STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00389598. Complaint IN00389598 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686. Survey dates: September 12, 13, 14, 15, 16, 19, and 20, 2022. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 5 Medicaid: 74 Other: 3 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 3, 2022.	F 0000	PLAN OF CORRECTION FOR ENVIVE OF INDIANAPOLIS F000 INITIAL COMMENTS 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 to respond to the allegation of noncompliance cited during the Recertification and State Licensure with a Complaint Survey IN IN00389598 completed on September 20, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance as of October 21, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance			

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

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	directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to ensure that residents had orders for	F 0578	**F578 – Request/Refuse/Discontinue**	10/21/2022

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	advanced directives for 2 of 2 residents (Residents 286 and 45). Findings include: 1. On 9/14/22 at 11:08 a.m. Resident 286's record was reviewed. Diagnoses included, but were not limited to chronic kidney disease, hyperlipidemia, iron deficiency anemia, and unspecified tremors. Resident 286's record lacked an order for advanced directives. On 9/15/22 at 9:36 a.m., Registered Nurse (RN) 27 was interviewed. He was unable to find an order for Resident 286's advanced directive. In the absence of an order for an advanced directive, Resident 286 would be considered a full code. 2. On 9/14/22 at 11:44 a.m., Resident 45's record was reviewed. His diagnoses included, but were not limited to chronic obstructive pulmonary disease, weakness, and hypertension. Resident 45's face sheet indicated that his advanced directive was for a Do Not Resuscitate (DNR). He had a physician's order, dated 5/8/22, for DNR. Resident 45 had a Physician's Order for Scope and Treatment (POST) dated 6/23/22. The POST assessment indicated that the resident desired to have Cardiopulmonary Resuscitation (CPR). On 9/15/22 at 11:00 a.m., the Vice President (VP) of Clinical Operations indicated that a building wide audit of resident records was being conducted. Resident 45's order was corrected to indicate that he was to have CPR. On 9/20/22 at 4:21 p.m., a current policy, dated		**Treatment; Formulate Advanced Directive** **SS=D** *"Based on record review and interview, the facility failed to ensure that residents had orders for advanced directives for 2 of 2 residents (Residents 286 and 45)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Advanced directive orders have been obtained for residents 286 and 45. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents admitted have the potential to be affected by the alleged deficient practice. · DNS/designee will audit all current residents by 10/21/2022 to ensure advanced directives orders are in place. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?**	

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	9/2022, titled, "Cardiopulmonary Resuscitation," was provided by the VP of Clinical Operations. The policy indicated, " ...A physician order shall be obtained to correspond with the resident/responsible party's wishes...." 3.1-4(d) 3.1-38(f)		· All licensed clinical staff and Admissions team will be in-serviced on: o "Advanced Directives Policy" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/designee will audit 5 newly admitted residents three times a week x4 weeks, then twice a week x8 weeks, then weekly x 3 months to ensure advanced directive orders are in place, POST completed, and care planned. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 10/21/2022	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State			

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	plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or			

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	resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 11) who received Medicare services, was provided appropriate and timely notification when her Medicare services came to an end for 1 of 3 resident reviewed for Notice of Medicare Non-Coverage (NOMNC). Findings include: On 9/12/22 at 10:55 a.m., Resident 11 was observed in her room. She was sitting upright in her wheelchair with her body hunched forward and leaned to the right. Her head was also tilted to the right. She was unable to answer simple yes/no questions, she was unable to maintain eye contact, and she stared off during conversation. On 9/13/22 at 11:53 a.m., a second attempt was made to interview Resident 11. She remained alert and occasionally made eye contact, but she was unable to state her name, or answer simple yes/no questions. On 9/14/22 at 2:11 p.m., Resident 11's medical record was reviewed. She had a current diagnosis of Cerebral Palsy (a disorder that affect a person's ability to move and maintain balance and posture). A Nurse Practitioner (NP) progress note, dated 2/9/22, indicated Resident 11 had a history of seizures and epilepsy after a left hemisphere stroke at an early age which also resulted in a	F 0582	**F582 – Medicaid/Medicare Coverage/Liability Notice SS=D** *"Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 11) who received Medicare services, was provided appropriate and timely notification when her Medicare services came to an end for 1 of 3 resident reviewed for Notice of Medicare Non-Coverage (NOMNC)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 11's POA was notified of situation and provided copy of NOMNC. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents receiving Medicare services have potential to be affected by this alleged deficient practice.	10/21/2022

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	developmental delay. The most recent comprehensive Minimum Data Set (MDS) assessment was an annual assessment, dated 6/24/22. The MDS indicated Resident 11 was rarely able to understand or make herself understood and was severely mentally impaired. Resident 11's mother had legal guardianship as declared by the local Superior Court on 5/10/2002. A NP progress note, dated 6/29/22 at 10:24 p.m., indicated the NP had been contacted to review labs, however, could not discuss the results with Resident 11 due to her cerebral palsy disease process. Resident 11 was issued a Notice of Medicare Non-Coverage (NOMNC) notice. The notice indicated her skilled Medicare services would end on 4/8/22. The form lacked the date the notice was received. The noticed was signed electronically with Resident 11's name in cursive. During an interview, on 9/20/22 at 10:15 a.m., with the Social Service Director (SSD) and the Administrator present, the SSD indicated Resident 11 was not competent to sign her name and the notice should have been provided to Resident 11's guardian. The Administrator indicated the Business Office Manager was responsible for providing NOMNC notifications, but there had been several changes in the department. The Administrator was not sure who had incorrectly issued the notice. Resident 11's guardian was "very" involved and should have received the notice instead. During an interview on 9/20/22 at 10:30 a.m., the SSD indicated there was no specific policy for the		· An audit was completed from April 8, 2022, to date, for residents receiving Medicare Services to ensure proper notification, signature and date are in place on Notice of Medicare Non-Coverage (NOMNC). Any issues noted were corrected immediately **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · Business Office Manager (BOM) will be in-serviced on: "NOMNC Form Instructions" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · BOM/designee will audit 5 residents receiving Medicare services three times a week x 4 weeks, then twice a week x 8/ weeks, then weekly x 3 months to ensure proper notification, signature and date are in place on Notice of Medicare Non-Coverage (NOMNC). The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued	

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	NOMNC notification, but the instructions were included on each form and should be issued with at least 48 hours' notice. If the resident was incompetent, it should be provided to the guardian/representative and/or next of kin. 3.1-4(f)(3)		recommendations for process monitoring and improvement until 100% compliance is achieved. . **5. Date of completion:** 10/21/2022	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)			

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	(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. A. Based on observation and interview, the facility failed to ensure the Behavioral Health Unit was maintained in a clean, comfortable, homelike environment by establishing an effective preventative maintenance and housekeeping program resulting in carpets that were growing what appeared to be mold, an empty resident room not cleaned after the ceiling caved in, a room with feces smeared on the mattress and carpet after the resident vacated, and an infestation of gnats. This deficient practice had the potential to effect 43 of 43 residents who resided on the Behavioral Health Unit. B. Based on observation and interview, the facility failed to ensure a resident on the C hall of the Behavioral Health Unit had a safe functioning toilet seat for 1 of 1 resident reviewed for a broken toilet seat (Resident C). C. Based on observation and interview, the facility failed to ensure 1 of 2 hallways on the Behavioral Health unit were maintained in a homelike environment (Residents 66 and 83). Findings include: A1. During a tour of the Behaviors Health Unit	F 0584	**F584 – Safe/Clean/Comfortable/Homelike Environment** **SS=E** *"A. Based on observation and interview, the facility failed to ensure the Behavioral Health Unit was maintained in a clean, comfortable, homelike environment by establishing an effective preventative maintenance and housekeeping program resulting in carpets that were growing what appeared to be mold, an empty resident room not cleaned after the ceiling caved in, a room with feces smeared on the mattress and carpet after the resident vacated, and an infestation of gnats. This deficient practice had the potential to effect 43 of 43 residents who resided on the Behavioral Health Unit.* *B. Based on observation and interview, the facility failed to ensure a resident on the C hall of the Behavioral Health Unit had a safe functioning toilet seat for 1 of*	10/21/2022

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	(BHU) on 9/12/22 from 1:04 p.m., until 1:15 p.m., the following was observed. Upon entrance onto the BHU, D-hall, there was a smell of stagnant, musty humid air. The door to room D3 was closed but unlocked and opened freely. The back corner ceiling had completely caved in. Parts of drywall, insulation, and splintered wood still hung down from the ceiling, and were scattered across the floor and all remaining furniture. When stepped on, the carpet was spongey and saturated with moisture, and there were irregular shaped patches of green/yellow/white substances growing on the carpet which appeared to be mold. The door to room D13 was closed but unlocked and opened freely. Upon opening the door, a putrid odor was noted, the carpeted floor was observed to be fully discolored with large patches of green/yellow/white substances that sprouted up from the carpet and appeared to be mold. A copious amount of gnats were observed flying throughout the room. The door to room D15 was closed but unlocked and opened freely. Although the room appeared neat and cleaned, the carpets were spongey and saturated underfoot. There were patches of discoloration throughout the carpet that appeared to be mold. The door to room D22 was closed and locked. A potted plant was placed in front of the door, however, the bathroom door shared between D22 and D20 was unlocked. The bathroom door opened into D22 and there was a foul odor of excrement as a brown smeared substances was noted on the mattress and enmeshed in the carpet.		*1 resident reviewed for a broken toilet seat (Resident C).* *C. Based on observation and interview, the facility failed to ensure 1 of 2 hallways on the Behavioral Health unit were maintained in a homelike environment (Residents 66 and 83)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Room number D3, D13, D15, D20, D22 have been and will remained locked until repairs have been completed. · Resident C has a new toilet seat in place. All holes in the ceiling on C and D hall have been patched. · Residents 66 and 83 have had ceiling and walls repaired. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by this alleged deficient practice. · 100 % audit was completed on all active resident rooms and common areas on C and D hall (Behavior Unit). Any issues noted were fixed immediately.	

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	The D-Hall common area where residents gathered for activities, television (T.V.), and use of the vending machines was observed. The majority of the floor surface area was discolored and damp with moisture. The wall under the T.V. was densely speckled with gnats too great in number to count. When a nearby trash can was disturbed, the gnats took to flight and needed to be swatted away. During an interview on 9/12/22 at 2:15 p.m., the Administrator indicated there had been several leaks previously and when it rained really hard it leaked in several places. When there was a leak or an issue with the roof, the Maintenance Director would usually patch the repairs as best he could at that time, but he had the rest of the building to keep up with as well. The Administrator indicated to her knowledge the roof had been outsourced by corporate for replacement and they had still not determined a definitive timeframe to complete the replacement. Additionally, there had been a malfunction in the sprinkler system several weeks ago which caused water to be released and affected several areas of the building. In the meantime, the Administrator did not want to replace the carpet/flooring until the roof was fixed so that the new flooring would not be ruined. During an interview on 9/12/22 at 3:07 p.m., the Maintenance Director indicated there had been an issue with the sprinkler system weeks ago when a pressurized test had been conducted which caused a backup and had sprung leaks in the system throughout the facility. There had been several areas in the ceiling that the Maintenance Director cut out, so when the repairs were made the contractor could get to the pipes. As for the roof, it continued to leak when it rained and was		**3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · Maintenance and Housekeeping will be in-serviced on: "Homelike Environment" **4.How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · Maintenance Director /Designee will complete random audits on C and D hall three times a week x4 weeks, then twice a week x8 weeks, then weekly x 3 months to ensure facility is maintaining a clean, comfortable and safe homelike environment. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved **5 Date of completion:** 10/21/2022	

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	badly in need of replacement. However, he was not qualified to do it and could not to it by himself. He did not know if or when the roof would be repaired. In the meantime, he made trips to the hardware store to get materials to patch as needed, sometimes daily. A2. On 9/12/22 at 3:15 p.m., an environmental tour was conducted with the Maintenance Director. The above areas of concern were reviewed. At room D3 the Maintenance Director indicated he could not identify if the ceiling had caved due to the sprinkler system or the leaking roof. At room D13 the Maintenance Director indicated he had been notified by Housekeeping (HK) the previous Friday that the carpet needed to be replaced, but he had not been given any specifics. When he observed the room and carpet he indicated it was "really bad" and needed to come up as soon as possible (ASAP) but he had not seen it until now. At room D15 the Maintenance Director indicated sometimes the Packaged Terminal Air Conditioner (PTAC) units leaked and it was a "quick easy" repair. It appeared that the PTAC unit in D15 had not been turned off when the resident left, so it had continued to leak which had caused the carpets to become saturated. In the D-Hall common area, the Maintenance Director indicated he was not able to locate the source of the leak which had caused the carpets to become wet, but he assumed it had probably come from the sprinkler malfunction. He indicated the carpets needed to be cleaned. At room D22 the Maintenance Director indicated			

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	he had shut and locked the entrance to that room because when the sprinkler system malfunctioned it had caused some water to leak around some electrical cords and he did not want any residents to get into the room because of the potential for accidents. He observed the smeared substance on the mattress and floor and indicated he was aware of the issue because he saw it when he came in to repair the sprinkler. He had let HK know, but evidently it had not been cleaned yet. A3. On 9/12/22 at 3:48 p.m., an environmental tour was conducted with the Administrator and Vice President of Clinical Operations (VPCO) to observe the above areas of concern. At room D3, the Administrator indicated she did know there had been leaks but not specifically that D3 had been affected, and was unaware the ceiling had caved in. She indicated it needed to be repaired and the room should have been cleaned up immediately. At room D13, the Administrator indicated she had been notified on the previous Friday that the carpet needed to be replaced but was unaware of the extent of the concern. She raised her arm to her face due to the smell and left the room. At room D15, the Administrator indicated the floors were wet from the PTAC unit and the Maintenance Director was usually able to fix that if he had been notified. She indicated the carpet would need to be pulled up. At room D22, the Administrator indicated the door from the joining room needed to be locked to protect the other resident from going in and when she observed the smeared brown substance, she indicated it was stool and rooms should be deep			

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	cleaned as soon as a resident vacated. During an interview on 9/12/22 at 4:00 p.m., the Administrator was asked about the roof being replaced since during a previous complaint survey on 12/4/21, the Chief Operation Officer at that time had indicated a large budget had been granted with the specific intention to replace the roof and sprinkler system. The Administrator indicated she had asked repeatedly but, "every month, it is supposed to be next month." On 9/13/22 at 9:50 a.m., D3, D13, D15 and D22 had locks on the door with a sign that indicated, "out of order." During an interview on 9/13/22 at 10:00 a.m., the HK Supervisor indicated, she split her time between being HK Supervisor, Laundry Supervisor, and Central Supply Coordinator. Even though more HK staff had been hired, they still struggled to maintain daily tasks given the overall condition of the building and behavior of the residents. She had just been able to hire a floor tech, and a new carpet shampooer had arrived the previous week. She had been walking down D-Hall when she noted, "a funky smell." She traced it to D13 and when she opened the door, she was surprised to see how bad it had gotten. Approximately two months ago, the Administrator had made the decision to move residents around on the BHU to make a male and female hall. So, when a resident was moved out of their room on the D-hall, they were to deep clean the room and then close it up. No one had made regular checks into the closed rooms since there were no residents. On 9/21/22 at 1:06 p.m., the VPCO provided a copy of current facility policy title, "Clean Carpet Furn			

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	[Furniture]," dated 8/2022. The policy indicated, " ...Carpeting and cloth furnishings shall be cleaned regularly and repaired promptly...Carpets shall be deep-cleaned periodically (approximately once per month), or more often as needed...Carpet that becomes wet shall be dried thoroughly within 72 hours...."B. On 9/13/22 at 11:35 a.m., Resident C's room was observed. Resident C had his curtain pulled to his side of the bed. A hole with chipping material in the ceiling was observed in the corner of the room. A large amount of hard, white foam was observed behind the bed. The toilet seat was broken and attached by only one pin. During an interview on 9/13/22 at 11:35 a.m., Resident C indicated that he reported his broken toilet seat to maintenance. He indicated that the toilet seat was unsafe to sit on. During an interview on 9/13/22 at 12:05 p.m., the Administrator was made aware of the toilet seat being broken. During an observation on 9/14/22 at 11:00 a.m., the toilet seat remained broken. C. On 9/12/22 at 10:21 a.m., a large water stain around the ceiling light fixture to the right of the C Hall nurse's station was observed. The water stain was around 3 sides of the light, one side had a large hole in the ceiling. The ceiling tiles were observed bowing out with brown stains on the water stain. The hole in the ceiling was approximately 3 inches (") by (x) 7" in size. On 9/12/22 at 10:26 a.m., another large, unfinished ceiling repair was observed in the C hall between rooms C13 and C15. It was plastered, not sanded smooth, and not painted.			

