9:00 a.m. The diagnoses for Resident 35 included, but were not limited to, dementia with behavioral disturbance, psychotic disturbance, mood disturbance, chronic kidney disease, and pulmonary hypertension. A nursing progress note dated 4/14/23 indicated "Aide came and got writer and when writer went into resident's room resident had a napkin with yellow/green sputum resident had been coughing	F 0881	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; --Resident 35 is no longer receiving antibiotic therapy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; --All residents who are prescribed an antibiotic have the potential to be affected by the alleged deficient practice. --Audit completed to ensure all residents currently receiving antibiotic therapy are meeting criteria for true infection according to McGeers Criteria, corrective	06/02/2023

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	up. Upon respiratory assessment writer heard coarse crackles and resident sounded very congested...Writer contacted on-call and got new orders for chest x-ray 2 view and Augmentin 500 mg [milligrams] PO BID [twice a day by mouth] x 10 days. Writer notified mobilex of x-ray orders and they confirmed order for today confirmation number 39021756. Writer pulled first dose of ATB [antibiotic] out of EDK [electronic drug dispensing unit] and administered to resident as ordered..." A physician order dated 4/14/23 indicated Resident 35 was to receive 500 mg of Augmentin twice a day. The order was discontinued on 4/20/23. The April 2023 Medication Administration Record indicated Resident 35 had received the 500 mg of Augmentin starting a dose on the evening of 4/14/23, and then continued to receive twice a day on 4/15/23, 4/16/23, 4/17/23, 4/18/23, 4/19/23 and 4/20/23. A radiology report date of service on 4/16/23 with a reported result on 4/16/23 at 4:51 p.m, indicated "...The lungs demonstrate no significant consolidation, masses, effusions, or pneumothorax..." A physician visit note dated 4/18/23 indicated "...Nursing staff report pt [patient] started having cough 3 days ago and has yellow/green sputum. CXR [chest x-ray] was ordered (still pending) and she was started on Augmentin 500 mg PO BID x 10 days...On exam she is not coughing and does not appear SOB [shortness of breath] or ill appearing. She is a poor historian due to dementia. Her vitals are stable and she is afebrile [no fever]...Physical exam:...Respiratory:		action will be taken as needed. --Infection Preventionist has received education per Senior Executive Director on the Antibiotic Stewardship Program. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; --Infection Preventionist has received education per Senior Executive Director on the Antibiotic Stewardship Program. --IDT will review orders and infection control events daily in clinical meeting to ensure residents receiving antibiotic therapy have met criteria. -- IDT will review Antibiotic Stewardship at monthly QAPI meetings with Medical Director. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as antibiotic stewardship (see attachment R)will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter	

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	respiratory effort: no dyspnea [difficulty breathing/shortness of breath],..no wheezing, rales/crackles, or rhonchi and diminished air movement...Assessment Plan:...1. cough -...please call with CXR results when available..." A physician visit note for Resident 35 dated 4/19/23 indicated "...Patient reports sinus problems; congestion with post nasal drainage. She reports sore throat. She reports cough but reports no wheezing and no shortness of breath. She reports muscle weakness...She reports no chest pain and no shortness of breath when lying down...Physical Exam:...Respiratory: respiratory effort: no dyspnea...no wheezing or rales/crackles and breath sounds normal and good air movement...Assessment/Plan: 1. Acute sinusitis - sinus congestion with drainage and sinus tenderness. suspect that drainage is contributing to cough. Patient has already been receiving ABX due to prior concern for pneumonia. Don't see need to extend use of ABX. Add Allegra 180 mg for 7 days..." Resident 25's clinical record indicated Resident 35 continued to receive the 500 mg of Augmentin twice a day through 4/20/23. An interview was conducted with Float Director of Nursing (DNS) on 5/10/23 at 3:47 p.m. She indicated she was the infection preventionist and had taken over the antibiotic stewardship program in April. She uses Mcgreers to determine if antibiotic usage was necessary to treat an infection. Resident 35's infection did not meet the Mcgreers criteria to treat with an antibiotic. She had not notified the medical provider prior to starting the Augmentin antibiotic on 4/14/23, as she normally would have to clarify if the medical provider did want to continue with the antibiotic		until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	

