STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING 00 B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00433889. Complaint IN00433889 - No Federal/State deficiencies related to the allegations are cited. Survey dates: June 3, 4, 5, 6, 7 and 10, 2024. Facility number: 000547 Provider number: 155775 AIM number: 100267440 Census Bed Type: SNF/NF: 37 SNF: 19 Residential: 59 Total: 115 Census Payor Type: Medicare: 9 Medicaid: 37 Other: 10 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 18, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by Cumberland Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Cumberland Health Campus.¿ ¿ The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility.¿ It is thus submitted as a matter of statute only.¿ The facility respectfully requests from the department a desk review for substantial compliance.¿¿	
F 0642 SS=D Bldg. 00	483.20(h)-(j) Coordination/Certification of Assessment §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carol Ward	ED/ HFA	07/15/2024

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

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	appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) level 2 was accurately documented on the comprehensive/annual MDS (Minimum Data Set) assessment submitted for 1 of 3 residents reviewed for PASRR level 2. (Resident 34) Finding includes: The clinical record for Resident 34 was reviewed on 6/5/24 at 10:00 a.m. The diagnoses included,	F 0642	Resident 34 affected. No adverse effects noted. Resident's record has been updated. MDS education provided on the following RAI manual and ensuring Level II is accurately documented on the MDS assessment. All Level II on MDS have been reviewed and updated accordingly. As a measure of ongoing compliance,	07/19/2024

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	but were not limited to, cerebral palsy, major depressive disorder, bipolar disorder, anxiety disorder, and insomnia. A PASARR level 2 was completed on 9/12/23. An annual MDS assessment, dated 12/25/23, indicated a PASARR level 2 had not been completed. During an interview, on 6/7/24 at 11:12 a.m., the MDS Clinical Support nurse indicated the MDS assessment should have been marked to indicate the level 2 had been completed During an interview, on 6/7/24 at 11:30 a.m., the MDS Clinical Support nurse indicated the facility followed the RAI manual as a policy. 3.1-31(f)		MDS or designee will audit to ensure the Level II on MDS is documented accurately. Audit to consist of 3 residents, as available, 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual			

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	disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) after a resident was started on an antipsychotic medication for 1 of 3 residents reviewed for PASARR. (Resident 18) Finding includes: The clinical record for Resident 18 was reviewed on 6/6/24 at 10:08 a.m. The diagnoses included, but were not limited to bipolar disorder, insomnia, and depression. A physician's order, with a start date of 11/4/22 and an end date of 11/21/22, indicated to give Seroquel (an antipsychotic medication) 25 milligrams (mg) at bedtime. A current physician's order, with a start date of 11/21/22, indicated to give the resident Seroquel 50 milligrams (mg) at bedtime. A notice of PASARR level 2 outcome, dated 9/9/22, indicated the resident was approved for long term approval without specialized services. The resident's mental health medications did not include Seroquel. There had not been another PASARR assessment completed after the resident was placed on Seroquel. During an interview, on 6/7/24 at 11:14 a.m., the Assessment Clinical Support nurse indicated if a resident was placed on an antipsychotic medication, they would need a PASARR level 2 completed again.	F 0644	Resident 18 was affected. PASARR Level I been completed and reviewed by OBRA coordinators. No adverse effects noted. All residents with prescription(s) for psychotropic medications have the potential to be affected. All have been reviewed for completion of PASRR assessment. Education to occur with the Social Service Director (SSD) on the PASRR completion process. All in house residents have been reviewed to ensure PASRR was completed, if indicated. As a measure of ongoing compliance, the SSD or designee will audit 5 resident PASRRs, weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted	07/19/2024

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	A standard operating procedure, titled "Indiana PASRR," received from the Clinical Support nurse on 6/10/24 at 4:00 p.m., indicated "...Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure individuals are appropriately placed in nursing facilities for long-term care...Change in Status...PASRR Level 1 Complete for change in status...Required: H&P MAR...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)			
F 0684 SS=E 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 provide a bowel stimulant according to the bowel protocol, failed to ensure residents were wearing compression hose as ordered by the physician, failed to hold a medication per the physician's hold orders, and failed to ensure a preventive cushion was in place for 4 of 4 residents reviewed for quality of care. (Residents 43, 44, 15 and 25) Findings include: 1. The record for Resident 43 was reviewed on 6/4/24 at 3:44 p.m. The diagnoses included, but	F 0684	Resident 43, 44, 25 and 15 all remain in campus. Residents were immediately accessed with any findings updated in their record and provider notifications made. Residents did not experience any adverse effects related to alleged deficient practice. All residents have the potential to be affected. All nurses were educated on bowel protocol, medication administration guidelines and following physician orders. All	07/19/2024