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	On 9/19/22 at 8:48 a.m., Resident 66's wall was observed to be peeled. The paint and paper covering the plaster were missing. Scrapes and small gouges were observed in the plaster. The area was about 15" x 10". A numerous amount of peeled and curled wallboard paper was on the floor under the resident's bed. A white powder was observed on top of it all. Resident 66 indicated he had a habit of pulling on the wallboard. On 9/19/22 at 8:54 a.m., the C Hall light fixture with bowing, stained tiles had not been repaired. The hole in the ceiling had not been covered. On 9/19/22 at 8:59 a.m., the large, unfinished ceiling repair was observed in the C hall between rooms C13 and C15. The repaired was not finished. The plaster was not sanded, and it was not painted. On 9/19/22 at 9:10 a.m., a large stain was observed outside of a resident room C15. There was a new hole in the ceiling. On 9/19/22 at 9:38 a.m., a large, partially repaired hole, about 10" x 10," was observed in Resident 83's bedroom. A large piece of wallboard had been secured in the hole but did not cover it completely. Two holes were still visible, one hole was about 1" x 2," the other hole was approximately 1" x 3." No plaster had been applied and it was not painted. On 9/20/22 at 10:07 a.m., during a short tour of the behavior unit, the Maintenance Director indicated the large area of peeled wallboard in Resident 66's room was vandalism. No one had reported it to him, and he did not have a work order for it. The uncompleted repair in Resident 83's room			

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	happened because the resident punched the hole in the wall about a month ago. He indicated this hole was vandalism too. He indicated he had been busy the last 3 days pulling up carpet in 3 rooms in the D Hall. The issues in the resident's rooms were a low priority. He indicated the two large water stains in the C Hall were related to the sprinkler system leaking. The sprinkler system worked but did not drain correctly. An outside company was going to complete the repairs with the sprinkler system drainage and repair the water stains. Since they had not started the work yet, he would only be able to put a temporary patch on the hole. On 9/21/22 at 1:06 p.m., the VPCO provided a copy of current facility policy title, "Homelike Environment," dated 8/2022. The policy indicated, " ...Residents are provided with a safe, clean, comfortable and homelike environment...The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include...Clean, sanitary and orderly environment...Pleasant, neutral scents...." 3.1-9(a) 3.1-19(a)(4) 3.1-19(f) 3.1-19(f)(5)			
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to 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			

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	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 independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term			

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	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 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			

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	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 observation, interview, and record review, the facility failed to ensure resident's rights, and elder advocacy agencies information were posted in the locked Behavioral Health Unit. This potential deficiency had the potential to affect 43 of 43 residents who resided in the locked Behavioral Health Unit. Findings include: On 9/12/22 at 10:34 a.m., the locked Behavioral Health Unit was observed for resident rights and elder advocacy group information posted. None were observed. On 9/13/22 at 12:34 p.m., the locked Behavioral Health Unit was observed for resident rights and elder advocacy agencies information posted. None were observed. During an interview, on 9/20/22 at 10:11 a.m., Resident D indicated the Social Services Director (SSD) did not like him. He came in from outside and the SSD indicated to him he needed to go to the local homeless shelter for no reason. He was given documents that were a 30 day notice and a right to appeal. He provided the documents to review. Resident D began shaking badly and	F 0585	**F585 - Grievances** **SS=E** *"Based on observation, interview, and record review, the facility failed to ensure resident's rights, and elder advocacy agencies information were posted in the locked Behavioral Health Unit. This potential deficiency had the potential to affect 43 of 43 residents who resided in the locked Behavioral Health Unit."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The resident's rights and the elder advocacy agency information was posted on Behavioral health unit. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be**	10/21/2022

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	indicated this conversation was upsetting to him. He said he received the facility papers but did not understand what the notice of discharge or request for a hearing meant. He was sent to local homeless shelter and the staff at homeless shelter indicated the facility had no right to send him there. The SSD used to say that she would send him to homeless shelter as a "threat" to get him to go the psychiatric hospital. He had 3 to 4 big bags of clothes and medications sent with him but he did not know how to take medications or when. The homeless shelter staff called the facility and put all his stuff in a van and brought him back to nursing facility. He indicated he did not know he could have called the health department to make a complaint. If he known that, he would have never gone to the local homeless shelter. He was not aware of any elder agencies to help him. He resided on the locked Behavioral Health Unit. On 9/20/22 at 10:39 a.m., Certified Nursing Assistant (CNA) 48 indicated the elderly agencies information was in the Behavioral Health Unit activity room. On 9/20/22 at 10:41 a.m., the Activity Director indicated the resident's rights were on the wall in the Behavioral Health Unit activity room. On 9/20/22 at 10:43 a.m., a folder was observed stapled to the wall. It was labeled resident's rights. In the folder were several pages stapled together with elderly advocacy agencies on the last page. On 9/20/22 at 11:09 a.m., the Administrator indicated the resident rights and elder agency posting were in the main part of the building. The residents in the locked behavior unit could have come to the main activity area to see further information about resident rights and elder		**taken?** · All residents residing on the Behavioral Health unit have potential to be affected by this alleged deficient practice. · All Behavior residents were reviewed and no unsolved grievances noted. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All staff will be in serviced on the following o "Grievance process" o "Resident Rights" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · ED/Designee will complete an audit one time a month for 6 months to ensure Resident rights and elder advocacy agency information is posted in plane sight for all residents. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued	

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	information. She indicated some residents cannot leave the behavior unit. The Administrator indicated she thought it was enough to have that information posted in one place in the building and for the Behavioral Health Unit in the activity room. On 9/19/22 at 3:13 p.m., the Activity Director indicated the evening/night shift and weekends did know where the Behavioral Health Unit activity room key was kept. The activity personnel were in the building 7 days a week until 7:00 p.m. On 9/12/22, the Admissions Agreement was provided by the facility. A document within the admission agreement was titled, "Federal Resident Rights and Facility Responsibilities," was reviewed. It indicated, " ...Required Postings ...A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based services programs, and the Medicaid Fraud Control Unit; and a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, include but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advanced directives requirements ...and requests for information regarding returning to the community ...Survey Results: Posting and Access. The facility must post in a place readily accessible to residents, and family members and legal		recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 10/21/2022	

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	representative of residents, the results of the most recent survey of the facility...." 3.1-3(l) 3.1-3(t)			
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview, and record	F 0604	**F604 – Right to be Free from**	10/21/2022

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	review, the facility failed to ensure a resident, (Resident 12) who was in a fully enclosed bed was assessed on a regular basis and provided with stimulus to prevention isolation while in her bed and failed to assess safety precautions of the enclosed bed on a regular basis for 1 of 2 residents reviewed for restraints. Findings include: On 9/12/22 at 10:52 a.m., Resident 12 was observed sitting up in her Broda chair in her room. Her bed was a solid wood frame, with four fully enclosed walls, with blue plastic covered padding. The front wall was hinged at the bottom of the frame to swing down to open and close. There was a keyless latch which secured the wall in its upright position. The bed looked like a crib, but without slats, windows, or mesh. Attached to the ceiling at the foot of the bed, was a long metal wire that hung down into the enclosed bed. There was also a noted gap between the head of the bed frame and the mattress. There was no television (T.V.) within line of sight for Resident 12 if she were in the bed. There were no personal items, pictures, posters, comfort items posted on the surrounding walls or ceilings, and the blinds to her window remained closed throughout the survey timeframe. Additionally, there was way for staff could visualize Resident B from the hallway if she were in bed. During an interview on 9/19/22 at 10:39 a.m., Certified Nursing Assistant (CNA) 52 indicated Resident B used the padded bed to prevent her from falling. During an interview on 9/19/22 at 10:40 a.m., CNA 52 indicated she usually worked the night shift		**Physical Restraints** **SS=D** *"Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident 12) who was in a fully enclosed bed was assessed on a regular basis and provided with stimulus to prevention isolation while in her bed and failed to assess safety precautions of the enclosed bed on a regular basis for 1 of 2 residents reviewed for restraints."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 12 has been assessed and the bed has been found appropriate for resident to prevent injury. Resident has had personal items placed within sight for viewing while resting in her bed. Resident's TV has also been relocated so resident may view while in bed. Care plan has been reviewed and updated with appropriate interventions. MD order has been placed for crib bed. Bolster has been placed to prevent entrapment. **2. How other residents having the potential to be affected by the same deficient practice will be identified and**	

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	with Resident B. The bed had been put in to keep her from falling since she had lots of spasms. She was usually put in bed after dinner around 6 p.m., and got up around 6 a.m. During an interview in 9/19/22 at 10:44 a.m., CNA 51 indicated Resident B's bed was to help keep her from falling. The long metal wire that hung at the foot of the bed used to hold personal items like teddy bears or familiar objects, but he did not know where they went, and it was no longer utilized. On 9/19/22 at 12:39 p.m., the Director of Nursing (DON) provided additional documentation from Resident 12's hard chart. At this time, she indicated she had provided all she could find, but she did not have a revised care plan, the initial assessment or additional safety screenings or assessments which should have been conducted at least quarterly. The initial care plan she located in medical records had not been transcribed into the electronic record and the nursing staff did not have 24-7 access to the medical records. On 9/19/22 at 12:14 p.m., Resident 12's bed was observed with the Maintenance Director. At this time, he measured the gap between the head of the frame and the mattress as the mattress was positioned flat. It measured 4 inches. When the head of the bed was elevated to an approximate 30-degree angle, the measurements increased to 7.5 to 8 inches. The Maintenance Director indicated the gap was too wide. On 9/19/22 at 2:23 p.m., Resident 12's medical record was reviewed. Her primary active diagnosis was Huntington's disease. She had a current physician order for padded side		**what corrective action will be taken?** · All residents with crib beds have the potential to be affected by the alleged deficient practice. · DNS/designee will audit all residents with crib beds by 10/20/22 to ensure residents have been assessed and stimulus in place to prevent isolation while in bed and safety precautions are in place. No additional residents are in crib beds at this time. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur.** · All licensed clinical staff will be in-serviced on: o "Restraints" · Maintenance and all licensed clinical staff will be in serviced on: o "Bed Rails/Side Rails" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/designee will audit 5 residents in crib beds three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure residents have been assessed and stimulus in place to prevent isolation while in	

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	rails and an order to elevate the head of her bed per resident comfort to alleviate shortness of breath while lying flat, and to keep the head of bed elevated at a 34-40 degree angle 1-hour after her tube feedings. There was no order for a crib/cradle-bed. A nursing progress note, dated 2/27/20, indicated, " ... new bed arrived assessed for safety in bed ... bed is fully enclosed with padded siding ... full enclosure will prevent falls ... TV relocated so she may be able to see and provide stimulus. Mirror hung on wall so staff may visualize with bed walls up from the hall ... MD in agreement with bed choice will continue to evaluate to further mitigate risks ...." A side rail screen, dated 5/31/21, was provided but lacked specification for the intent which should be check marked for one of the three following reasons: Enabler, Provide Bed Parameters or Seizure Precautions. Parameters for the gap allowed between the rails and the mattress were restricted to less than 4 and 3/4 inches. The record lacked quarterly assessments and screening. The record lacked additional safety checks. The record lacked documentation less restrictive measures had been tried by the interdisciplinary team and shown to be ineffective. A comprehensive care plan, initiated 1/21/19 but last revised 2/20/22, indicated Resident 12 had Huntington's disease and required a fully enclosed bed with padded sides. On 9/19/22 at 3:45 p.m., the Administrator		bed and safety precautions are in place. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5.** Date of completion: 10/21/2022	

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	provided a copy of current facility policy titled, "Bed Rails/Side Rails," dated 8/2022. The policy indicated, " ...the resident's sleeping environment shall be assess by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement...try to prevent deaths/injuries and problems from the eds and related equipment (including frame, mattress, side rails, headboards, footboards, and bed accessories), the facility shall promote the follow approaches; Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; Review gaps within the bed system are within the dimension established by the FDA (note: the review shall consider situations that could be caused by the resident's weight, movement or bed position) ... side rails should not be used as protective restraints...." On 9/19/22 at 3:45 p.m., the Administrator provided a copy of current facility policy titled, "Restraints," dated 8/2022. The policy indicated, " ... Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convince, or for the prevention of falls...." 3.1-26(a) 3.1-26(s)			
F 0622 SS=G Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility			

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	unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a			

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	resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of			

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	care. A. Based on observation, interview, and record review, the facility failed to ensure a resident admitted to the behavior unit with diagnoses of Alzheimer's disease, psychotic disorder with delusions, and schizoaffective disorder was not threatened to be discharged due to behaviors without documentation of failed interventions which resulted in psychosocial harm when Resident D was discharged from the facility to a homeless shelter due to not controlling his behaviors for 1 of 3 residents reviewed for discharge (Resident D). B. Based on observation, interview, and record review, the facility failed to communicate pertinent information, COVID status, and an assessment of a resident's condition to a receiving hospital for a change in condition for 1 of 3 residents reviewed for transfer and discharge (Resident 81). Findings include: A. During an interview, on 9/20/22 at 10:11 a.m., Resident D indicated the Social Services Director (SSD) did not like him. He came in from outside and the SSD indicated to him he needed to go to the local homeless shelter for no reason. He indicated he was given documents that were a 30 day notice and a right to appeal. He provided the documents to review. Resident D began shaking badly and indicated this conversation was upsetting to him. He said he received the papers but did not understand what the notice of discharge or request for a hearing meant. On the day of his discharge, he was in his room at the facility and the SSD indicated it was time to go. He had just been laying down. He indicated he was sent to the local homeless shelter and the staff at local homeless shelter indicated the facility had no	F 0622	**F622 – Transfer and Discharge Requirements** **SS=G** *" A. Based on observation, interview, and record review, the facility failed to ensure a resident admitted to the behavior unit with diagnoses of Alzheimer's disease, psychotic disorder with delusions, and schizoaffective disorder was not threatened to be discharged due to behaviors without documentation of failed interventions which resulted in psychosocial harm when Resident D was discharged from the facility to a homeless shelter due to not controlling his behaviors for 1 of 3 residents reviewed for discharge (Resident D).* *B. Based on observation, interview, and record review, the facility failed to communicate pertinent information, COVID status, and an assessment of a resident's condition to a receiving hospital for a change in condition for 1 of 3 residents reviewed for transfer and discharge (Resident 81)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D remains in facility and failed interventions are being documented. Resident has no plan for discharge.	10/21/2022

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	right to send him there. He indicated the SSD used to say that she would send him to the local homeless shelter as "a threat" to get him to go the psych hospital. On the local homeless shelter day, he was mad and he faced the wall. The police came and got him to go to the front door. The police said if he didn't go to the local homeless shelter then he would go to jail in the police car. He had 3 or 4 big bags of clothes and medications. He indicated he did not know how to take medications or when. The people at local homeless shelter told him they do not dispense medications. He did not take any medications during his stay at local homeless shelter because he didn't know how to take it. The local homeless shelter staff called the facility and put all his stuff in a van and brought him back to the nursing facility. One resident at local homeless shelter tried to "start something with him," he just turned and walked away. His medication remained locked in his locked locker the whole time he was at Local homeless shelter. Resident D indicated with his occasional severe shaking he was unable to read. He indicated he did not try to read the medication packaging. He did not know how to take the medication, he did not know what kind of medications he takes now, so he left them alone. He indicated sometimes he thought about killing people. He had never killed anyone or tried to kill anyone. He only thought about killing his brother and sister because they took his money and threw him out. He indicated he was mad at the SSD but had not thought about killing her. Sometimes he felt like fighting, but not fighting to kill them. During an interview on 9/20/22 at 10:47 a.m., the		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents with behaviors and scheduled discharges have the potential to be affected by this alleged deficient practice. · Social Service (SS) has reviewed all residents with behaviors and pending discharges to ensure failed interventions are documented and communication with receiving facility has been completed. No residents with behaviors are currently pending discharge. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff and Social Services will be in-serviced on: o "Discharge/Transfer/Death" policy **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · SSD /Designee will complete an audit on 5 behavior residents with pending discharges three	

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	Administrator (ED) and SSD indicated they were trying to discharge Resident D from the facility because of his behaviors. The psych physician indicated he had a personality disorder, not behaviors. His behaviors were at a very high level compared to the other residents. The facility was trying to care for his needs. They were able to care for his needs. But this was a personality disorder. He did not "need to be around other people." On 9/15/22 at 11:50 a.m., Resident D's record was reviewed. Resident D was admitted on 10/15/21. His diagnoses included, but were not limited to, Parkinson's disease (progressive deterioration of motor function), Alzheimer's disease(progressive mental deterioration), Homicidal Ideations (thinking about, considering, or planning a homicide), Psychotic disorder with delusions (a mental disorder with a disconnection from reality with a belief in altered reality), anxiety disorder (mental health disorder of feelings of worry, or fear that interfere with daily activities), diabetes mellitus (blood sugar disorder), cognitive decline (reduction in cognitive ability such as memory, awareness, judgment and/or mental acuity), and Schizoaffective disorder, bipolar type (includes features of both schizophrenia, affects a person's thinking, sense of self, and perceptions, and a mood disorder such as bipolar disorder which includes mania and depression). He resided on the locked behavior unit. On 9/15/22 at 11:54 a.m., a review of Resident D's care plans was completed. They were created on 5/4/22. The care plans lacked documentation of no revisions after the resident's 2 psychiatric hospital stays, 2/24 to 3/11/22 and 7/20 to 7/29/22, and 5 incidents with other residents. The care plan problems were:		times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure residents have failed interventions documented and receiving facility has received communication regarding COVID status, resident assessment and change of condition. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5. **Date of completion:** 10/21/2022	

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	1. Resident D had a diagnosis of homicidal behavior. 2. The resident uses anti-anxiety medication related to anxiety disorder. 3. The resident uses anti-psychotic medications related to schizoaffective disorder, bipolar type. Behavior management, Potential for injury to self or others. 4. Resident D exhibits restlessness, nervousness and/or other anxiety symptoms related to a diagnosis of anxiety. 5. Resident D had impaired cognitive function/impaired thought process related to diagnosis of Alzheimer's and is at risk for decline. 6. Impaired thought processes/altered mental status related to diagnoses of schizoaffective disorder, bipolar type and Psychotic disorder with delusions due to known physiological condition. A care plan, revised on 9/22/22, indicated the problem was Resident D had (Auditory, Visual) hallucinations (perception of something not present), delusional episodes, talking to himself in hallway and in his room, he had a history of threatening behaviors towards others, history of verbal aggression towards others, abusive language, history of throwing items, making statements about females and wanting a girlfriend. He was manipulative towards others, lunging at staff making threats, and making threatening gestures. The goal and interventions had not been updated since the care plan was created on 5/4/22. Resident D's reportable incidents to the Indiana Department of Health for the last 8 months were as follows: a. On 2/17/22, it was reported that Resident D wanted to borrow Resident 16's cell phone. She denied him and he called her a b***h.			