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	treatment prior to confirmation of the chest x-ray the resident had pneumonia. This Federal tag relates to Complaints IN00402254.			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to provide a clean, sanitary, and homelike environment by having: a broken window in a residents room, black substance on P-Tack unit vents, a purple stain on marble surround on window sill, toilet not securely fastened to the floor, missing bathroom light covers, not maintaining walls in good repair from scratches, peeling paint on walls and bathroom door, bedside table missing a wheel, missing closet doors, mechanical lift equipment covered with dirt and debris, toilet paper not fitting on toilet paper holder, and a missing piece of hallway handrail. (Facility) Findings include: An observation of Resident 17's room was conducted on 5/4/23 at 3:22 p.m. The P-Tack unit (heating and cooling unit) had a black substance on the unit's vents, one of the windows had blue tape all around it, the window sill had a large purple stained area, the toilet was loose from the floor, and the bathroom light did not have a cover. An observation made on 5/5/23 at 9:28 a.m. of Resident 40 and 42's room. The walls were marred behind both beds, the paint on the wall near the bathroom was peeling off the wall and paint was	F 0921	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice - all identified concerns have been repaired - room 17 black substance removed from p-tac units and cleaned , blue tape removed and cleaned, area with purple stain area removed and cleaned, toilet secured to the floor and bathroom light cover corrected - rooms 40 and 42 walls repaired and painted - room 141 bathroom toilet paper issue corrected and toilet paper fits correctly in toilet paper holder, wall repaired and painted. - handrail in hallway between	06/02/2023

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	peeling off the inside of the bathroom door. An environmental tour of the facility was conducted with ED on 5/11/23 at 11:40 a.m. During the tour the following was witnessed: - Inside Resident 17's room, the P-Tack unit still had a black substance on the air vents, the ED removed the blue tape from the window and exposed shards of broken glass still in the window framing and the window was missing the inside pane of glass, the purple area on the window sill was still present, the toilet bowl was shifted off to the right side and needed to be tightened into its correct position, and the bathroom light fixture was missing its cover. - In the hallway, the mechanical lift was "parked" next the wall and it had dirt and debris all over the base of the unit. - Room 141's bathroom toilet paper was on the sink, next to the wall farthest away from the toilet. The toilet paper did not fit the toilet paper holder because the toilet paper tube's hole was too small to fit on the toilet paper holder and a toilet riser was blocking access to the toilet paper holder. The walls behind both beds were marred. - Resident 137's bedside table had a broken wheel and the closet was missing its doors. - Resident 40 and 42's wall near the bathroom and the inside of the bathroom door had peeling paint. - In the hallway, between a storage room and room 134, a section of the handrail was missing exposing metal hardware. An interview with ED conducted at the end of the environmental tour indicated, the observed items needed to be fixed/repaired as soon as possible. This Federal tag relates to Complaint IN00399680 and IN00402254.		storage room and room134 has been repaired How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents have the potential to be affected by this alleged deficient practice - Maintenance Director has conducted a full facility audit to determine where repairs are needed - Senior Executive Director will educate all staff by 6/2/23 on Environment and submitting proper work order procedures (see Attachment AA) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Senior Executive Director will educate all staff by 6/2/23 on Environment and submitting proper work order procedures (see Attachment AA) - The	

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	3.1-19(f) 3.1-19(f)(3) 3.1-19(f)(5) 3.1-19(m)(4)(E) 3.1-19(x)		Executive Director will make weekly rounds with the Maintenance Director through the facility including resident rooms to ensure that the alleged deficient practice does not recur - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Environment (see Attachment S) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 6/2/23	