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	were not limited to, metabolic encephalopathy (a problem in the brain, caused by a chemical imbalance in the blood) and constipation. a. The bowel record was reviewed and did not include documentation of a bowel movement between 2/11/24 to 2/14/24 (4 days). The Medication Administration Record, for February 2024, did not have documentation to show the resident received the PRN (as needed) bowel stimulants to promote bowel movements. The bowel protocol was not initiated. A physician's order, initiated on 2/7/24, indicated if there was no bowel movement within 72 hours give 2 tablespoons of Natural Laxative and assign to bowel protocol flow sheet. If no results within 24 hours of Natural Laxative give 30 milliliters (ml) of Milk of Magnesia (MOM). The special instructions indicated to give every day for constipation. If no results, within approximately 12 hours from the administration of MOM, give Dulcolax suppository rectally. The instructions indicated to give daily if no results from MOM. If results of suppository are not satisfactory within 2 hours give a Fleets enema rectally. A physician's order, initiated on 2/7/24, indicated to give senna (a laxative) tablet 8.6 mg daily as needed for constipation. During an interview, on 6/7/24 at 10:32 a.m., the Corporate Support Nurse 2 indicated the bowel protocol was not started and four (4) days was outside the parameters for the bowel protocol. b. During an observation, on 6/5/24 at 10:20 a.m., Resident 43 was observed up in the dining area		residents were assessed for bowel management with any findings updated in the record and appropriate interventions made. All residents with medication orders with administration parameters have been reviewed to ensure MD notification and parameters followed with provider updated of findings. All residents with ted hose and pressure reducing cushions orders have been reviewed to ensure they are in place per MD orders. As a measure of on-going compliance, the Director of Health Services (DHS) or designee will complete audits of 3 residents, as available, requiring medication administration with parameters in addition to appropriate notification 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. The DHS or designee will review the bowel management report for those who have not had a bowel movement in to ensure the bowel protocol has been initiated 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. The DHS or will complete audits of 3 residents, as available, to ensure ted hose on in place 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. The DHS or designee will	

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	watching television, she was wearing nonskid shoes and regular socks. She was not wearing compression hose/socks. During an observation, on 6/6/24 at 9:28 a.m., Resident 43 was up in activities without compression hose on her legs. During an observation, on 6/7/24 at 9:44 a.m., Resident 43 was observed up in a wheelchair in her room, the resident did not have compression stockings/hose on at the time. A physician's order, initiated on 2/22/24, indicated to apply TED hose (compression hose) to the bilateral lower extremities every morning. A care plan, initiated on 2/8/24, indicated "...Ted hose/Splints: ted hose as ordered...." During an interview, on 6/5/24 at 11:02 a.m., LPN 4 indicated the resident was to have compression stockings/hose on. The resident should have had them put on when she got up in the morning. During an interview, on 6/6/24 at 9:30 a.m., RN 5 indicated they were not putting compression hose/stocking on Resident 43 per the daughters request due to a wound on the resident's leg. During a telephone interview, on 6/7/24 at 10:49 a.m., the responsible party/daughter indicated she did not tell the facility not to use the compression hose on the resident. There was no documentation in the resident's notes to indicate the daughter did not want compression hose used. There was no order found in the chart to hold the		complete audits of 3 residents, as available, to ensure pressure reducing cushions are in place 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. The results of the audit observations will be reported to, reviewed by, and trended the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved.	