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	b. On 5/10/22, it was reported that Resident D made contact with Resident 17. Resident 17 was hallucinating and was sent to the hospital. c. On 5/17/22, it was reported that Resident 83 made racial comments to Resident D, and Resident D made contact with Resident 83. d. On 6/2/22, it was reported that Resident 17 made racial comments to Resident D, and Resident D pushed Resident 17. It was known that Resident 17 was in need of psych services. e. On 6/22/22, it was reported that Resident 83 made contact with Resident D for no reason. f. On 7/16/22, it was reported that Resident D pushed Resident C. Resident C fell and fractured his wrist. On 9/15/22 at 11:50 a.m., Resident D's "soft file" was provided by the SSD. These were dated paragraphs of information regarding Resident D and his progress to discharge. No times were noted. - On 2/23/22 with no time noted, the Social Services Director (SSD) indicated she had a conversation with the Ombudsman 41. She recommended the SSD to schedule a discharge care plan meeting, issue 30-day notice and allow Resident D to make an appeal within 10 days. She stated if an appeal had not been made within 10 days, then the facility had the right to discharge Resident D to the local homeless shelter. She recommended the SSD set the resident up with an appointment with the local mental health outpatient center. SSD had told the Ombudsman 41 the resident had made sexual comments, verbal and physical aggression towards staff and peers, but was independent with all ADLs, scored high on BIMS (brief interview for mental status) and inquired about discharge to the local homeless shelter.			

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	-On 3/9/22 with no time noted, SSD indicated she contacted the office of the Ombudsman but was unable to get through, left a voicemail and emailed Ombudsman 43. The SSD received a phone number for the local homeless shelter. -On 3/9/22 with no time noted, SSD received a call from Ombudsman 42 who stated she was filling in. SSD provided information to Ombudsman 42 on Resident D. She explained safety concerns with the resident returning to the facility. She stated that the facility should decide based on the safety of the patients in the facility but indicated to understand that the psych hospital can call the board of health to file a complaint and there could be repercussions. Ombudsman 42 recommended that SSD try to work with psych hospital to find alternative placement that would agree to accept him, especially all male facility. -On 3/11/22 with no time noted, Resident D scored 13/15 on BIMS. SSD contacted Ombudsman 42 to discuss the facility's right to discharge Resident D to Local homeless shelter due to concerns with him. She stated the facility had the right to discharge him to the Local homeless shelter. SSD informed Ombudsman 42 that Resident D was independent with all ADLs, recommended for medication management, and informed Ombudsman 42 that SSD had already contacted the local mental health outpatient center regarding scheduling an appointment. The SSD had contacted the transportation number that was provided to SSD from the mental health outpatient center. SSD provided information of the discharge location to the transportation provider, and transportation stated they just needed a contact number at the local homeless shelter to inform them of pick-up times for Resident D on appointment days. The transportation provider			

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	stated the local mental health outpatient center would contact transportation to schedule transport with date and time, they stated SSD does not need to schedule this with them. -On 3/11/22 with no time noted, a care plan meeting was held with SSD, Assistant Director of Nursing (ADON) and Resident D. SSD discussed recently being readmitted to facility this morning from an inpatient psychiatric (psych) stay. SSD asked Resident D if he recalled the reason for the psych stay, Resident D indicated he got into a fight. SSD agreed and discussed behaviors of becoming very loud with threatening behavior yelling and screaming out. We discussed his ADL (activity of daily living) status of being independent with all ADLS except medication management., discussed his potential 30-day notice to Local homeless shelter due to safety concerns of other residents. Resident D became very agitated and began yelling and screaming at SSD and ADON, stated he's not leaving, and he wanted to stay at the facility. SSD had difficulty speaking to Resident D due to yelling, screaming out. SSD educated Resident D on current verbal behavior and disruption to other peers. Resident continued to yell and scream. SSD attempted to redirect him but was unsuccessful. He screamed at SSD and ADON to leave his room. - On 3/16/22 at 2:53 p.m., the SSD was notified by the DON of Resident D had become agitated with staff regarding the smoking time. He slammed his jacket on the chair in hallway. SSD spoke with Resident D this afternoon regarding his behaviors. He denied having these behaviors. SSD re-educated him on appropriate behaviors. He expressed understanding. No behaviors noted during this visit.			

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	- On 3/18/22 at 12:54 p.m., a Social Services (SS) note indicated Resident D was visited by Psych therapist on this day with no concerns regarding behavior, psychosocial well-being, or mood. The Social Service Director (SSD) also visited with Resident D who was pleasant. No signs or symptoms of psychosocial well-being, mood concerns, or behaviors noted. - On 3/21/22 with no time noted, the SSD was notified Resident D was upset with a female peer and told her she cannot have another boyfriend. SSD and ADON spoke with him. He admitted to having this behavior and state he was jealous. SSD educated Resident D of previous conversation of him having behaviors and the potential for a 30-day discharge. He expressed understanding that this behavior could cost him a 30-day notice. He asked for a second chance. SSD stated she would speak with the Administrator. They would speak to him again next week. - On 3/23/22 at 1:33 p.m., an SSD note indicated the SSD visited with Resident D who was in good spirits. He showed no behaviors, no signs or symptoms of psychosocial well-being or mood concerns. - On 3/24/2022 at 2:34 p.m., an SSD note indicated the SSD and ADON visited with Resident D. SSD discussed threatening behaviors towards staff with yelling and screaming out, his impulsive outbursts, and safety concerns. Resident D was educated on 30 Day Discharge Notice that was issued to him on this day. He was educated on the right to file an appeal, and provided details on how to do so, and educated Resident D that he would discharge to the local homeless shelter. Educated Resident D on being followed by the local mental health outpatient center for			

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	medication management after his discharge. Resident D became agitated and began to raise his voice, he continued to ask for another chance. SSD educated Resident D again on his behaviors. Writer emailed a 30-Day Notice to Discharge Resident D to the Ombudsman. -On 4/8/22 at 10:46 a.m., a nursing note indicated the Assistant Director of Nursing (ADON), currently the Interim DON, indicated Resident D scored at a high risk on an elopement assessment due to being independently mobile and having dementia. -On 4/22/22 12:21 a.m., the Nurse Practitioner (NP) 40 indicated in a late entry that she had a discharge visit with Resident D. She indicated he was being seen today for discharge planning to the local homeless shelter per the facility. He had a past medical history of psychotic disorder, Alzheimer's disease, Schizoaffective disorder, Parkinson's disease, diabetes mellitus type 2, age-related cognitive decline, anxiety disorder, tremor, muscle weakness, difficulty in walking, and insomnia. He did not appear to be in any acute distress at this time or during this visit. He was resting quietly in a chair. He was oriented to person and place with periods of confusion. He was pleasant and cooperative. Medications were sent with Resident D upon his discharge. - On 4/22/22 at 2:53 p.m., the Discharge Summary indicated the SSD had spoken with Resident D several times throughout this week regarding his upcoming discharge on 4/22/22. She informed Resident D of the clinic providing transportation from the facility to their clinic for an initial appointment on 4/22/22, then would be transported to the local homeless shelter. Resident D became agitated throughout these			

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	visits and asked on different occasions for another chance. SSD attempted to redirect Resident D by educating him but was unable to due to him yelling at writer. Staff members visited with Resident D on this day regarding his discharge to the local homeless shelter related to the 30-day discharge notice. Resident refused to leave facility. He was yelling and screaming, with threatening behaviors. He told the staff the only way he was leaving was if the cops were called. Non-emergency police were contacted to assist with escorting Resident D to an outpatient clinic's vehicle. The police escorted Resident D outside and into van. He was discharged with medications, contact numbers, and discharge information. - On 4/25/22 at 5:56 p.m., the Staffing Coordinator/Unit Manager indicated Resident D returned to facility at 5:15 p.m. today. Resident returned with medications and his belongings. He was placed in a room on the locked behavior unit. Physician's orders were received to give him his 9:00 a.m. medication now per NP 40. He was alert and oriented times 3. He ambulated on own without an assistive device. His gait was steady. - On 4/25/22 at 6:00 p.m., Resident D's Admission/Readmission form indicated he was admitted from the local homeless shelter. He was oriented to person, place, time, and situation. He had a diagnosis of dementia and used 9 or more medication. His cognition was intact. - On 4/26/22 with no time noted, the SSD indicated she spoke with the local homeless Shelter Director. He indicated the shelter sent Resident D back to the facility as no one contacted them to inform them of Resident D being dropped off.			

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	- On 5/26/22 SSD was notified of Resident D "smacking" a Certified Nursing Aide (CNA) on the buttocks. SSD asked Resident D why he did it, educated him on appropriate behaviors and explained this behavior was inappropriate. Resident D apologized. - On 6/1/22 with no time noted, SSD was notified of Resident D becoming agitated and verbally aggressive as he stated he was jealous of the other peers wanting a girlfriend. SSD was able to redirect him with conversation, walking on the unit and offered activities of interest. He appeared in a better mood with no further behaviors noted. - On 7/20/22 with no time noted, the SSD, DON and the Rounding Psych physician and the Rounding Psych NP discussed Resident D and his behaviors. Possible in-patient referral was discussed. The Rounding Psych physician who also works at the local inpatient Psych denied him for inpatient psych stating medications would not help his behaviors. This was his personality and medication would not change or help him. He recommended the facility send Resident D to the local mental health outpatient center emergency room and recommended the facility to not accept him back to the facility. - On 8/4/22 with no time noted, the SSD attempted to contact the local mental health outpatient center to discuss group home placement but was unable to get through and unable to leave a voice message. - On 8/9/22 with no time noted, SSD spoke with Ombudsman 44 and requested recommendations and thoughts regarding placement for Resident D. Ombudsman 44 indicated a place to try who accepted residents with behaviors.			

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	- On 9/19/22 at 8:31 a.m., Administrator indicated she received a call from the local homeless shelter, and he indicated they would not accept him. He said you must have our permission; we will not accept him. - On 9/19/22 at 2:32 p.m., the SSD indicated she had provided all transfer documents to Resident D. He did not sign any transfer or discharge documents. - On 9/19/22 at 2:35 p.m., the Administrator indicated Resident D did not have a behavioral contract with the facility. On 9/19/22 at 3:13 p.m., the Activity Director (AD) indicated Activity Aide 36 had a good relationship with Resident D and was able to redirect him. Resident D liked to do crafts, loved newspapers, and activity staff talked to him. She indicated she did not know if the evening/night shift or weekends had special activities for him, but they did know where the activity room key was kept so they could have had access to supplies for his leisure. The facility also bought him cigarettes when he was out. Activity personnel were in the building 7 days a week until 7:00 p.m. On 9/19/22 at 3:14 p.m., the SSD indicated Resident D loved cleaning and organizing things in his room. The staff knew the resident very well. He liked to talk about cars. He liked to compare prices. The AD indicated she would take a computer to him to look at ads. The SSD indicated she was looking into making a binder of activities of interest for him. On 9/20/22 at 10:53 a.m., the SSD indicated the			

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	psych physician indicated to the facility to send Resident D to the local mental health outpatient center emergency room and not accept him back. They did not follow these instructions. On 9/20/22 at 11:00 a.m., the SSD provided a list of referred facilities to whom she had applied to send Resident D. Many of these buildings did not have a locked unit. Her documentation indicated she referred him to 37 buildings, 3 of them twice. On 9/20/22 at 11:16 a.m., the SSD indicated the Director of the Local homeless shelter called and talked to SSD and Administrator. He was very upset about Resident D arriving at the homeless shelter. He indicated the facility had to have permission. He called on 4/25/22 and insisted Resident D come back to the facility. On 9/12/22, the Admissions Agreement was provided by the facility. A document within the Admission Agreement titled, "Indiana Resident Rights and Facility Responsibilities," was reviewed. It indicated, " ...The resident has the right to be cared for in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...A copy of the resident's rights must be available in a publicly accessible area. The copy must be at least 12-point type...The transfer and discharge rights of residents of a facility are as follows...before an interfacility transfer or discharge occurs, the facility must ...place a copy of the notice in the resident's clinical record and transmit a copy to the following ...the local long term care ombudsman program for involuntary relocations or discharges only ...the notice of transfer or discharge...must be made by the facility at least thirty (30) days before the resident is transferred			

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	or discharged...At the planning conference, the resident's medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs...If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident's legal representative...The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan...." B. A record review was completed for Resident 81 on 9/20/22 at 9:41 a.m. She had the diagnoses including, but not limited to chronic obstructive pulmonary disease, atrial fibrillation, acute kidney failure, type 2 diabetes mellitus, congestive heart failure, and edema. A Nurse Practitioner progress note, dated 9/2/22 at 12:32 p.m., indicated a blood pressure of 99/58. It indicated that Resident 81 had pitting edema in her lower extremities and hands. Torsemide (diuretic) was increased on 8/29/22. A nursing progress note, dated 9/3/22 at 10:13 a.m., indicated that the resident refused to be weighed indicating that she did not feel good and did not want to be rolled (turned) yet. A nursing progress note, dated 9/3/33 at 2:33 p.m., indicated that Resident 81 refused torsemide indicating that the side effects, unusual dry mouth/thirst of torsemide and uncontrollable hand movement making it hard for her to eat. A nursing progress note, dated 9/4/22 at 1:36 p.m., indicated that the resident refused torsemide (a diuretic) indicating that she thought that the medication made her shake. There was no documentation to indicate that the physician was notified.			

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A nursing progress note, dated 9/4/22 at 4:21 p.m., indicated that Resident 81 had a blood pressure of 129/84.

A nursing progress note, dated 9/6/22 at 6:17 p.m., indicated a blood pressure reading of 109/57 and that resident was on daily diuretics but had to receive 80mg of Lasix intramuscular due to increased swelling. She was noted to be anxious with no shortness of breath and oxygen saturation of 96% on room air. It indicated that her blood pressure was slightly low the day prior and her metoprolol (a medication used to treat high blood pressure) was held as a result. She had labs ordered for later in the day, BMP (basic metabolic profile), CBC (complete blood count) and BNP (b-natriuretic profile) to evaluate volume status.

Resident 81 was sent to the local hospital on 9/7/22 for unstable vital signs, weakness, dilated pupil, and difficulty speaking. There were no vital signs documented at time of transfer. Resident 81 was admitted to the hospital with hypotension (low blood pressure) and altered mental status.

The VP of Clinical Services was interviewed on 9/20/22 at 12:49 p.m. She indicated that a discharge/transfer summary was not completed upon transfer of Resident 81 to the hospital to communicate Resident 81's pertinent information and assessment of her condition.