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	compression hose. 2. During an observation, on 6/6/24 at 9:27 a.m., Resident 44 was in an activity. He was not wearing his TED hose. The record for Resident 44 was reviewed on 6/3/24 at 1:19 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, hypertensive heart, chronic kidney disease, and heart failure. A physician's order, initiated on 3/26/24, indicated "...Apply TED hose to bilateral lower extremities every am. Remove at HS (bedtime)...." A care plan, initiated on 3/21/24, indicated ".... Ted Hose/Splints: Ensure Ted hose is worn daily to prevent swelling...." During an interview, on 6/6/24 at 9:31 a.m., RN 5 indicated she did not know why the resident was not wearing his TED hose and she would have it corrected. 3. The clinical record for Resident 15 was reviewed on 6/6/24 at 2:48 p.m. The diagnoses included, but were not limited to, chronic combined systolic (congestive) and diastolic (congestive) heart failure), hypertensive heart disease with heart failure and atherosclerotic (plaque buildup) heart disease. A physician's order, with a start date of 4/3/24, indicated the resident received metoprolol (a medication which lowers blood pressure) 25 milligrams twice per day. Hold the medication for a systolic (top number) blood pressure (BP) under 110 or a heart rate (HR) under 65 beats per minute. The Medication Administration Record (MAR) indicated the following:			

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	On 4/14/24, the HR was 62. The medication was administered. On 4/21/24, the systolic BP was 103. The medication was administered. On 4/27/24, the systolic BP was 101 and the HR was 62. The medication was administered. On 5/2/24, the systolic BP was 100. The medication was administered. On 5/4/24, the systolic BP was 107. The medication was administered. On 5/5/24, the systolic BP was 106. The medication was administered. On 5/9/24, the systolic BP was 107. The medication was administered On 5/18/24, the systolic BP was 102. The medication was administered. On 5/19/24, the systolic BP was 102. The medication was administered. On 5/26/24, the systolic BP was 104. The medication was administered. On 5/30/24, the systolic BP was 100. The medication was administered. During an interview, on 6/7/24 at 3:14 p.m., the Clinical Support Nurse indicated she did not see any notes to indicate the metoprolol was held. During an interview, on 6/10/24 at 11:14 a.m., the Clinical Support Nurse indicated they did not have a policy about following physicians orders. 4. During an observation, on 6/5/24 at 11:11 a.m., Resident 25 was sitting in her wheelchair in the activities room. A pressure reducing cushion was not located in her wheelchair. During an observation, on 6/5/24 at 3:02 p.m., Resident 25 was sitting in her wheelchair in the activities room. A pressure reducing cushion was not located in her wheelchair.			

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During an observation, on 6/6/24 at 10:40 a.m., Resident 25 was in the activities room sitting in her wheelchair. A pressure reducing cushion was not located in her wheelchair.

The clinical record for Resident 25 was reviewed on 6/5/24 at 10:36 a.m. The diagnoses included, but were not limited to, unstageable pressure ulcer of the sacral region, encounter for surgical aftercare following debridement on the skin and subcutaneous tissue to the coccyx, and type 2 diabetes mellitus with other skin ulcers.

A current care plan, with a start date of 8/5/2021, indicated the resident was to have a Roho cushion (pressure reducing cushion) applied to her wheelchair.

A physician's order, with a start date of 9/20/23, indicated the resident was to have a pressure reducing cushion to her wheelchair.

During an interview, on 6/6/24 at 10:42 a.m., CRCA 15 indicated she could not find the resident's pressure reducing cushion in the resident's room and she was not sure where it was.

During an interview and observation, on 6/6/24 at 10:45 a.m., CRCA 15 went to observe the resident in the activities room for the cushion and indicated the resident was not sitting on a pressure reducing cushion.

During an interview and observation, on 6/6/24 at 10:50 a.m., CRCA 15 searched the resident's room again and indicated she could not find the pressure reducing cushion.