A policy titled, Discharge/Transfer/Death with a date of 8/2022, was provided by the Administrator on 9/21/22 at 1:06 p.m., it indicated, " ...A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the

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	resident's discharge needs, b. The post-discharge plan, c. The discharge summary ....". 3.1-12(a)(4) 3.1-12(a)(6)(A)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)			

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	(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a			

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	mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on observation, interview, and record review, the facility failed to ensure a resident in the locked behavioral unit received proper notice of discharge and failed to notify the ombudsman of a facility initiated resident discharge for 1 of 3 residents were reviewed for discharge (Resident D). Findings include: During an interview on 9/19/22 at 2:17 p.m., the Social Service Director (SSD) indicated she provided the Notice of Transfer or Discharge to	F 0623	**F623 – Notice Requirements Before Transfer/Discharge SS=D** *"Based on observation, interview, and record review, the facility failed to ensure a resident in the locked behavioral unit received proper notice of discharge and failed to notify the ombudsman of a facility initiated resident discharge for 1 of 3 residents were reviewed for discharge (Resident D)."*	10/21/2022

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	Resident D on 3/24/22 at 4:30 p.m. It was at the end of the business day and did not count as day 1. It indicated the effective date for the discharge was 4/23/22. Resident D was removed from the locked unit and escorted by the police out of the building on 4/22/22. The SSD indicated she did not realize the date was different on the Notice of Transfer/Discharge. The reason indicated the safety of the individuals in the facility was endangered. Resident D was removed from the building after 28 days had expired on 4/22/22. A Discharge Information document with Resident D name and dated 4/22/22 indicated Resident D would be discharged with 30 days' worth of medications. His prescriptions would be filled monthly by a local clinic. Part of his discharge information was a copy of his April MAR. During an interview on 9/19/22 at 2:20 p.m., the Administrator indicated Resident D did not sign any discharge documents. The ombudsman had indicated the resident would have 10 days to appeal. She believed he was not appealing by screaming and yelling when escorted out of the building by the police. On 9/15/22 at 11:50 a.m., Resident D's record was reviewed. Resident D was admitted on 10/15/21. His diagnoses included, but were not limited to, Parkinson's disease (progressive deterioration of motor function), Alzheimer's disease(progressive mental deterioration), Homicidal Ideations (thinking about, considering, or planning a homicide), Psychotic disorder with delusions (a mental disorder with a disconnection from reality with a belief in altered reality), anxiety disorder (mental health disorder of feelings of worry, or fear that interfere with daily activities), diabetes mellitus (blood sugar disorder), cognitive decline		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D remains in the facility and has no plan for discharge currently. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents in the locked behavior unit with planned discharges have the potential to be affected by this alleged deficient practice. · SS/Designee will audit all pending discharges from the locked behavior unit to ensure resident, and ombudsman have been notified. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff and SS will be in-serviced on: o "Discharge Policy" **4. How the corrective action will be monitored to ensure the**	

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	155077	A. BUILDING 00 B. WING	09/20/2022

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	(reduction in cognitive ability such as memory, awareness, judgment and/or mental acuity), and Schizoaffective disorder, bipolar type (includes features of both schizophrenia, affects a person's thinking, sense of self, and perceptions, and a mood disorder such as bipolar disorder which includes mania and depression). He resided on the locked behavior unit. Resident D's reportable incidents to the Indiana Department of Health for the last 8 months were as follows: a. On 2/17/22, it was reported that Resident D wanted to borrow Resident 16's cell phone. She denied him and he called her a b***h. b. On 5/10/22, it was reported that Resident D made contact with Resident 17. Resident 17 was hallucinating and was sent to the hospital. c. On 5/17/22, it was reported that Resident 83 made racial comments to Resident D, and Resident D made contact with Resident 83. d. On 6/2/22, it was reported that Resident 17 made racial comments to Resident D, and Resident D pushed Resident 17. It was known that Resident 17 was in need of psych services. e. On 6/22/22, it was reported that Resident 83 made contact with Resident D for no reason. f. On 7/16/22, it was reported that Resident D pushed Resident C. Resident C fell and fractured his wrist. On 9/15/22 at 11:50 a.m., Resident D's "soft file" was provided by the SSD. These were dated paragraphs of information regarding Resident D and his progress to discharge. No times were noted. - On 2/23/22 with no time noted, the Social Services Director (SSD) indicated she had a conversation with the Ombudsman 41. She recommended the SSD to schedule a discharge		**deficient practice will not recur i.e., what quality assurance program will be put into place?** · SSD/Designee will audit residents in the locked behavior unit with pending discharges three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure resident and ombudsman have received notice of discharge. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 10/21/2022	

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	care plan meeting, issue 30-day notice and allow Resident D to make an appeal within 10 days. She stated if an appeal had not been made within 10 days, then the facility had the right to discharge Resident D to the local homeless shelter. She recommended the SSD set the resident up with an appointment with the local mental health outpatient center. SSD had told the Ombudsman 41 the resident had made sexual comments, verbal and physical aggression towards staff and peers, but was independent with all ADLs, scored high on BIMS (brief interview for mental status) and inquired about discharge to the local homeless shelter. -On 3/9/22 with no time noted, SSD indicated she contacted the office of the Ombudsman but was unable to get through, left a voicemail and emailed Ombudsman 43. The SSD received a phone number for the local homeless shelter. -On 3/9/22 with no time noted, SSD indicated she was asked to contact local mental health outpatient center once a discharge date was established and she would set up an initial appointment. The local mental health outpatient center provided their transportation number to contact. Resident would be seen once every 3 months by a psychiatrist, and a therapist twice a month. -On 3/9/22 with no time noted, SSD received a call from Ombudsman 42 who stated she was filling in. SSD provided information to Ombudsman 42 on Resident D. She explained safety concerns with the resident returning to the facility. She stated that the facility should decide based on the safety of the patients in the facility but indicated to understand that the psych hospital can call the board of health to file a complaint and there could			

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	be repercussions. Ombudsman 42 recommended that SSD try to work with psych hospital to find alternative placement that would agree to accept him, especially all male facility. -On 3/9/22 with no time noted, SSD referred Resident D to several facilities, most have denied him. -On 3/11/22 with no time noted, Resident D scored 13/15 on BIMS. SSD contacted Ombudsman 42 to discuss the facility's right to discharge Resident D to Local homeless shelter due to concerns with him. She stated the facility had the right to discharge him to the Local homeless shelter. SSD informed Ombudsman 42 that Resident D was independent with all ADLs, recommended for medication management, and informed Ombudsman 42 that SSD had already contacted the local mental health outpatient center regarding scheduling an appointment. -On 3/11/22 with no time noted, a care plan meeting was held with SSD, Assistant Director of Nursing (ADON) and Resident D. SSD discussed recently being readmitted to facility this morning from an inpatient psychiatric (pysch) stay. SSD asked Resident D if he recalled the reason for the psych stay, Resident D indicated he got into a fight. SSD agreed and discussed behaviors of becoming very loud with threatening behavior yelling and screaming out. We discussed his ADL (activity of daily living) status of being independent with all ADLS except medication management., discussed his potential 30-day notice to Local homeless shelter due to safety concerns of other residents. Resident D became very agitated and began yelling and screaming at SSD and ADON, stated he's not leaving, and he wanted to stay at the facility. SSD had difficulty			

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	speaking to Resident D due to yelling, screaming out. SSD educated Resident D on current verbal behavior and disruption to other peers. Resident continued to yell and scream. SSD attempted to redirect him but was unsuccessful. He screamed at SSD and ADON to leave his room. - On 3/16/22 at 2:53 p.m., the SSD was notified by the DON of Resident D had become agitated with staff regarding the smoking time. He slammed his jacket on the chair in hallway. SSD spoke with Resident D this afternoon regarding his behaviors. He denied having these behaviors. SSD re-educated him on appropriate behaviors. He expressed understanding. No behaviors noted during this visit. - On 3/18/22 at 12:54 p.m., a Social Services (SS) note indicated Resident D was visited by Psych therapist on this day with no concerns regarding behavior, psychosocial well-being, or mood. The Social Service Director (SSD) also visited with Resident D who was pleasant. No signs or symptoms of psychosocial well-being, mood concerns, or behaviors noted. - On 3/21/22 with no time noted, the SSD was notified Resident D was upset with a female peer and told her she cannot have another boyfriend. SSD and ADON spoke with him. He admitted to having this behavior and state he was jealous. SSD educated Resident D of previous conversation of him having behaviors and the potential for a 30-day discharge. He expressed understanding that this behavior could cost him a 30-day notice. He asked for a second chance. SSD stated she would speak with the Executive Director (ED). They would speak to him again next week.			

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	- On 3/23/22 at 1:33 p.m., a SSD note indicated the SSD visited with Resident D who was in good spirits. He showed no behaviors, no signs or symptoms of psychosocial well-being or mood concerns. - On 3/24/2022 at 2:34 p.m., a SS note indicated the SSD and ADON visited with Resident D. SSD discussed threatening behaviors towards staff with yelling and screaming out, his impulsive outbursts, and safety concerns. Resident D was educated on 30 Day Discharge Notice that was issued to him on this day. He was educated on the right to file an appeal, and provided details on how to do so, and educated Resident D that he would discharge to the local homeless shelter. Educated Resident D on being followed by the local mental health outpatient center for medication management after his discharge. Resident D became agitated and began to raise his voice, he continued to ask for another chance. SSD educated Resident D again on his behaviors. Writer emailed a 30-Day Notice to Discharge Resident D to the Ombudsman. - On 3/25/22 at 12:29 p.m., an SSD note indicated the SSD contacted an outpatient clinic and attempted to schedule an initial primary care physician (PCP) appointment the outpatient clinic stated someone from admissions would contact SSD next week to schedule initial appointment. The outpatient clinic would provide transportation to and from his appointments. -On 4/8/22 at 10:46 a.m., a nursing note indicated the Assistant Director of Nursing (ADON), currently the Interim DON, indicated Resident D scored at a high risk on an elopement assessment due to being independently mobile and having dementia.			

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	-On 4/22/22 12:21 a.m., the Nurse Practitioner (NP) 40 indicated in a late entry that she had a discharge visit with Resident D. She indicated he was being seen today for discharge planning to the local homeless shelter per the facility. He had a past medical history of psychotic disorder, Alzheimer's disease, Schizoaffective disorder, Parkinson's disease, diabetes mellitus type 2, age-related cognitive decline, anxiety disorder, tremor, muscle weakness, difficulty in walking, and insomnia. He did not appear to be in any acute distress at this time or during this visit. He was resting quietly in a chair. He was oriented to person and place with periods of confusion. He was pleasant and cooperative. Medications were sent with Resident D upon his discharge. - On 4/22/22 at 2:53 p.m., the Discharge Summary indicated the SSD had spoken with Resident D several times throughout this week regarding his upcoming discharge on 4/22/22. She discussed scheduling an initial PCP appointment through local outpatient clinic, informed Resident D of the clinic providing transportation from the facility to their clinic for an initial appointment on 4/22/22, then would be transported to the local homeless shelter. The outpatient clinic would refill his medications monthly. She provided Resident D with the transportation number. She contacted the local mental health outpatient center to schedule initial appointment, they indicated they would transport him to and from appointments. The local mental health outpatient center was to contact writer back with initial appointment date as writer left a voice mail. Resident D became agitated throughout these visits and asked on different occasions for another chance. SSD attempted to redirect Resident D by educating him but was unable to due to him yelling at writer. Staff			

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	members visited with Resident D on this day regarding his discharge to the local homeless shelter related to the 30-day discharge notice. Resident refused to leave facility. He was yelling and screaming, with threatening behaviors. He told the staff the only way he was leaving was if the cops were called. Non-emergency police were contacted to assist with escorting Resident D to an outpatient clinic's vehicle. The police escorted Resident D outside and into van. SSD had made contact the outpatient clinic regarding Resident D's initial appointment; they stated Resident D had arrived and would be checked in. He was discharged with medications, contact numbers, and discharge information. - On 4/25/22 at 5:56 p.m., the Staffing Coordinator/Unit Manager indicated Resident D returned to facility at 5:15 p.m. today. Resident returned with medications and his belongings. He was placed in a room on the locked behavior unit. Physician's orders were received to give him his 9:00 a.m. medication now per NP 40. He was alert and oriented times 3. He ambulated on own without an assistive device. His gait was steady. - On 4/25/22 at 6:00 p.m., Resident D's Admission/Readmission form indicated he was admitted from the local homeless shelter. He was oriented to person, place, time, and situation. He had a diagnosis of dementia and used 9 or more medication. His cognition was intact. - On 4/26/22 with no time noted, the SSD indicated she spoke with the local homeless Shelter Director. He indicated the shelter sent Resident D back to the facility as no one contacted them to inform them of Resident D being dropped off. SSD informed the Shelter Director that she was unaware of needing to inform them of residents'			

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	arrival because they took walk-ins. The Shelter Director indicated that was no longer the case. On 9/21/22 at 2:44 p.m., the Ombudsman Leader indicated Ombudsman 41 was not employed by the Ombudsman program on 2/23/22 and believed the SSD entry for that date was invalid. The Ombudsman Leader indicated she had been in the facility several times for other residents but information or questions regarding Resident D's discharge never came up. Her office never received a Notification of Discharge document from the facility for Resident D. Whenever they got a notice of discharge, they would go to the facility to advocate for the resident. In our training, we learn to not send people to specific places, and we do not approve transfer discharges. No ombudsman spoke with Resident D. If the Ombudsman would have known they planned to discharge Resident D to the local homeless shelter they would not have agreed to this placement. The SSD never asked us to see Resident D. She only asked questions about how to help the facility discharge residents, nothing about how to advocate for the residents. On 9/21/22 at 4:03 p.m., Ombudsman 42 indicated she talked with the SSD on 3/9/22. The SSD provided no name and gave no specific information, she just indicated they had a resident who had aggressive behaviors, especially with women. The SSD indicated they wanted to discharge him to the local homeless shelter. Ombudsman 42 indicated she did not think that was appropriate to send him there, and the SSD needed to talk to them first because he was aggressive and had behaviors. Ombudsman 42 indicated it was apparent that the SSD did not like that information. Ombudsman 42 indicated she did not advise or tell them to send him to the local			

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	homeless shelter, she told them to call the local homeless shelter. She warned the SSD of the possibility of consequences if she refused to take him back, someone could call the Board of Health and file a complaint because that was considered "dumping" (residents suffering from mental illness are often released even though they are unable to care for themselves). On 9/12/22, the Admissions Agreement was provided by the facility. A document within the Admission Agreement, titled, "Indiana Resident Rights and Facility Responsibilities," was reviewed. It indicated, " ...The resident has the right to be cared for in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality ...A copy of the resident's rights must be available in a publicly accessible area. The copy must be at least 12-point type ...The transfer and discharge rights of residents of a facility are as follows ...before an interfacility transfer or discharge occurs, the facility must ...place a copy of the notice in the resident's clinical record and transmit a copy to the following ...the local long term care ombudsman program for involuntary relocations or discharges only ...the notice of transfer or discharge ...must be made by the facility at least thirty (30) days before the resident is transferred or discharged ...At the planning conference, the resident's medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs ...If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident's legal representative ...The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan ...."			

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	A current policy, titled, "Discharge," dated 8/2022, was provided by the VPCS on 9/21/22 at 1:03 p.m. A review of the policy indicated, " ...The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's ...As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be documented ...The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident ...A description of the resident's stated goals; the degree of caregiver/support person availability, capacity and capability to perform required care ...what factors may make the resident vulnerable to preventable readmission ...The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge ...The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan ...Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences ...If it is deterred that returning to the community is not feasible, it will be documented why this is the case and who made the determination ...A member of the IDT (interdisciplinary team) will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the			

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	discharge is to take place ...A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: An evaluation of the resident's discharge needs; the post-discharge pan; and the discharge summary ...." 3.1-12(a)(6)(A)(iv) 3.1-12(a)(7)			
F 0624 SS=G Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on observation, interview, and record review, the facility failed to ensure a resident was oriented and prepared for discharge with no plan with the receiving facility, the resident experienced psychosocial harm for 1 of 3 residents reviewed for discharge (Resident D). Findings include: On 9/15/22 at 11:50 a.m., Resident D's chart and the "soft file" from the Social Services Director (SSD) were reviewed. The "soft file," was provided by the SSD. These were dated paragraphs of information regarding Resident D and his progress to discharge. No times were noted. Resident D was admitted on 10/15/21. His diagnoses included, but were not limited to, Parkinson's disease (progressive deterioration of motor function), Alzheimer's disease(progressive	F 0624	**F624 – Preparation for Safe/Orderly Transfer/Discharge** **SS=G** *"Based on observation, interview, and record review, the facility failed to ensure a resident was oriented and prepared for discharge with no plan with the receiving facility, the resident experienced psychosocial harm for 1 of 3 residents reviewed for discharge (Resident D)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D remains in the facility and has no plan for	10/21/2022

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	mental deterioration), Homicidal Ideations (thinking about, considering, or planning a homicide), Psychotic disorder with delusions (a mental disorder with a disconnection from reality with a belief in altered reality), anxiety disorder (mental health disorder of feelings of worry, or fear that interfere with daily activities), diabetes mellitus (blood sugar disorder), cognitive decline (reduction in cognitive ability such as memory, awareness, judgment and/or mental acuity), and Schizoaffective disorder, bipolar type (includes features of both schizophrenia, affects a person's thinking, sense of self, and perceptions, and a mood disorder such as bipolar disorder which includes mania and depression). He resided on the locked behavior unit. On 9/15/22 at 11:54 a.m., a review of Resident D's care plans were completed. They were created on 5/4/22, with no revisions, even with 2 psych hospital stays, 2/24-3/11/22 and 7/20-7/29/22, and 5 incidents with other residents. Resident C sustained a fractured wrist after he was pushed by Resident D. The care plan problems were: 1. Resident D had a diagnosis of homicidal behavior. 2. The resident uses anti-anxiety medication related to anxiety disorder. 3. The resident uses anti-psychotic medications related to schizoaffective disorder, bipolar type. Behavior management, Potential for injury to self or others. 4. Resident D exhibits restlessness, nervousness and/or other anxiety symptoms related to a diagnosis of anxiety. 5. Resident D had impaired cognitive function/impaired thought process related to diagnosis of Alzheimer's and is at risk for decline. 6. Impaired thought processes/altered mental status related to diagnoses of schizoaffective		discharge. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents with planned discharge have potential to be affected by deficient practice. · SS/Designee will audit all residents with pending discharges to ensure residents are oriented and prepared for discharge and a plan is in place with receiving facility. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical and SS staff will be in-serviced on: o "Discharge Policy" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/designee will audit 5 pending discharges three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure discharging residents are oriented and prepared for discharge and a plan	

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	disorder, bipolar type and Psychotic disorder with delusions due to known physiological condition. A care plan was revise dated 9/22/22, it indicated the problem was Resident D had (Auditory, Visual) hallucinations (perception of something not present), delusional episodes, talking to himself in hallway and in his room, he had a history of threatening behaviors towards others, history of verbal aggression towards others, abusive language, history of throwing items, making statements about females and wanting a girlfriend. He was manipulative towards others, lunging at staff making threats, and making threatening gestures. The goal and interventions had not been updated since the care plan was created on 5/4/22. Resident D's reportable incidents to the Indiana Department of Health for the last 8 months were as follows: a. On 2/17/22, it was reported that Resident D wanted to borrow Resident 16's cell phone. She denied him and he called her a b***h. b. On 5/10/22, it was reported that Resident D made contact with Resident 17. Resident 17 was hallucinating and was sent to the hospital. c. On 5/17/22, it was reported that Resident 83 made racial comments to Resident D, and Resident D made contact with Resident 83. d. On 6/2/22, it was reported that Resident 17 made racial comments to Resident D, and Resident D pushed Resident 17. It was known that Resident 17 was in need of psych services. e. On 6/22/22, it was reported that Resident 83 made contact with Resident D for no reason. f. On 7/16/22, it was reported that Resident D pushed Resident C. Resident C fell and fractured his wrist.		is in place with receiving facility. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 10/21/2022	

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	On 2/23/22 with no time noted, the SSD indicated she had a conversation with the Ombudsman 41. She recommended the SSD to schedule a discharge care plan meeting, issue 30-day notice and allow Resident D to make an appeal within 10 days. She stated if an appeal had not been made within 10 days, then the facility had the right to discharge Resident D to the Wheeler Mission. She recommended the SSD set the resident up with Midtown Eskenazi (mental health center). SSD had told the Ombudsman 41 the resident had made sexual comments, verbal and physical aggression towards staff and peers, but was independent with all ADLs, scores high on BIMS (brief interview for mental status) and inquired about discharge to the Wheeler Mission. On 3/9/22 with no time noted, SSD indicated she contact the office of the Ombudsman but was unable to get through, left a voicemail and emailed Ombudsman 43. The SSD received a phone number for Wheeler Mission. On 3/9/22 with no time noted, SSD indicated she was asked to contact Midtown once a discharge date was established and she would set up an initial appointment. Midtown provided their transportation number through Eskenazi to contact. Resident would be seen once every 3 months by a psychiatrist, and a therapist twice a month. On 3/9/22 with no time noted, SSD received a call from Ombudsman 42 who stated she is filling in. SSD provided information to Ombudsman 42 on Resident D. She explained safety concerns with the resident returning to the facility. She stated that the facility should decide based on the safety of the patients in the facility but indicated to understand that the psych hospital can call the			

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	board of health to file a complaint and there could be repercussions. Ombudsman 42 recommended that SSD try to work with psych hospital to find alternative placement that would agree to accept him, especially all male facility. On 3/9/22 with no time noted, SSD referred Resident D to several facilities, most have denied him. On 3/11/22 with no time noted, Resident D scored 13/15 on BIMS. SSD contacted Ombudsman 42 to discuss the facility's right to discharge Resident D to Wheeler Mission due to concerns with him. She stated the facility had the right to discharge him to the Wheeler Mission. SSD informed Ombudsman 42 that Resident D was independent with all ADLs, recommended for medication management, and informed Ombudsman 42 that SSD had already contacted Midtown Eskenazi regarding scheduling an appointment. The SSD had contacted the transportation number that was provided to SSD from Midtown. SSD provided information of the discharge location to the transportation provider, and transportation stated they just needed a contact number at the Wheeler Mission to inform them of pick-up times for Resident D on appointment days. The transportation provider stated Midtown Eskenazi will contact transportation to schedule transport with date and time, they stated SSD does not need to schedule this with them. On 3/11/22 with no time noted, a care plan meeting was held with SSD, ADON and Resident D. SSD discussed recently being readmitted to facility this morning from Assurance Psych. SSD asked Resident D if he recalls the reason for the psych stay, Resident D indicated he got into a fight. SSD agreed and discussed behaviors of becoming very			

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	loud with threatening behavior yelling and screaming out. We discussed his ADL (activity of daily living) status of being independent with all ADLS except medication management., discussed his potential 30-day notice to Wheeler Mission due to safety concerns of other residents. Resident D became very agitated and began yelling and screaming at SSD and ADON, stated he's not leaving, and he wants to stay at the facility. SSD had difficulty speaking to Resident D due to yelling, screaming out. SSD educated Resident D on current verbal behavior and disruption to other peers. Resident continued to yell and scream. SSD attempted to redirect him but was unsuccessful. He screamed at SSD and ADON to leave his room. 3/16/22 at 2:53 p.m., the SSD was notified by the DON of Resident D had become agitated with staff regarding the smoking time. He slammed his jacket on the chair in hallway. SSD spoke with Resident D this afternoon regarding his behaviors. He denied having these behaviors. SSD re-educated him on appropriate behaviors. He expressed understanding. No behaviors noted during this visit. On 3/18/22 at 12:54 p.m., a Social Services (SS) note indicated Resident D was visited by Greenhouse Psych therapist on this day with no concerns regarding behavior, psychosocial well-being, or mood. The Social Service Director (SSD) also visited with Resident D who was pleasant. No signs or symptoms of psychosocial well-being, mood concerns, or behaviors noted. On 3/21/22 with no time noted, the SSD was notified Resident D was upset with a female peer and told her she cannot have another boyfriend. SSD and ADON spoke with him. He admitted to having this behavior and state he was jealous.			

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	SSD educated Ray of previous conversation of him having behaviors and the potential for a 30-day discharge. He expressed understanding that this behavior could cost him a 30-day notice. He asked for a second chance. SSD stated she would speak with the Executive Director (ED). They will speak to him again next week. On 3/23/22 at 1:33 p.m., a SS note indicated the SSD visited with Resident D who was in good spirits. He showed no behaviors, no signs or symptoms of psychosocial well-being or mood concerns. On 3/24/2022 at 2:34 p.m., a SS note indicated the SSD and ADON visited with Resident D. SSD discussed threatening behaviors towards staff with yelling and screaming out, his impulsive outbursts, and safety concerns. Resident D was educated on 30 Day Discharge Notice that was issued to him on this day. He was educated on the right to file an appeal, and provided details on how to do so, and educated Resident D that he would discharge to Wheeler Mission. Educated Resident D on being followed by Midtown Eskenazi Health for medication management after his discharge. Resident D became agitated and began to raise his voice, he continued to ask for another chance. SSD educated Resident D again on his behaviors. Writer emailed a 30-Day Notice to Discharge Resident D to the Ombudsman. On 3/25/22 at 12:29 p.m., a SS note indicated the SSD contacted Oak St. Health and attempted to schedule an initial primary care physician (PCP) appointment. Oak St. Health stated someone from admissions will contact SSD next week to schedule initial appointment. Oak St. Health would provide transportation to and from his appointments.			

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On 4/8/22 at 10:46 a.m., a nursing note indicated the Assistant Director of Nursing (ADON), currently the Interim DON, indicated Resident D scored at a high risk on an elopement assessment due to being independently mobile and having dementia.

On 4/22/22 12:21 a.m., the Nurse Practitioner (NP) 40 indicated in a late entry that she had a discharge visit with Resident D. She indicated he was being seen today for discharge planning to the Wheeler Mission per the facility. He had a past medical history of psychotic disorder, Alzheimer's disease, Schizoaffective disorder, Parkinson's disease, diabetes mellitus type 2, age-related cognitive decline, anxiety disorder, tremor, muscle weakness, difficulty in walking, and insomnia. He did not appear to be in any acute distress at this time or during this visit. He was resting quietly in a chair. He was oriented to person and place with periods of confusion. He was pleasant and cooperative. Medications were sent with Resident D upon his discharge.

On 4/22/22 at 2:53 p.m., the Discharge Summary indicated the SSD had spoken with Resident D several times throughout this week regarding his upcoming discharge on 4/22/22. She discussed scheduling an initial PCP appointment through Oak St. Health, informed Resident D of Oak St. Health providing transportation from the facility to their clinic for an initial appointment on 4/22/22, then will be transported to Wheeler Mission. Oak St. Health would refill his medications monthly. She provided Resident D with the transportation number to Southeast Trans for transportation. She contacted Midtown Eskenazi Health to schedule initial appointment, they indicated they can transport him to and from appointments, Midtown

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	to contact writer back with initial appointment date as writer left a voice mail at Midtown Eskenazi. Resident D became agitated throughout these visits and asked on different occasions for another chance. SSD attempted to redirect Resident D by educating him but was unable to due to him yelling at writer. Staff members have visited with Resident D on this day regarding his discharge to the Wheeler Mission related to the 30-day discharge notice. Resident refused to leave facility. He was yelling and screaming, with threatening behaviors. He told the staff the only way I'm leaving was if the cops were called. Non-emergency police were contacted to assist with escorting Resident to an Oak St. Health vehicle. The police escorted Resident D outside and into van. SSD had made contact Oak St. Health regarding Resident D's initial appointment; they stated Resident D had arrived and would be checked in. He was discharged with medications, contact numbers, and discharge information. On 4/25/22 with no time noted, the SSD contacted Eskenazi Midtown to follow up regarding scheduling an appointment for Resident D's transportation. Midtown indicated she recalled speaking with SSD in March and informed SSD that their policy had changed for scheduling appointments and scheduling transportation for clients. She stated they do not schedule appointments or transportation because it is all now walk-ins only on Monday - Friday, from 9:00 a.m. to 12:00 p.m. Midtown provided SSD a transportation number to contact to schedule for pick up to and from Midtown. Midtown indicated patient would now need to schedule their own appointments. On 4/25/22 at 5:56 p.m., the Staffing Coordinator/Unit Manager indicated Resident D			

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	returned to facility at 5:15 p.m. today. Resident returned with medications and his belongings. He was placed in a room on the locked behavior unit. Physician's orders were received to give him his 9:00 a.m. medication now per NP 40. He was alert and oriented x 3. He ambulated on own without an assistive device. His gait was steady. On 4/25/22 at 6:00 p.m., Resident D's Admission/Readmission form indicated he was admitted from Wheeler Mission. He was oriented to person, place, time, and situation. He had a diagnosis of dementia and used 9 or more medication. His cognition was intact. On 4/26/22 with no time noted, the SSD indicated she spoke with the Wheeler Mission Director (WMD). He indicated the facility send Resident D back to the facility as no one contacted them to inform them of Resident D being dropped off. SSD informed WMD that she was unaware of needing to inform them of residents' arrival because they took walk-ins. The WMD indicated that was no longer the case. On 5/26/22 SSD was notified of Resident D "smacking" a Certified Nursing Aide (CNA) on the buttocks. SSD asked Resident D why he did it, educated him on appropriate behaviors and explained this behavior was inappropriate. Resident D apologized. On 6/1/22 with no time noted, SSD was notified of Resident D becoming agitated and verbally aggressive as he stated he was jealous of the other peers wanting a girlfriend. SSD was able to redirect him with conversation, walking on the unit and offered activities of interest. He appeared in a better mood with no further behaviors noted.			

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	On 7/20/22 with no time noted, the SSD, DON and the Rounding Psych physician and the Rounding Psych NP discussed Resident D and his behaviors. Possible in-patient referral was discussed. The Rounding Psych physician who also works at Assurance Psych denied him at Assurance stating medications will not help his behaviors, stat this was his personality and medication will not change or help him. He recommended the facility send Resident D to Eskenazi ER and recommended the facility to not accept him back to the facility. On 8/4/22 with no time noted, the SSD attempted to contact Eskenazi Midtown to discuss group home placement but was unable to get through and unable to leave a voice message. On 8/8/22 with no time noted, SSD emailed Ombudsman office and attempted to contact Ombudsman 44 and left a voice mail. On 8/9/22 with no time noted, SSD spoke with Ombudsman 44 and requested recommendations and thoughts regarding placement for Resident D. Ombudsman 44 indicated a place to try who accepted residents with behaviors. On 9/19/22 at 8:31 a.m., ED indicated she received a call from the WMD and he indicated they would not accept him. He said you must have our permission, we will not accept him. On 9/19/22 at 2:32 p.m., the SSD indicated she had provided all transfer documents to Resident D. He did not sign any transfer or discharge documents. On 9/19/22 at 2:35 p.m., the ED indicated Resident D did not have a behavioral contract with the facility.			

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	On 9/19/22 at 2:36 p.m., the SSD indicated she believed Resident D left with a 30-day supply of all April MAR medications because he was a Medicaid recipient. 1. Aripiprazole tab 20 mg (milligram), take 1 tablet by mouth once daily for schizophrenia. 2. Quetiapine fumarate (anti-psychotic) tab 50 mg, take 1 tablet by mouth every morning. 3. Quetiapine fumarate tab 300 mg, take 1 tablet by mouth every night at bedtime. 4. Buspirone Hcl (anti-anxiety) tab 5 mg, take 5 mg by mouth 3 times a day for anxiety. 5. Lactulose (laxative) 10 gr (grams)/15 mL, take 30 mL by mouth once daily for hyperammonemia (high ammonia). 6. Trazodone Hcl (antidepressant/sedative) tab 50 mg, take 1 tablet by mouth every night at bedtime for insomnia. 7. Carbidopa/Levodopa (dopamine promotor for Parkinson's disease) tab 25-100 mg, take 1 tablet by mouth once daily. 8. Amantadine Hcl (dopamine promotor) cap 100 mg, take 100 mg by mouth once daily at 9:00 a.m. for Parkinson's. 9. Amlodipine Besylate (calcium channel blocker for high blood pressure) tab 10 mg, take 1 tablet by mouth once daily for hypertension. 10. Donepezil Hcl tab 10 mg, take 1 tablet by mouth at bedtime for major depressive disorder. 11. Gabapentin cap 300 mg, take 1 capsule by mouth three times daily for bipolar disorder. 12. Hydrochlorothiazide tab 25 mg, take 1 tablet by mouth daily for hypertension. 13. Lamotrigine tab 200 mg, take 1 tablet by mouth once daily for bipolar disorder. 14. Vitamin D cap 1.25 mg (50,000 units), take q capsule by mouth every week for vitamin daily deficiency. 15. Acetaminophen tabs 325 mg, take 2 tablets by			

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	mouth every 6 hours as needed for pain. On 9/19/22 at 3:12 p.m., the ED indicated Resident D did not have a self-administration assessment, but the resident had no narcotics. On 9/19/22 at 3:13 p.m., the Activity Director (AD) indicated Activity Aide 36 had a good relationship with Resident D and was able to redirect him. Resident likes to do crafts, loves newspapers, and we talked to him. She indicated she did not know if the evening/night shift or weekends had special activities for him, but they did know where the activity room key was kept so they could have had access to supplies for his leisure. The facility also buys him cigarettes when he is out. Activity personnel are in the building 7 days a week until 7:00 p.m. On 9/19/22 at 3:14 p.m., the SSD indicated Resident D loved cleaning and organizing things in his room. The staff knows the resident very well. He likes to talk about cars. He like to compare prices. The AD indicated she would take a computer to him to look at ads. The SSD indicated she was looking into making a binder of activities of interest for him. On 9/19/22 at 3:19 p.m., the ED indicated the Staff Coordinator was trained to run the locked behavior health unit and for the most part there was a dedicated staff on the behavioral health unit. The ED provided the specific training the Staff Coordinator did to be over the locked behavior unit. She watched 6 YouTube videos, totally 62.5 minutes. Then, she educated the behavioral health staff, who also watched the 6 videos. The YouTube videos were provided online by BJC Behavioral Health. They were called, Do This Not That: Providing Care for			

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	Medical Patients with Psychiatric Issues. 1. The video to educate about anxiety issues was 9:09 minutes long. 2. The video to educate about anger and aggression issues was 11:57 minutes long. 3. The video to educate about delusions issues was 9:37 minutes long. 4. The video to educate about suicide risk issues was 11:52 minutes long. 5. The video to educate about depression issues was 10:15 minutes long. 6. The video to educate about hallucination issues was 9:47 minutes long. On 9/19/22 at 2:17 p.m., the SSD indicated she provided the Notice of Transfer or Discharge to Resident D on 3/24/22 at 4:30 p.m. It was at the end of the business day and did not count as day 1. It indicated the effective date for the discharge was 4/23/22. Resident D was removed from the locked unit and escorted by the police out of the building on 4/22/22. The SSD indicated she did not realize the date was different on the Notice of Transfer/Discharge. The reason indicated the safety of the individuals in the facility was endangered. Resident D was removed from the building after 28 days had expired on 4/22/22. A Discharge Information document with Resident D name and dated 4/22/22 indicated Resident D would be discharged with 30 days' worth of medications. His prescriptions would be filled monthly by Oak St. Health. Part of his discharge information was a copy of his April MAR. On 9/19/22 at 2:20 p.m., the ED indicated Resident D did not sign any discharge documents. The ombudsman had indicated the resident would have 10 days to appeal. She believes he was not appealing by screaming and yelling when			