During an interview, on 6/6/24 at 10:55 a.m., the

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	Administrator indicated the cushion could have been soiled so they would check the laundry. During an interview, on 6/6/24 at 11:15 a.m., the Administrator indicated if a pressure relieving cushion was soiled or needed cleaned, they would replace the cushion right away until the soiled one was clean. During an interview, on 6/10/24 at 11:14 a.m., the Corporate Support Nurse 10 indicated she did not have a policy for following physician orders. During an interview, on 6/10/24 at 3:00 p.m., Clinical Support Nurse 10 indicated the facility did not have a policy for ensuring a resident was to wear their pressure reducing cushion. A facility policy, titled "Bowel Protocol Guidelines," dated as last reviewed on 12/31/23 and received from Corporate Support Nurse 2 on 6/7/24 at 10:02 a.m., indicated "...The Ineffective Bowel Pattern Event should be initiate for any resident does not have a BM (bowel movement) with 72 hours...orders may be written as follows...If no bowel movement within 72 hours, 2 tablespoons...of 'Natural Laxative'...." 3.1-37(a)			
F 0697 SS=D 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	F 0697		07/19/2024

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	failed to administer pain medication as ordered by the physician and failed to notify the physician when the medication was not administered for 1 of 1 resident reviewed for pain. (Resident 9) Finding includes: During an interview, on 6/4/24 at 11:23 a.m., the resident indicated she had pain due to not getting her medications on time. The clinical record for Resident 9 was reviewed on 6/4/24 at 3:38 p.m. The diagnoses included, but were not limited to, chronic pain, chronic respiratory failure, and type 2 diabetes mellitus. A care plan, dated 4/18/24 and last updated on 5/17/24, indicated the resident was at risk for pain related to the diagnosis of chronic pain and decreased mobility. The interventions included, but were not limited to, administering medications as ordered. A physician's order, dated 2/14/24, indicated to give hydrocodone-acetaminophen (an opioid pain medication) every 6 hours for pain. A Medication Administration Record (MAR), dated 5/1/24 through 5/31/24, indicated the resident did not receive the 6:00 a.m. dose and 6:00 p.m. dose of hydrocodone-acetaminophen on 5/5/24 due to the medication was not available and the staff were waiting on the pharmacy. During an interview, on 6/10/24 at 12:55 p.m., the Clinical Support Nurse indicated the facility had hydrocodone-acetaminophen 10-325 in the Emergency Drug Kit (EDK) and the staff could have obtained the medication from there and did not. The electronic health record did not include		Resident 9 was affected. immediately assessed with any findings updated in their record and provider notifications made. All residents have the potential to be affected. All nurses were educated on medication ordering and receiving from pharmacy policy and physician-provider notification guidelines. All residents were assessed who are on pain management and any findings updated in the record and appropriate interventions made. As a measure of on-going compliance, the Director of Health Services (DHS) or designee will complete audits of 3 residents, as available, requiring pain management 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. The results of the audit observations will be reported to, reviewed by, and trended the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained.¿ On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved.¿¿	

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	155775	A. BUILDING 00 B. WING	06/10/2024

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	notification to the physician of the pain medication not being administered as ordered. A current policy, titled "Medication Ordering and Receiving from Pharmacy," dated as revised on 1/17 and received from the Clinical Support Nurse on 6/10/24 at 2:19 p.m., indicated "...Emergency pharmacy services are available on a 24-hour basis. Emergency needs for medications are met by using the facility's approved emergency medication supply or by special order from PCA Pharmacy. PCA Pharmacy supplies emergency medications in compliance with applicable state regulations...There is a physician on call 24/7...Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency drug supply, from the provider pharmacy or a back-up pharmacy...To access medication from the emergency medication supply, secondary to a new order or when medication for which there is a current prescription is not readily available, the appropriate facility personnel should not take a medication from the e-box or ADS without checking allergies on the medical record and possible drug-drug interactions...The appropriate facility personnel confers with the prescriber to determine whether the order is true emergency...order cannot be delayed until the scheduled pharmacy delivery...If the medication is a controlled substance, the prescriber either faxes a complete prescription to the facility and pharmacy or communicates the verbal order to both the appropriate facility personnel and directly to the pharmacist along with details about the situation to verify it meets the criteria of an 'emergency situation'...." 3.1-37(a)			

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F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, interview and record review, the facility failed to provide a full meal in a timely manner, as noted on the dietary menu slip, to a resident on a gluten free diet for 1 of 1 resident reviewed for an alternate diet. (Resident 43) Finding includes: During a dining observation, on 6/3/24 beginning at 12:13 p.m., Resident 43 was observed at the	F 0803	Resident was affected. Food of appropriate diet and monitored each meal for accuracy. No adverse effects noted. All residents with altered diets have the potential to be affected. All staff educated on verification of proper diet consistency prior to serving the resident meals. As a	07/19/2024

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	dining table with her meal consisting of chicken, brussels sprouts, and a dessert. The menu, for Resident 43, indicated she was to have a gluten free diet of caprese chicken with gluten free pasta, roasted brussels sprouts, gluten free garlic bread, and lemon mousse. During an interview, on 6/3/24 at 12:23 p.m., Cook 12 indicated the resident did not receive her gluten free items because it was not prepared. She indicated the meal should have been served all at once and not in parts. She would call the kitchen to have the remainder of the meal prepared. During an observation, on 6/3/24 at 12:37 p.m., Resident 43 did not have her gluten free garlic bread or gluten free pasta. During an observation, on 6/3/24 at 12:44 p.m., Resident 43 had not received her gluten free items. The resident had one half of a brussels sprout left on her plate. At that time, Cook 12 indicated she had not called the kitchen and she could call them "now". During an interview, on 6/4/24 at 3:44 p.m., Cook 7 indicated he had prepared the previous days gluten free items and did not know why it was not served to her. During an interview, on 6/6/24 at 9:37 a.m., the Dietary Manager indicated the missing items for Resident 43's lunch were delivered to her at around 1:00 p.m., the entire meal should have been delivered at the same time, and they were to check the meal ticket to ensure the meal was per the diet order. A facility policy, titled "Altered Diet Verification Process," dated as approved 3/2024 and received		measure of ongoing compliance, the DFS or designee will audit 5 altered diets weekly for accuracy x4 weeks, then every other week x2 months, then monthly x3 months. As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	from the Corporate Support Nurse 2 on 6/7/24 at 10:02 a.m., indicated "...During meal service the meals will be plated according to diet requirements listed on the tray card...." 3.1-20(a)			
F 0810 SS=D Bldg. 00	483.60(g) Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. Based on observation, interview and record review, the facility failed to provide adaptive dining equipment for 1 of 3 residents reviewed for dining. (Resident 43) Finding includes: During a dining observation, on 6/3/24 at 12:13 p.m., Resident 43 was observed to have chicken, brussels sprouts and a dessert. Her meal was served on a regular plate. During a dining observation, on 6/7/24 at 12:08 p.m., the resident was served grilled cheese, applesauce, and tomato soup on regular dishes. CNA 1 indicated the resident should have had a divided plate. The record for Resident 43 was reviewed on 6/4/24 at 3:44 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy (a problem in the brain, caused by a chemical imbalance in the blood) and constipation.	F 0810	Resident was affected, adaptive equipment was not provided with each meal for accuracy. No adverse effects noted. All residents with assisted devices have the potential to be affected. All staff educated on verification of proper diet, consistency, and adaptive equipment prior to serving the resident meals. As a measure of ongoing compliance, the DFS or designee will audit 5 residents with adaptive equipment weekly for accuracy x4 weeks, then every other week x2 months, then monthly x3 months. As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be	07/19/2024

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	A care plan, initiated on 2/8/24, indicated a divided plate at meals. A facility document, titled "Profile Care Guide," included an intervention which was initiated, on 3/1/24, which indicated "...Resident should have divided Plates with all meals...." A physician's order, initiated on 5/14/24, indicated a divided plate at meals. The dietary menu indicated Resident 43 was to have a divided plate. During an interview, on 6/4/24 at 3:44 p.m., Cook 7 indicated he was not aware the resident had a divided plate for meals. During an interview, on 6/6/24 at 9:37 a.m., the Dietary Manager indicated Resident 43 should have a divided plate, it was on her menu ticket. Staff were to ensure the meal was served per diet order to include silverware and plates, etc. (other assistive dining equipment). A facility policy, titled "Assistive Device Guideline," undated and received from the Corporate Support Nurse 10 on 6/10/24 at 5:21 p.m., indicated "...Assistive eating devices, such as plate guards and built up utensils, are provided for individuals who need them to encourage feeding independence...A physician's order will be obtained for all assistive devices and Dining Services department will be notified of the new order...Dining services and direct care staff will be responsible for insuring the individuals received the appropriate assistive devices for each meal as ordered...." 3.1-21(h)		reviewed and updated as warranted.	