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	escorted out of the building by the police. On 9/19/22 at 2:22 p.m., the SSD indicated during a 7/20/22 meeting with the psychiatric physician 47 and the NP, it was disclosed Resident D was denied at admission to Assurance. Physician 47 indicated to send Resident D to Eskenazi ER and not accept him back. On 9/19/22 at 2:26 p.m., the SSD indicated the ombudsman correspondence was with Ombudsman 42, 43, and 44. A review of documents provided by the SSD on 9/19/22 at 2:17 p.m., provided typed narratives of several conversations. On 9/19/22 at 3:11 p.m., the SSD indicated that the information regarding the contact with the ombudsman program was in the "soft file" narrative. On 9/20/22 at 9:41 a.m., the DON indicated she was the Assistant Director of Nursing (ADON) when Resident D left for Wheeler Mission on 4/22/22. His ride was here and he did not want to go, His 30 days was over and he had to go. He sat up front in a lobby chair. The police indicated he had to leave the building or the police would arrest him. He was not aware he was asked to leave before the 30 days were over. He was yelling in the lobby about how he didn't want to go and he wanted to stay here. In the begin, he was offered to make an appeal of the 30 day notice, the SSD, ED, and ADON, were present. It probably would have been an appropriate idea to begin an appeal if he had said or was yelling he did not want to leave here. She indicated she didn't know of anyone was advocating for the resident's wants and needs. He had his medications with him in bubble pack cards. He did			

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	not have any narcotics with him. During an interview, on 9/20/22 at 10:11 a.m., Resident D indicated the SSD doesn't like him. He came in from outside and the SSD indicated to him he needed to go to the Wheeler Mission for no reason. He indicated he was given documents that were a 30 day notice and a right to appeal. He provided the documents to review. Resident D began shaking badly, this conversation was upsetting to him. He said he received the papers but did not understand what the notice of discharge or request for a hearing meant. He indicated he was send to Wheeler Mission and they (the staff at Wheeler Mission) indicated the facility had no right to send him there. He was in room at the facility and the SSD indicated it was time to go. He had been laying down. He indicated she used to say that she would send him to Wheeler Mission as a threat to get him to go the (psych) hospital. On the Wheeler Mission day, he was mad and he faced the wall. The police came and got him to go to the front door. The police said if he didn't go to the Wheeler Mission then he would go to jail in the police car. He had 3-4 big bags of clothes and medications. He indicated he did not know how to take medications or when. The people at Wheeler Mission told him they do not dispense medications. He did not take any medications during his stay at Wheeler Mission because he didn't know how to take it. The Wheeler Mission staff called the facility and put all his stuff in a van and brought him back to Envive. On arrival, the ED indicated he could stay at the facility. Resident D did not know why the ED let			

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	him come back. He came back with his medications. At the Wheeler Mission, his medications were locked in a locker, he had the key. One resident at Wheeler Mission tried to start something with him, he just turned and walked away. His medication remained locked in his locked locker the whole time he was at Wheeler Mission because didn't know how to take the medications, so he left them alone. Resident D indicate with his sometime severe shaking he was unable to read. He indicated he did not try to read the medication packaging. He didn't know how to take the medication, he did not know what kind of medications he takes now. He indicated sometimes he thought about killing people. He had never killed anyone or tried to kill anyone. He only thought about killing his brother and sister because they took his money and threw him out. He indicated he was mad at the SSD but had not thought about killing her. Sometimes he felt like fighting, but not fighting to kill them. He indicated he did not know he could have called the health department to make a complaint. If he knew that, he would have never gone to Wheeler Mission. He was not aware of any elder agencies to help him. On 9/20/22 at 10:46 a.m., the SSD indicated she provided the 30 day notice to discharge to Resident D on 3/24/22 at 4:34 p.m.. She indicated she provided the notice and immediately put the progress note in his chart. On 9/20/22 at 10:47 a.m., the ED and SSD were trying to get him to leave the facility because of			

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	his behaviors. The psych physician indicate he had a personality disorder, not behaviors. His behaviors were at a very high level compared to the other residents. The facility was trying to care for his needs. We were able to care for his needs. But this was a personality disorder. He didn't need to be around other people. On 9/20/22 at 10:53 a.m., the SSD indicated the psych physician indicated to the facility to send Resident D to Eskenazi ER and not accept him back. They did not follow these instructions. On 9/20/22 at 11:00 a.m., the SSD provided a list of referred facilities to whom she had applied to send Resident D. Many of these buildings did not have a locked unit. Her documentation indicated she referred him to 37 buildings, 3 of them twice. On 9/20/22 at 11:16 a.m., the SSD indicated the Director of the Wheeler Mission called and talked to SSD and ED. He was very upset about Resident D arriving at Wheeler Mission. He indicated the facility had to have permission. He called on 4/25/22 and insisted Resident D come back to the facility. On 9/20/22 at 12:03 p.m., the DON indicated the list of medications were on the April MAR provided in Resident D's discharge documents, but the quantity of medications we not part of the discharge summary. She indicated the facility did not count they medications given to Resident D upon his discharge. On 9/20/22 at 12:05 p.m., the VPCS indicated the facility did not need to count the non-narcotic medications. Those medications belonged to Resident D. If we would have destroyed them, we would have completed a disposition of the			

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	medications. On 9/20/22 at 12:29 p.m., the Vice President of Clinical Services (VPCS) indicated the SSD believed because Resident D was a Medicaid recipient he left here with a 30 day supply of all his medications. The VPCS indicated the facility did not count how many medications Resident D left with on 4/22/22 and did not count how many medications he returned with on 4/25/22. She indicated we do not know how many pills went out or came beck in. There are no regulations requiring we do so. On 9/20/22 at 12:32 p.m., the DON indicated when the medications were returned to the building after being at the Wheeler Mission they were put back in use for Resident D. On 9/21/22 at 2:44 p.m., the Ombudsman Leader (OL) indicated Ombudsman 41 was not employed by the Ombudsman program on 2/23/22 and believed the SSD entry for that date was invalid. The OL indicated she had been in the facility several times for other residents but information or questions regarding Resident D's discharge never came up. She indicated they never received a Notification of Discharge document from the facility for Resident D. Whenever they get a notice of discharge, they will go to the facility to advocate for the resident. In our training, we learn to not send people to specific places, and we do not approve transfer discharges. No ombudsman spoke with Resident D. If the Ombudsman would have known they planned to discharge Resident D to Wheeler Mission they would not have agreed to this placement. The SSD never asked us to see Resident D. She only asked questions about how to help the facility discharge residents, nothing about how to advocate for the residents.			

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	On 9/21/22 at 4:03 p.m., Ombudsman 42 indicated she talked with the SSD on 3/9/22. The SSD provided no name and gave no specific information, she just indicated they had a resident who had aggressive behaviors, especially with women. The SSD indicated they wanted to discharge him to Wheeler Mission. Ombudsman 42 indicated she did not think that was appropriate to send him there, and the SSD needed to talk to them first because he was aggressive and had behaviors. Ombudsman 42 indicated it was apparent that the SSD did not like that information. Ombudsman 42 indicated she did not advise or tell them to send him to Wheeler Mission, she told them to call Wheeler Mission. She warned the SSD of the possibility of consequences if she refused to take him back, someone could call the Board of Health and file a complaint because that was considered "dumping" (residents suffering from mental illness are often released even thought they are unable to care form themselves). On 9/12/22, the Admissions Agreement was provided by the facility. A document within the Admission Agreement, titled, "Indiana Resident Rights and Facility Responsibilities," was reviewed. It indicated, " ...The resident has the right to be cared for in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality ...A copy of the resident's rights must be available in a publicly accessible area. The copy must be at least 12-point type ...The transfer and discharge rights of residents of a facility are as follows ...before an interfacility transfer or discharge occurs, the facility must ...place a copy of the notice in the resident's clinical record and transmit a copy to the			

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	following ...the local long term care om budsman program for involuntary relocations or discharges only ...the notice of transfer or discharge ...must be made by the facility at least thirty (30) days before the resident is transferred or discharged ...At the planning conference, the resident's medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs ...If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident's legal representative ...The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan ...." A current policy, titled, "Discharge," dated 8/2022, was provided by the VPCS on 9/21/22 at 1:03 p.m. A review of the policy indicated, " ...The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's ...As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication			

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	reconciliation will be documented ...The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident ...A description of the resident's stated goals; the degree of caregiver/support person availability, capacity and capability to perform required care ...what factors may make the resident vulnerable to preventable readmission ...The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge ...The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan ...Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences ...If it is deterred that returning to the community is not feasible, it will be documented why this is the case and who made the determination ...A member of the IDT (interdisciplinary team) will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place ...A copy of the following will be provided to the resident and receiving			

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	facility and a copy will be filed in the resident's medical records: An evaluation of the resident's discharge needs; the post-discharge pan; and the discharge summary ...."3.1-12(a)(21)			
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to accurately code the Preadmission Screening and Resident Review (PASRR) section (Residents 7, 57, 39, and 56) and restraints section (Resident 11) on the Minimum Data Set (MDS) assessment for 5 of 5 residents reviewed for MDS assessments Findings include: 1. On 9/14/22 at 2:22 p.m. a record review was completed for Resident 7. She had diagnoses of schizoaffective disorder, bipolar disorder, and anxiety. Resident 7 had a "Notice of PASRR Level II Outcome" on 5/13/21. It indicated that the facility should mark yes for question A1500 on the MDS, "is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" A comprehensive MDS with an assessment reference date (ARD) of 3/8/22 was reviewed. Question A1500 was marked no, indicating that resident did not require a level II. 2. On 9/15/22 at 3:15 p.m., a record review was	F 0641	**F641 – Accuracy of Assessments** **SS=E** *"Based on record review and interview, the facility failed to accurately code the Preadmission Screening and Resident Review (PASRR) section (Residents 7, 57, 39, and 56) and restraints section (Resident 11) on the Minimum Data Set (MDS) assessment for 5 of 5 residents reviewed for MDS assessments"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The MDS assessments for resident 7, 57, 39 and 56 have been corrected ensuring the Preadmission Screening and Resident Review (PASRR) and Restraint sections are accurate. **2. How other residents having the potential to be affected by the same deficient**	10/21/2022

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	completed for Resident 57. He had diagnoses of schizoaffective disorder, unspecified mood disorder, delirium, anxiety, major depressive disorder, and insomnia. Resident 57 had a "Notice of PASRR Level II Outcome" on 2/16/21. It indicated that the facility should mark yes for question A1500 on the MDS, "is the resident currently considered by the state level II PASRR process to have a serious mental health illness and/or intellectual disability or a related condition?'. A comprehensive MDS with an ARD of 8/5/22 was reviewed. Question A1500 was marked no, indicating that the resident did not require a level II. 3. On 9/14/22 at 12:25 p.m., a record review was completed for Resident 39. He had the following diagnoses but not limited to schizophrenia and depression. Resident 39 had a level II that indicated he was approved for short term without specialized services. The date short term approval ended on 8/2/22. A comprehensive MDS with an ARD of 8/5/22 was reviewed. Question A1500 was marked no, indicating that resident C did not require a level II. 4. On 9/16/22 at 10:15 a.m., Resident 56's record was reviewed. His Pre-Admission Screening and Resident Review (PASRR), dated 11/22/21, indicated his Level II screening indicated he had Long Term Approved without Services Resident 56 was discharged from 2/26/22 to 3/17/22. The mental healthcare documentation, dated 3/18/22, indicated he had new onset of		**practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · MDS/Designee audited all residents to ensure the MDSs were completed appropriately for PASRR and restraints. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · MDS Coordinator will be in-serviced on: o "RAI manual and Section A" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · MDS/designee will audit 5 MDSs three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure the Preadmission Screening and Resident Review (PASRR) and Restraint sections are coded accurately. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for	

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	mental health issues on 2/17/22 of visual hallucinations, severe major depression with psychotic features, generalized anxiety disorder, and suicidal thoughts. The severity indicated he had no desire to continue living, had made a suicide plan, and had access to means to carry out suicide plan. A Minimum Data Set (MDS) assessment, dated 1/5/22, indicated Resident 56 was not considered by the state level II PASRR process to have serious mental illness. His active diagnoses included, but were not limited to, anxiety disorder, depression, and psychotic disorder. On 9/13/22 at 10:00 a.m., the Administrator and Social Service Director (SSD) were interviewed. They indicated that an audit was completed for level II assessments and there was a plan in place to address level II's on 8/22/22. On 9/19/22 at 3:45 p.m., a policy titled, Indiana PASRR was provided by the ED. It indicated, " ...Screening levels, the level I screen is completed to identify residents who may have a mental illness (MI), mental retardation/development disability (MR/DD), mental illness/mental retardation/developmental disability (MI/MR/DD), or related conditions. The Ascend generated outcome letter will indicate if a level II is necessary. The NF (nursing facility) (if a resident is at home or community setting at the time of the assessment) or hospital (if resident is currently in the hospital) is responsible for referring the resident to the appropriate agency, such as a community mental health center (CMHC) or Bureau of Developmental Disability Services (BDDS). The level II assessment typically involves an in-depth clinical evaluation by a trained mental health professional to verify		patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 10/21/2022	

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	whether an individual has a serious mental illness. The level II assessment must be completed within seven to nine days from the date of the referral. If the level II screen is positive for serious mental illness, a two-pronged determination is made as to whether the individual requires a.) specialized mental health services and b.) nursing facility services (specific to the facility where that application is made). The same process is followed for residents with mental retardation/developmental disability or dually diagnosed with MI and MR/DD; D&E teams complete these in-depth evaluations ...."5. On 9/12/22 at 10:55 a.m., Resident 11 was observed in her room. Although she was sat upright in her wheelchair, her body was hunched forward and leaned to the right. Her head was also tilted to the right. She was unable to answer simple yes/no questions, she was unable to maintain eye contact, and stared off during conversation. No restraint device was observed in place. On 9/13/22 at 11:53 a.m., a second attempt was made to interview Resident 11. Although she remained alert and occasionally made eye contact, she was unable to state her name, or answer simple yes/no questions. No restraint device was observed in place. On 9/14/22 at 2:11 p.m., Resident 11's medical record was reviewed. She had a current diagnosis of Cerebral Palsy (a disorder that affect a person's ability to move and maintain balance and posture). She had a current physician's order for an abdominal binder, to be used to secure her tube feeding. A nursing progress note 7/1/22 at 3:58 p.m., indicated Resident 11's guardian agreed to use the			

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	abdominal binder even though it was a "restraint." The annual MDS assessment, dated 6/24/22, indicated Resident 11 required the use of "other" type of restraints on a daily basis. During an interview on 9/19/22 at 11:00 a.m., the Vice President of Clinical Operations (VPCO) indicated abdominal binders were not considered a restraint and should not be coded on the MDS. The "CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2017, indicated, "...A1500: Preadmission Screening and Resident Review (PASRR)...Coding Instructions...Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness...and continue to A1510, Level II Preadmission Screening and Resident Review Conditions...." 3.1-31(i)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.			