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F 0812 SS=D 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 ensure staff were wearing hair and facial covers while in the kitchen for 3 of 3 randomly observed staff members. (Staff Member 52, Cook 6 and Kitchen Employee 13) Finding includes: During a random observation, on 6/6/24 at 9:35 a.m., Staff Member 52 and Cook 6 were observed in the kitchen. Staff Member 52 was in the kitchen past the line by the door, and did not have a hairnet over her hair. Cook 6 who was standing between the grill and the prep table did not have a facial covering over his mustache.	F 0812	No resident was affected. No adverse effects noted. All residents have the potential to be affected. All staff educated on verification of proper hair/beard restraints prior to entering the kitchen. As a measure of ongoing compliance, the DFS or designee will audit adherence to this policy for accuracy x4 weeks, then every other week x2 months, then monthly x3 months. As a quality measure, the DFS or designee will review any findings and corrective	07/19/2024

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	During a random observation, on 6/7/24 at 8:50 a.m., Kitchen Employee 13 was observed at the prep table to the left of the door wearing a facial hair covering under his chin. At that time, he indicated he forgot to put it back on. He was noted to have hair on his chin, jaw line and under his nose. During an interview, on 6/6/24 at 9:38 a.m., Staff Member 52 indicated Cook 6 did have facial hair which should have been covered. During an interview, on 6/10/24 at 11:09 a.m., Kitchen Employee 13 indicated noone was to be past the barrier on the kitchen floor without a head and/or facial hair covering. The border was noted to be approximately 2.5 feet into the kitchen and approximately 3 feet wide and found on the floor right inside the door to the kitchen. A facility policy, titled "Hair Restraint," dated as last approved January 2024 and received from the Regional Coorporate Nurse on 6/6/24 at 1:50 p.m., indicated "...employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair...." 3.1-21(i)(3)		action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0882 SS=D Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology,			

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	microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) was professionally trained in nursing, medical technology, microbiology, epidemiology, or other related field and was also able to dedicate at least part-time to the roll for 1 of 1 Infection Preventionist reviewed. Findings include: During an interview, on 6/10/24 at 3:00 p.m., the Executive Director indicated she was the Infection Preventionist. She had taken CEU (continuing education unit) classes for the Infection Preventionist. The Assistant Director of Nursing (ADON) was the acting Infection Preventionist. The ADON had not passed the testing and was not certified. The Executive Director did not have a nursing degree and could not dedicate part-time to the role of the Infection Preventionist while overseeing the day-to-day operations of the facility. The State Operations Manual (SOM) indicated "...The intent of this regulation is to ensure that the facility designates a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control	F 0882	No residents were affected by the alleged deficient practice. All residents have the potential to be affected. Education provided to the ED/DHS to ensure that the facility has a designated nurse who has completed the specialized training in infection and prevention control. The ADHS completed training for the Infection Preventionist role on 6/18/2024. As a measure of on-going compliance, the Director of Health Services (DHS) or will ensure that there is always a certified IP nurse in place. The results of the audit observations will be reported to, reviewed by, and trended by, the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved.	07/19/2024

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	infections...The IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or other related field...The facility should ensure the individual selected as the IP has the background and ability to fully carry out the requirements of the IP based on the needs of the resident population, such as interpreting clinical and laboratory data...the amount of time required to fulfill the role must be at least part-time and should be determined by the facility assessment...Based upon the assessment, facilities should determine if the individual functioning as the IP should be dedicated solely to the IPCP. A facility should consider resident census as well as resident characteristics, types of units such as respiratory care units, memory care, skilled nursing and the complexity of the healthcare services it offers as well as outbreaks and seasonality of infections such as influenza in determining the amount of IP hours needed. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA...." 3.1-18(b)(1)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00483889. Complaint IN00483889 - No Federal/State deficiencies related to the allegations are cited.	R 0000	The submission of this plan of correction does not indicate an admission by Cumberland Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Cumberland	

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	Survey dates: June 3, 4, 5, 6, 7 and 10, 2024. Facility number: 000547 Residential Census: 59 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 18, 2024.		Health Campus.¿ ¿ The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility.¿ It is thus submitted as a matter of statute only.¿ The facility respectfully requests from the department a desk review for substantial compliance.¿¿	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview and record review, the facility failed to ensure a severely cognitively impaired resident was not self-administering medications and a physician's order for the medications to be self-administered was obtained for 1 of 3 residents reviewed for self-medication administration. (Resident 42) Finding includes:	R 0216	All residents have the potential to be affected. All nurses were educated on residents who can self-administer. All residents requesting self-administer medications will be reviewed for completion of the self-administration observation. As	07/19/2024

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	During an observation with the Clinical Support Nurse and Administrator in Training, on 6/6/24 at 3:19 p.m., Resident 42 had one 7-day pill container on top of her dresser and another 7-day pill container in the top drawer of her dresser. There were also various pill bottles in the top drawer of the dresser including one bottle of vitamin D3, one bottle of lysine (an amino acid supplement), one bottle of anti-diarrheal medication, one container of CBD cream, one bottle of vitamin B12, one bottle of acetaminophen, one bottle of aspirin, one bottle of Pepcid, one bottle of calcium magnesium, and one bottle of healthy eye vitamins. The resident was not able to identify the medications in the pill containers or in the drawer and she indicated she did not know what all the pills were for. The clinical record was reviewed on 6/6/24 at 4:27 p.m. The diagnoses included, but were not limited to, dementia and heart failure. A self-administration of medication assessment, dated 11/22/23, indicated the resident's cognitive status was modified independence with some difficulty in new situations only. The resident was able to name the dosage, frequency and reason for the use of each medication. The resident was able to self-administer medications and the medications would be stored in the resident's room. The assessment did not include the resident's family would administer the medications. A service plan, signed on 5/6/24, indicated the resident BIMS score was 0 which indicated severe impairment. The resident did not require assistance in administering, organizing and storing medications. The medications were to be		a measure of ongoing compliance, the DHS or designee will audit medication passes during rounding to ensure that medications are administered according to policy. Audit of 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. The IDT will pull the PRN administration history to ensure the appropriate documentation is in place. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	

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	available for self-administration. A physician's order, dated 6/5/24, indicated to complete a self-medication administration observation every 3 months. There was no physician's order for which medications could be self-administered. During an interview, on 6/6/24 at 3:24 p.m., the Clinical Support Nurse indicated the resident had a Brief Interview for Mental Status (BIMS) of 5 which indicated the resident was severely cognitively impaired. The resident's family administered the medications and not the resident. A current policy, titled "AL-Self Administration Guidelines," dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 6/7/24 at 11:20 a.m., indicated "...To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care...Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed for safety by a licensed nurse...Results of the assessment will be presented to the physician for evaluation and an order for self-medication...The order should include the type of medication[s] the resident is able to self-medicate...."			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for			

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	155775	A. BUILDING 00 B. WING	06/10/2024

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	authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure as needed (prn) medications were authorized by a licensed nurse prior to the Qualified Medication Assistant (QMA) administering the medication for 1 of 7 residents reviewed for prn medications. (Resident 43) Finding includes: The clinical record for Resident 43 was reviewed on 6/6/24 at 2:31 p.m. The diagnoses included, but were not limited to, osteoarthritis, diverticulosis, heart failure, and stage 3 chronic kidney disease. A physician's order, dated 5/20/24, indicated to give loperamide (an anti-diarrheal) 2 milligram (mg) one capsule every 12 hours as needed for diarrhea. A Medication Administration Record, dated 5/20/24 through 6/4/24, indicated QMA 14 gave a dose of loperamide on 5/24/24 at 10:54 p.m. There was no documentation in the electronic health record (EHR) to show a licensed nurse authorized the use of the prn loperamide. During an interview, on 6/7/24 at 12:14 p.m., the Clinical Support Nurse indicated there was no documentation in the EHR to show a licensed nurse gave authorization for the use of the prn loperamide. A current policy, titled "Administration of PRN Medications," dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 6/7/24 at 11:20 a.m., indicated "...If PRN medication is to	R 0246	Res 43 was affected. No adverse effects noted. Immediately assessed with any findings updated in their record and provider notifications made. All residents have the potential to be affected. Education provided to CRMAs and Nurses on Medication and Treatment Records Guidelines to ensure all PRN medications have been authorized by a licensed nurse and documented in the resident's chart. As a measure of ongoing compliance, the DHS or designee will audit PRN medication passes during rounding to ensure that medications are administered according to policy and documentation is in place. Audit of 3 residents, 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	07/19/2024