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	(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to failed to revise care plans for 3 of 5 residents reviewed for care plans (Residents 23, 78, and 55). Findings include: 1. On 9/16/22 at 12:08 p.m., a record review was completed for Resident 23. Resident 23 had diagnoses including but not limited to cerebral infarction, muscle weakness, difficulty in walking, history of venous thrombosis, history of falling, psychotic disorder with delusions, major depression, Alzheimer's disease, and hypertension. Resident 23 had a current care plan indicating that he exhibited signs and symptoms of depression. An intervention was to administer medications as ordered. Resident 23's medication administration record indicated to observe for anti-depressant side effects every shift.	F 0657	**F657– Care plan Timing and Revision** **SS=D** *"Based on record review and interview, the facility failed to revise care plans for 3 of 5 residents reviewed for care plans (Residents 23, 78, and 55)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 23, 78 and 55 have had all care plans reviewed and updated. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the	10/21/2022

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	Resident 23's record lacked a current order for an antidepressant medication. 2. On 9/16/22 at 10:03 a.m., a record review was completed for Resident 56. He had the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), pneumonia, type 2 diabetes, major depression, nicotine dependence, and vitamin D deficiency. Resident 56 had an order, dated 9/15/22, for nicotine 14mg/24hour transdermal patch one time a day for smoking cessation remove per schedule. Resident 56's care plan lacked a care plan addressing the nicotine patch or smoking cessation. Resident 56 had a care plan indicating that he had emphysema/COPD related to smoking. He had a care plan indicating that he had a history of nicotine dependence. The goal indicated that he would adhere to the smoking policy. Interventions included to assist him to the designated smoking area during scheduled time. 3. On 9/14/22 at 11:47 a.m., a record review was completed for Resident 78. She had diagnoses including but not limited to schizophrenia, hypertension, chronic obstructive pulmonary disease, obesity, and difficulty swallowing. Resident 78 recently quit smoking. A nicotine patch 21mg/24hour one time daily for 6 weeks was ordered on 8/29/22. Resident 78 had a care plan indicating that she had shortness of breath related to chronic obstructive pulmonary disease. Non adherent to		potential to be affected by the same deficient practice. · MDS/designee will audit all residents with a MDS assessment in the last 30 days to ensure care plans are up to date. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · MDS Coordinator will be in-serviced on: o "Comprehensive Care Plan" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · MDS/designee will audit 5 residents three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure care plans are up to date. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5. **Date of completion**:	

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	wearing oxygen during the day due to smoking. Resident 78's record lacked a care plan to address the nicotine patch or smoking cessation. On 9/20/22 at 12:30 p.m., an interview was conducted with Resident 78. She indicated she had a patch on her left shoulder. She indicated that she wanted to stop smoking and that it had been a month since she quit smoking. A policy titled; "Comprehensive Care Plan" dated 9/2022 was provided by the ED on 9/19/22 at 3:45 p.m. It indicated " ...care plan problems, goals and interventions will be updated on changes in resident assessment/condition, resident preference or family input. 3.1-35(a)		10/21/2022	
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			

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	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 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 observation, interview, and record review, the facility failed to ensure a resident's medications were counted pre-discharge and post-discharge for 2 of 2 residents reviewed for medication upon discharge (Residents D and 57). Findings include: 1. On 9/15/22 at 11:50 a.m., Resident D's was reviewed. Resident D was admitted on 10/15/21. His diagnoses included, but were not limited to, Parkinson's disease (progressive deterioration of motor function), Alzheimer's disease (progressive mental deterioration), Homicidal Ideations (thinking about, considering, or planning a homicide), Psychotic disorder with delusions (a mental disorder with a disconnection from reality with a belief in altered reality), anxiety disorder (mental health disorder of feelings of worry, or fear that interfere with daily activities), diabetes mellitus (blood sugar disorder), cognitive decline (reduction in cognitive ability such as memory, awareness, judgment and/or mental acuity), and Schizoaffective disorder, bipolar type (includes features of both schizophrenia, affects a person's thinking, sense of self, and perceptions, and a mood disorder such as bipolar disorder which	F 0661	**F661– Discharge Summary SS=D** *"Based on observation, interview, and record review, the facility failed to ensure a resident's medications were counted pre-discharge and post-discharge for 2 of 2 residents reviewed for medication upon discharge (Residents D and 57)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents D and 57 had medication audits completed and resident has all prescribed medications available for administration. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be**	10/21/2022

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	includes mania and depression). He resided on the locked behavior unit. On 4/22/22 at 2:53 p.m., the Discharge Summary indicated the SSD had spoken with Resident D several times throughout this week regarding his upcoming discharge on 4/22/22. She discussed scheduling an initial Primary Care Provider (PCP) appointment through the clinic, informed Resident D of the clinic providing transportation from the facility to their clinic for an initial appointment on 4/22/22, then would be transported to the local homeless shelter. The clinic would refill his medications monthly. She provided Resident D with the transportation number. She contacted local clinic to schedule initial appointment, they indicated they would transport him to and from appointments. Resident D became agitated throughout these visits and asked on different occasions for another chance. SSD attempted to redirect Resident D by educating him but was unable to due to him yelling at writer. Staff members visited with Resident D on this day regarding his discharge to the local homeless shelter related to the 30-day discharge notice. Resident refused to leave the facility. He was yelling and screaming, with threatening behaviors. He told the staff the only way he was leaving was if the cops were called. Non-emergency police were contacted to assist with escorting Resident to the local health clinic's vehicle. The police escorted Resident D outside and into van. SSD had made contact with the local health clinic regarding Resident D's initial appointment. They stated Resident D had arrived and would be checked in. He was discharged with medications, contact numbers, and discharge information. On 4/22/22 12:21 a.m., the Nurse Practitioner (NP) 40 indicated in a late entry that she had a discharge visit with Resident D. She indicated he		**taken?** · All discharging residents have the potential to be affected by this alleged deficient practice. · All current residents pending discharge will be audited to ensure medications are counted pre-discharge and post discharge. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff will be in-serviced on: o "Discharge Policy" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/designee will audit 5 discharges three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure medications are counted pre-discharge and post discharge. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until	

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	was being seen today for discharge planning to the homeless shelter per the facility. He had a past medical history of psychotic disorder, Alzheimer's disease, Schizoaffective disorder, Parkinson's disease, diabetes mellitus type 2, age-related cognitive decline, anxiety disorder, tremor, muscle weakness, difficulty in walking, and insomnia. He did not appear to be in any acute distress at this time or during this visit. He was resting quietly in a chair. He was oriented to person and place with periods of confusion. He was pleasant and cooperative. Medications were sent with Resident D upon his discharge. A Discharge Information document, with Resident D name and dated 4/22/22, indicated Resident D would be discharged with 30 days' worth of medications. His prescriptions would be filled monthly by the local health clinic. Part of his discharge information was a copy of his April MAR. The Social Services Director (SSD) provided a "soft file" which was dated paragraphs of information regarding Resident D and his progress to discharge. No times were noted. On 4/25/22 at 5:56 p.m., the Staffing Coordinator/Unit Manager indicated Resident D returned to facility at 5:15 p.m. today. Resident returned with medications and his belongings. He was placed in a room on the locked behavior health unit. Physician's orders were received to give him his 9:00 a.m. medication now per Nurse Practitioner (NP) 40. He was alert and oriented times 3. He ambulated on own without an assistive device. His gait was steady. On 4/25/22 at 6:00 p.m., Resident D's Admission/Readmission form indicated he was		100% compliance is achieved. 5. **Date of completion:** 10/21/2022	

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	admitted from the local homeless shelter. He was oriented to person, place, time, and situation. He had a diagnosis of dementia and used 9 or more medication. His cognition was intact. On 9/15/22 at 11:54 a.m., a review of Resident D's care plans were completed. They were created on 5/4/22, with no revisions. The care plan problems included: 1. Resident D had a diagnosis of homicidal behavior. 2. The resident used anti-anxiety medication related to anxiety disorder. 3. The resident used anti-psychotic medications related to schizoaffective disorder, bipolar type. Behavior management, Potential for injury to self or others. 4. Resident D exhibited restlessness, nervousness and/or other anxiety symptoms related to a diagnosis of anxiety. 5. Resident D had impaired cognitive function/impaired thought process related to diagnosis of Alzheimer's and was at risk for decline. 6. Impaired thought processes/altered mental status related to diagnoses of schizoaffective disorder, bipolar type and Psychotic disorder with delusions due to known physiological condition. A care plan, revision date of 9/22/22, indicated the problem was Resident D had (Auditory and Visual) hallucinations (perception of something not present), delusional episodes, talking to himself in hallway and in his room, he had a history of threatening behaviors towards others, history of verbal aggression towards others, abusive language, history of throwing items, making statements about females and wanting a girlfriend. He was manipulative towards others, lunging at staff making threats, and making			

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	threatening gestures. The goal and interventions had not been updated since the care plan was created on 5/4/22. During an interview on 9/19/22 at 2:32 p.m., the SSD indicated she had provided all transfer documents to Resident D. He did not sign any transfer or discharge documents. On 9/19/22 at 2:36 p.m., the SSD indicated she believed Resident D left with a 30-day supply of all April MAR medications because he was a Medicaid recipient. 1. Aripiprazole tab 20 mg (milligram), take 1 tablet by mouth once daily for schizophrenia. 2. Quetiapine fumarate (anti-psychotic) tab 50 mg, take 1 tablet by mouth every morning. 3. Quetiapine fumarate tab 300 mg, take 1 tablet by mouth every night at bedtime. 4. Buspirone Hcl (anti-anxiety) tab 5 mg, take 5 mg by mouth 3 times a day for anxiety. 5. Lactulose (laxative) 10 gr (grams)/15 mL, take 30 mL by mouth once daily for hyperammonemia (high ammonia). 6. Trazodone Hcl (antidepressant/sedative) tab 50 mg, take 1 tablet by mouth every night at bedtime for insomnia. 7. Carbidopa/Levodopa (dopamine promotor for Parkinson's disease) tab 25-100 mg, take 1 tablet by mouth once daily. 8. Amantadine Hcl (dopamine promotor) cap 100 mg, take 100 mg by mouth once daily at 9:00 a.m. for Parkinson's. 9. Amlodipine Besylate (calcium channel blocker for high blood pressure) tab 10 mg, take 1 tablet by mouth once daily for hypertension. 10. Donepezil Hcl tab 10 mg, take 1 tablet by mouth at bedtime for major depressive disorder. 11. Gabapentin cap 300 mg, take 1 capsule by mouth three times daily for bipolar disorder.			

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	12. Hydrochlorothiazide tab 25 mg, take 1 tablet by mouth daily for hypertension. 13. Lamotrigine tab 200 mg, take 1 tablet by mouth once daily for bipolar disorder. 14. Vitamin D cap 1.25 mg (50,000 units), take q capsule by mouth every week for vitamin daily deficiency. 15. Acetaminophen tabs 325 mg, take 2 tablets by mouth every 6 hours as needed for pain. On 9/19/22 at 3:12 p.m., the Administrator indicated Resident D did not have a self-administration assessment, but the resident had no narcotics. On 9/19/22 at 2:17 p.m., the SSD indicated she provided the Notice of Transfer or Discharge to Resident D on 3/24/22 at 4:30 p.m. It was at the end of the business day and did not count as day 1. It indicated the effective date for the discharge was 4/23/22. Resident D was removed from the locked unit and escorted by the police out of the building on 4/22/22. The SSD indicated she did not realize the date was different on the Notice of Transfer/Discharge. The reason indicated the safety of the individuals in the facility was endangered. Resident D was removed from the building after 28 days had expired on 4/22/22. During an interview on 9/20/22 at 9:41 a.m., the DON indicated she was the Assistant Director of Nursing (ADON) when Resident D left for the homeless shelter on 4/22/22. She indicated he had his medications with him in bubble pack cards. He did not have any narcotics with him. On 9/20/22 at 12:03 p.m., the DON indicated the list of medications were on the April MAR provided in Resident D's discharge documents, but the quantity of medications we not part of the			

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	discharge summary. She indicated the facility did not count they medications given to Resident D upon his discharge. On 9/20/22 at 12:05 p.m., the Vice President of Clinical Services (VPCS) indicated the facility did not need to count the non-narcotic medications. Those medications belonged to Resident D. If we would have destroyed them, we would have completed a disposition of the medications. On 9/20/22 at 12:29 p.m., the VPCS indicated the SSD believed because Resident D was a Medicaid recipient he left here with a 30 day supply of all his medications. The VPCS indicated the facility did not count how many medications Resident D left with on 4/22/22 and did not count how many medications he returned with on 4/25/22. She indicated we do not know how many pills went out or came back in. There were no regulations requiring they count the medications. On 9/20/22 at 12:32 p.m., the DON indicated when the medications were returned to the building after being at the Wheeler Mission they were put back in use for Resident D. On 9/21/22 at 2:44 p.m., the Ombudsman Leader (OL) indicated Ombudsman 41 was not employed by the Ombudsman program on 2/23/22 and believed the SSD entry for that date was invalid. The OL indicated she had been in the facility several times for other residents but information or questions regarding Resident D's discharge never came up. She indicated they never received a Notification of Discharge document from the facility for Resident D. Whenever they get a notice of discharge, they will go to the facility to advocate for the resident. In our training, we learn to not send people to specific places, and we do not approve transfer discharges. No ombudsman			

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	spoke with Resident D. If the Ombudsman would have known they planned to discharge Resident D to the homeless shelter they would not have agreed to this placement. The SSD never asked them to see Resident D. She only asked questions about how to help the facility discharge residents, nothing about how to advocate for the residents. 2. On 9/20/22 at 11:55 a.m., a record review was completed for Resident 74. He had the following diagnoses but no limited to chronic obstructive pulmonary disease, heart failure, hypertensive heart, chronic kidney disease, anxiety hyperlipidemia, and chronic pain. Resident 74 admitted to the facility on 6/22/21. He discharged from the facility to an assisted living facility on 8/31/22. A progress note, dated 8/31/22 at 11:49 a.m., indicated that resident was being seen for discharge planning. All medications were sent to the assisted living with Resident 74. He was sent 3 days of clonazepam (a medication to treat anxiety) and oxycodone (a medication to treat pain). During an interview on 9/19/22 at 3:05 p.m., the VP of Clinical Services indicated she was unable to provide disposition and accountability of non-controlled medications. She also indicated that she was unaware of the need to account for non-controlled medications. On 9/12/22, the Admissions Agreement was provided by the facility. A document within the Admission Agreement, titled, "Indiana Resident Rights and Facility Responsibilities," was reviewed. It indicated, " ...The resident has the right to be cared for in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of			

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	his or her individuality ...A copy of the resident's rights must be available in a publicly accessible area. The copy must be at least 12-point type ...The transfer and discharge rights of residents of a facility are as follows ...before an interfacility transfer or discharge occurs, the facility must ...place a copy of the notice in the resident's clinical record and transmit a copy to the following ...the local long term care ombudsman program for involuntary relocations or discharges only ...the notice of transfer or discharge ...must be made by the facility at least thirty (30) days before the resident is transferred or discharged ...At the planning conference, the resident's medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs ...If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident's legal representative ...The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan ...." A current policy, titled, "Discharge," dated 8/2022, was provided by the VPCS on 9/21/22 at 1:03 p.m. A review of the policy indicated, " ...The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's ...As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be documented ...The post-discharge plan will be developed by the Care Planning/Interdisciplinary			

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	Team with the assistance of the resident ...A description of the resident's stated goals; the degree of caregiver/support person availability, capacity and capability to perform required care ...what factors may make the resident vulnerable to preventable readmission ...The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge ...The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan ...Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences ...If it is deterred that returning to the community is not feasible, it will be documented why this is the case and who made the determination ...A member of the IDT (interdisciplinary team) will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place ...A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: An evaluation of the resident's discharge needs; the post-discharge pan; and the discharge summary ...." 3.1-36(a)(1) 3.1-36(a)(2)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to monitor for new or worsening wounds which resulted in actual harm when a change of condition in his skin integrity led to his hospitalization and a diagnosis of a necrotic decubitus ulcer and coccygeal osteomyelitis; and the facility failed to ensure interventions to prevent the wound from worsening were in place per his plan of care and infection control techniques were taken during wound treatments for 1 of 1 resident reviewed for wounds (Resident B). Findings include: On 9/12/22 at 11:36 a.m., Resident B was observed. He was lying in bed, flat on his back. Although his eyes were open, he did not respond appropriately to questions and closed his eyes and appeared to sleep. His bed was a low air loss mattress bed and was observed to be operating at the appropriate setting. On 9/13/22 at 10:56 a.m., Resident B was observed. He was lying flat on his back. On 9/13/22 at 11:33 a.m., Resident B remained on his back.	F 0686	**F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer SS=G** *"Based on observation, interview, and record review, the facility failed to monitor for new or worsening wounds which resulted in actual harm when a change of condition in his skin integrity led to his hospitalization and a diagnosis of a necrotic decubitus ulcer and coccygeal osteomyelitis; and the facility failed to ensure interventions to prevent the wound from worsening were in place per his plan of care and infection control techniques were taken during wound treatments for 1 of 1 resident reviewed for wounds (Resident B)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident returned to facility and wound monitoring/treatments are in place. Care plan updated to	10/21/2022

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	On 9/13/22 at 11:51 a.m., Resident B was observed and remained lying flat on his back. On 9/14/22 at 9:57 a.m., Resident B was observed. He was lying in bed flat on his back. On 9/14/22 at 2:10 p.m., Resident B remained flat on his back. On 9/15/22 at 10:00 a.m., Resident B was observed. He was lying flat on his back. On 9/15/22 from 11:45 a.m., Resident B was observed. He was lying flat on his back. On 9/15/22 from 1:05 p.m., until 2:35 p.m., a continuous observation was conducted for Resident B. Although he had been assisted to try and eat lunch, Resident B was never turned or repositioned to offload the pressure from his bottom. On 9/16/22 at 12:13 a.m., Resident B was observed. He remained in bed, flat on his back. During an interview on 9/16/22 at 12:33 a.m., LPN 23 indicated Resident B should be turned or repositioned to offload the sore on him bottom at least every two hours. On 9/19/22 at 3:05 p.m., Resident B's medical record was reviewed. His record indicated he had been a long-term care resident for many years, and previously resided on the Behavioral Health Unit. He had chronic disease diagnoses which included, but were not limited to schizoaffective disorder, type II diabetes, and chronic obstructive pulmonary disease (COPD). He had an active order for weekly skin		include wound prevention and infection control measures. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents with wounds have the potential to be affected by this alleged deficient practice. · All residents with wounds were assessed and records reviewed to ensure wound monitoring/treatments and care plan interventions are in place and being completed per physician orders. No deficiencies noted. · All licensed nursing staff received training on infection control practices/hand hygiene during wound treatments. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed nurses will be educated on: o "Handwashing/Hand Hygiene" o "Dressing Change" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**	

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	assessments to be completed every Wednesday on day shift. On 9/16/22 at 10:28 a.m., the Director of Nursing (DON) provided copies of Resident B's weekly skin assessments and were reviewed at this time. On 3/30/22, no skin alterations were noted on the weekly skin check log. However, a Nurse Practitioner (NP) progress note, dated 3/31/22 at 10:33 a.m., indicated Resident B was being seen per nursing request for "rash on buttocks." Nursing was unclear of onset of rash, and Resident B reported tenderness, local pain and itching, "down there." The NP diagnosed Resident B with genital herpes and prescribed Acyclovire (an oral antiviral medication). The skin assessment logs indicated from 3/16/22 to 4/20/22 indicated LPN 23 had conducted the assessments and no new alterations in his skin integrity were noted. The record lacked documentation of a change in condition related to the development of a new wound/skin area. The record lacked documentation of continued monitoring of the outbreak area. The record lacked documentation that the diagnosis was added to his comprehensive plan of care. On 9/19/22 at 9:30 a.m., the DON provided copies of Resident B's March and April Certified Nursing Assistant (CNA) Point of Care (POC) documentation for March indicated: Resident B was at risk for behaviors and monitored each shift with no refusal of care noted. Resident B was at risk for alterations in skin integrity but only		· DNS/designee will observe and audit wound treatments, orders and interventions on 5 residents with wounds twice a week x8 weeks, then weekly x4 weeks, then monthly x3 months to ensure all orders, wound treatments, and care plan interventions are in place and infection control being followed during wound treatments. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5. **Date of completion:** 10/21/2022	