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	be administered by a QMA the Standards of Practice for PRN, medication administration by a Qualified Medication Assistant shall be observed under the direction of a licensed nurse...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure staff were wearing hair and facial covers while in the kitchen for 3 of 3 randomly observed staff members. (Staff Member 52, Cook 6 and Kitchen Employee 13) Finding includes: During a random observation, on 6/6/24 at 9:35 a.m., Staff Member 52 and Cook 6 were observed in the kitchen. Staff Member 52 was in the kitchen past the line by the door, and did not have a hairnet over her hair. Cook 6 who was standing between the grill and the prep table did not have a facial covering over his mustache. During a random observation, on 6/7/24 at 8:50 a.m., Kitchen Employee 13 was observed at the prep table to the left of the door wearing a facial hair covering under his chin. At that time, he indicated he forgot to put it back on. He was noted to have hair on his chin, jaw line and under his nose. During an interview, on 6/6/24 at 9:38 a.m., Staff Member 52 indicated Cook 6 did have facial hair which should have been covered.	R 0273	No resident was affected. No adverse effects noted. All residents have the potential to be affected. All staff educated on verification of proper hair/beard restraints prior to entering the kitchen. As a measure of ongoing compliance, the DFS or designee will audit adherence to this policy for accuracy x4 weeks, then every other week x2 months, then monthly x3 months. As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	07/19/2024

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	During an interview, on 6/10/24 at 11:09 a.m., Kitchen Employee 13 indicated noone was to be past the barrier on the kitchen floor without a head and/or facial hair covering. The border was noted to be approximately 2.5 feet into the kitchen and approximately 3 feet wide and found on the floor right inside the door to the kitchen. A facility policy, titled "Hair Restraint," dated as last approved January 2024 and received from the Regional Coorporate Nurse on 6/6/24 at 1:50 p.m., indicated "...employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair...."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure a resident who was listed as being able to self-administer medications had the medications secured in the room for 1 of 3 residents reviewed for self-medication administration. (Resident 42) Finding includes: During an observation with the Clinical Support Nurse and Administrator in Training, on 6/6/24 at 3:19 p.m., Resident 42 was in the bathroom, the door to her room was opened. There was a 7-day pill container sitting on top of her dresser. The resident then came out of the bathroom and showed the top drawer of her dresser was not locked and she had another 7-day pill container filled with medications and one bottle of vitamin D3, one bottle of lysine (an amino acid	R 0295	br=""> ="" p=""> All residents have the potential to be affected. Education provided to nurses on Self- Administration of Medication Guidelines and to ensure medications are kept in a locked drawer in the residents' room. As a measure of on-going compliance, the DHS or will audit who are able to self- administer their medications to ensure they are in a locked drawer. Audit to consist of 3 residents, as available, 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. As a quality measure, the DHS or	07/19/2024

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	supplement), one bottle of anti-diarrheal medication, one container of CBD cream, one bottle of vitamin B12, one bottle of acetaminophen, one bottle of aspirin, one bottle of Pepcid, one bottle of calcium magnesium, and one bottle of healthy eye vitamins. The resident was not able to identify the medications in the pill container or in the drawer. The clinical record for Resident 42 was reviewed on 6/6/24 at 4:27 p.m. The diagnoses included, but were not limited to, dementia and heart failure. During an interview, on 6/6/24 at 3:24 p.m., the Clinical Support Nurse indicated the medications were not secure in the resident's room. The resident had a Brief Interview for Mental Status (BIMS) of 5 which indicated the resident was severely cognitively impaired. The resident's family administered the medications and not the resident. A current policy, titled "AL-Self Administration of Medications Guidelines," dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 6/7/24 at 11:20 a.m., indicated "...Residents requesting to self-medicate or had self-medication as a part of their plan of care shall be assessed for safety by a licensed nurse...The medication will be kept in a locked drawer in the residents' room...The resident will maintain the key and a second key will be maintained by the licensed nurse and or QMA [Qualified Medication Assistant]...."		designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	