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	monitored as needed. March 1st-24th were all blank, NA (not applicable), or 5 (none observed). March 25, 26 and 27th were left blank. On March 30th, a new area of "discoloration" was noted but also coded "no," it was not a new area. March 31st, was coded NA (not applicable). It appeared no bed baths or showers had been provided as each observation was blank or coded NA. Shower sheets were requested for March but were not able to be provided by survey exit. Point of care Documentation for the month of April indicated: Resident B was at risk for behaviors and monitored each shift with no refusal of care noted. Resident B was at risk for alterations in skin integrity but still only monitored as needed. On April 24th, 25th and 26th, no new areas were noted. On the 27th an open area was noted but not coded a "new." A nursing progress note, dated 4/24/22 at 5:52 a.m., indicated Resident B had an open wound on his coccyx. The nurse assessed the area and applied a dressing. The Resident was repositioned on his left side and the nurse educated the resident about the importance of being turned every two hours. An NP progress note, dated 4/25/22 at 1:46 p.m., indicated Resident B was being seen for a new open area on his intergluteal cleft. Alleyn ([ALLEVYN]] is a range of moist wound environment dressings designed specifically for the management of chronic and exuding fluid from the wounds) currently covering open area. A small amount of serosanguinous dressing was noted on the dressing. No slough was noted within wound. An order was given for silver alginate and to cover with Alleyn. The NP note			

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	did not include measurements. A Pressure Ulcer Skin Log, dated 4/27/22, indicated Resident B had three areas that were acquired on 4/24/22. Wound 1: Stage III (full thickness skin loss where fat is visible) pressure ulcer to the coccyx with moderate serosanguinous drainage that measured 3 cm (centimeters) long by 3 cm side and 0.5 cm deep. Wound 2: Unstageable (full thickness skin loss where the wound bed is not visible due to slough or eschar) to the left buttock, purple in color which measured 11 cm long by 6.8 cm wide. Wound 3: Unstageable to the left glute, red/purple in color which measured 8 cm long by 6 cm wide. A nursing progress note, dated 5/1/22 at 6:15 a.m., indicated Resident B was noted to have difficulty swallowing pills and was shaking uncontrollably with signs/symptoms of shortness of breath. The On-Call doctor was notified and gave no new orders, "just continue to monitor." His O2 (oxygen) was not in place and his 02 saturation (sats) was 87%. When his 02 was placed his sats increased to 94%. A Pressure Ulcer Skin Log, dated 5/4/22, indicated Resident B's areas were "improved." Wound 1: Unstageable to the left glute, purple/red in color and measured 7.5 cm long by 5.5 cm wide, being treated with skin prep. Wound 2: Unstageable to the sacrum, red in color with slough and serosanguineous drainage that now measured 13 cm long by 9 cm wide. A NP progress note, dated 5/4/22 at 2:28 a.m., indicated Resident B was being seen after nursing staff reported he had a decreased level of orientation for the last day, and she ordered labs			

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	for a CBC (complete blood count) and Urinalysis. A nursing progress note, dated 5/6/22 at 11:11 a.m., indicated Resident B was sent to the ER (emergency room) for further evaluation due to continued decreased levels of conscious. On 5/16/22 Resident B remained at the hospital and required a surgical debridement of the wound and a bone biopsy was conducted which revealed necrosis of the bone. A hospital Discharge Summary dated 6/1/22 indicated, " ...Collateral was obtained via his nurse at his ECF [extended care facility]. His nurse stated that normally patient is AAx4 [alert and oriented to person, time, place and situation] at baseline but this morning he woke up and remained somnolent and would not open his eyes or swallow his medicines. He stated that he was overall sluggish and had to manually remove the medication from his mouth after he administered them. When asking patient regarding his symptoms he did endorse feeling confused ...." The primary diagnosis was a necrotic decubitus ulcer and coccygeal osteomyelitis (infection of the bone). An MRI completed on 5/8/22 revealed findings consistent with osteomyelitis of coccygeal segments with subjacent cellulitis. Resident B's current CNA assignment sheet was reviewed and indicated, "up for all meals," however throughout the surveyor timeframe, Resident B was never observed out of bed. The record lacked documentation of Resident B's refusals to get out of bed. The pressure ulcer wound treatments were observed twice.			

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	1. A wound treatment observation occurred on 9/14/22 from 3:15 p.m., until 4:00 p.m. The following was observed: Licensed Practical Nurse (LPN 23) indicated she would be changing the wound vacuum (vac) dressing to Resident B's coccyx wound. Certified Nursing Assistant (CNA) 23, CNA 51, and CNA 22 were present for the treatment of wounds. CNAs 23 and CNA 51 entered room after using hand sanitizer in the hall and applied a clean pair of gloves. CNA 23 indicated it usually took two people to hold and position the resident during the treatment. The CNAs stood on the right side of the resident and held him over to his left side. LPN 23 put on a clean pair of gloves at the door, then opened sani-wipes and wiped off the overbed table surface, placed a plastic barrier on the table and set up station with supplies to provide wound care. LPN 23 removed the old dressing dated with yesterday's date from the resident's ischium. There was a minimal amount of yellow fluid on the old dressing. LPN 23 did not have the ordered dressing present to apply to the wound. LPN 23 received the xeroform dressing and applied it to the wound to the intact skin around the peri-wound. She applied a dressing over the xeroform and secured the dressing with a white adhesive tape over the xeroform. CNA 23 was waving away gnats during the treatment. LPN 23 indicated that resident had a wound on his sacrum and was going to change the wound vac dressing. LPN 23 exited the room and came back into the room with linens. She placed a new pair of gloves on and did not perform hand hygiene prior			

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	to putting on gloves. LPN 23 cleaned a pair of scissors with a disinfectant. LPN 23 called Resident B by name, adjusted his nasal cannula tubing and lowered the head of his bed. LPN 23 measured from the peri-wound to the opposite peri-wound instead of the wound edges. LPN 23 removed the wound vac dressing. She measured the wound that was a stage 4 pressure ulcer (full thickness skin and tissue loss with muscle, bone, and/or tendon visible). She used a saline syringe and pushed saline into the wound on his sacrum to clean the wound. LPN 23 adjusted the resident's indwelling catheter. She used hand sanitizer and then applied a new pair of gloves. She used a saline syringe and pushed the saline into the wound on his sacrum. She opened the wound vac dressing. LPN 23 indicated that the depth of the sacral wound was 2.2 centimeters and used a cotton tipped applicator to obtain the depth. There was undermining around the entire the wound. The VP of clinical operations came into the room to assist LPN 23. LPN 23 was cutting a clear adhesive dressing to the peri-wound after applying skin prep to the peri-wound. LPN 23 was using the clear adhesive dressing and placing on the dressing to border of the wound (windowpane) instead of using the clear dressing sheet and covering the entire wound. LPN 23 cut the foam dressing and placed the foam dressing against her uniform. On 9/14/22 at 3:56 p.m., the Vice President (VP) of Clinical Operations was summoned to the room. She attempted to identify tunneling of the wound with a tongue depressor. The VP of Clinical Operations placed gloved fingers into the wound. She cut the foam dressing with scissors that were laying on the bed on and placed the foam dressing into the wound. The VP of Clinical Operations stayed with LPN 23 and			

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	finished the dressing change. As Resident B was lying on his side, there were abnormal areas observed on the back of his left calf. LPN 23 indicated that the areas were bruising and shearing. One area was open and had a black edge at the top of the wound. These areas were identified as deep tissue injuries by the VP of Clinical Operations. When asked when the last time Resident B had been turned or repositioned, CNA 51 started to give an answer, but was interrupted by the LPN 23 who indicated, "it's 4:00 p.m. now, so he would have been turned at 2:00 p.m." 2. A second wound treatment observation occurred on 9/16/22. The following was observed: At 1:18 p.m., Resident B's active sacral pressure ulcer change order was reviewed. It indicated to cleanse with normal saline (NS) and apply the wound vac on every dayshift on Mondays, Wednesdays, and Fridays for wound care related to a stage 4 sacral pressure ulcer. At 1:38 p.m., Certified Nursing Assistant (CNA) 22 entered Resident B's room to assist the Director of Nursing (DON) with positioning the resident during the sacral wound dressing change. She did not wash her hands before putting on disposable gloves that she had in her pocket. At 1:38 p.m., the DON did not wash her hands before she put on gloves. She used a Super Sani cloth to wipe the resident's over-the-bed table and laid a white trash bag on it. The DON's table set up included wound vac supplies, hand sanitizer, an Optifoam gentle dressing, and a pink bin of dressing supplies. The DON removed her gloves and did not wash her hands but used hand sanitizer gel on her hands. The resident's door			

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	was left wide open and the resident's privacy curtain was left partially open. When CNA 22 removed Resident B's hip pillow, the resident's body did not shift to center. The DON and CNA 22 moved the resident onto his left side. Bodily fluids were observed on the resident's calf pillow that was used to relieve pressure on his heels. A weeping wound was observed on his left posterior-lateral calf. The bodily fluids were a tannish color, some fluids were dried on the pillowcase in several places, some were still wet. The wound was not dressed, and it was slightly larger than the size of a quarter. At 1:43 p.m., LPN 23 did not knock and wait for permission to enter the resident's room, she just called out "knock knock." She requested to assist with holding the resident in position for the sacral dressing change. She did not wash her hands or use hand sanitizer gel. She put on gloves and held the resident's legs. The DON removed the outer portion of the previous sacral dressing and indicated it did not have the date, time, or initials for the staff person who placed it. It should have been labeled correctly. She removed her gloves, sanitized her hands, and put on new gloves. She laid a white towel on the resident's bed as a clean area. She removed the soiled black sponge from the resident's deep wound. She removed her gloves, sanitized her hands, and put on new gloves. The DON indicated she would clean the resident's wound with normal saline (NS). She was observed digging in the pink bin of dressing supplies with her gloved hands. She retrieved a 10 mL syringe of NS and opened it. Without changing gloves, she squirted the NS into the surface of the center of the wound. She indicated there was undermining of the wound from 3:00 to 6:00. She did not clean the undermined areas.			

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	With the same soiled gloves, she put a gauze square over the end of her index finger and wiped the center of the resident's wound, she did not wipe the undermined area. She the indicated the wound measured 3 cm (centimeter) x 6 cm and she would measure the depth of wound after she changed her contaminated gloves. She removed the gloves and sanitized her hands. After putting on new gloves she opened the sterile packaging for the wound vac dressing and suction system. She reached back into the bin of dressing supplies and pulled out a pair of scissors. She did not clean them before cutting the plastic adhesive part of the wound vac system into strips. Then, she cut the black sponge into 2 round circles and a long black strip. She placed the cut wound supplies inside the sterile packaging to keep them clean. The DON indicated the resident's wound was 70% granulation tissues and 30% slough. She indicated she forgot to measure the depth. At 1:53 p.m., the DON began placing adhesive plastic strips on the resident skin around the sacral wound. The first strip was from 9:00 to 12:00, the second strip, slightly over the wound was from 12:00 to 6:00 o'clock position. She placed the round black sponge in the wound. She placed another long plastic strip and adhesive plastic from the top of the wound to the left lateral hip. Then placed the long black sponge over it. She began placing cut adhesive plastic strips over the black sponges but was not able to make a seal. LPN 23 lifted her hand off of the resident's unwashed legs and pressed her unwashed gloved hand on the long plastic covered sponge before it was sealed. She pressed down with her hand trying to affect a seal. The DON was cutting more adhesive plastic strips with the unwashed scissors and continued to place them, trying the get a seal on the wound vac.			

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	The DON placed a suction device with tubing attached to it at the end of the long plastic covered black sponge. She attached additional tubing and then attached it to the wound vac machine. She checked the wound vac machine again. She placed an additional plastic adhesive strip over the wound. She pressed down on the plastic covered sponges many times trying to create a seal. She continued to push on the wound and the long plastic covered foam strip in several places for 3 minutes, from 2:05 to 2:08 p.m. She was unable to create a seal and was out of the plastic strips. At 2:09 p.m., LPN 23 opened the resident's curtain, removed her gloves, washed her hands, and left to get more adhesive plastic for the wound. She did not close the door when she left. The Nurse Practitioner (NP) did not knock and entered the room, she was in a position to see the resident exposed in his bed. She wanted the keys to the QMA's cart. As soon as the NP left, an x-ray technician did not knock and came into the room, she was in a position to see the resident exposed in his bed. She wanted to know if we were almost finished with him. At 2:12 p.m., the DON indicated the wound on Resident B's left lower leg area was open with a stage 3 pressure wound. This open area was not over a bony prominence. The three raised, irregular, deep purple areas around the wound, she indicated were pressure ulcers at stage 2. These areas were not over a bony prominence. CNA 22, with her unwashed gloves hands that had been holding the resident on his side, pressed on the purple areas to see if they wound blanch. They did not. CNA 22 removed her gloves, sanitized her hands, and put on new gloves.			

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	At 2:15 p.m., the Vice President of Clinical Services (VPCS) came in the room to see if the staff needed assistance, she was in a position to see the resident exposed in his bed. At 2:17 p.m., the DON indicated there was an issue with privacy during Resident B's dressing change. The door and privacy curtains should have remained closed. At 2:18 p.m., after asking about hand washing during dressing changes, the DON left to wash her hands. She was observed to wash her hands correctly, but she rubbed the paper towels on water running from her hands to her elbows, then finished drying her hands with contaminated paper towels. At 2:21 p.m., LPN 23 provided another packaged wound vac system. The DON opened it, cut more adhesive plastic strips with the contaminated scissors, and used them on the resident's new wound vac dressing to complete the seal. During an interview on 9/16/22 at 9:20 a.m., the Former DON (who was DON at the time Resident B developed the wound) indicated at the time of the development of the wound, weekly skin assessments were being conducted by the nurse on the floor and documented on paper. During an interview on 9/16/22 at 10:30 a.m., with the DON and Administrator present, the DON indicated weekly skin assessments should have been conducted by the floor nurse on duty. Any new break in skin integrity were reported to the DON for follow up. A turning and repositioning program was standard practice. In the weeks leading up to the development of the area he was			

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	wanting to stay in bed more, and he did refuse a lot of care. Care plans were put into place for continuity of care so that all the nursing staff could have a complete picture of the resident and their specific needs. During an interview on 9/16/22 at 10:36 a.m., with the Administrator present, LPN 23 indicated she typically did not work on the floor. Every now and then she would be called to help the nurse on the floor with insulin if needed or would be pulled to the floor for call-ins. It was the floor nurses' responsibility to complete the weekly skin assessments. She had not assessed Resident B on a weekly basis, and only saw the area on his bottom after it had opened up, and at that time there was a dressing in place. So, she never visualized the wound until the resident returned from the hospital During an interview on 9/16/22 at 11:07 a.m., the DON indicated it was the nurse on duty's responsibility to conduct the weekly skin assessments and it was important for the direct care nurse to complete skin checks to maintain continuity of care. During a follow up interview on 9/16/22 at 11:22 a.m., LPN 23 indicated she had reviewed the weekly skin check log with her signature and indicated, "oh, well if I signed it I did it." LPN 23 indicated if she was called down for a skin assessment, it was usually just a quick look over as the CNA would have been cleaning him up. During an interview on 9/19/22 at 8:40 a.m., the Former DON indicated, after a discussion with the current DON, Administrator, and VPCO, it was assumed that Resident B's osteomyelitis infection must have come from the genital herpes outbreak.			

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	Unfortunately, it looked like the new diagnosis had not been added to his medical record which meant it was missed for care planning. A current policy, titled, "Handwashing/Hand Hygiene," dated 9/2022, was provided by the VPCS, on 9/19/22 at 10:53 a.m. A review of the policy indicated, " ...Handwashing is the single most important factor in preventing transmission of infections ...All healthcare workers shall utilize hand hygiene frequently and appropriately ...." A current policy, titled, "Dressing Change," dated 9/2022, was provided by the VPCS, on 9/19/22 at 3:45 p.m. A review of the policy indicated, " ...to ensure measure that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination ... create a clean field ...Wash hands with soap and water. Open dressing pack. Put on first pair of disposable gloves. Remove soiled dressing and discard in plastic bag or trash can. Dispose of gloves in plastic bag or trash can. Wash hands with soap and water. Put on second pair of disposable gloves. Follow doctor's recommendations for treatment. Apply dressing and secure with tape when done with treatment if necessary. If using scissors make sure, it is clean with antiseptic ...Removes gloves and discard. Wash hands with soap and water ...." On 9/12/22, the Admissions Agreement was provided by the facility. A document titled, "Federal Resident Rights and Facility Responsibilities," was reviewed. It indicated, " ...The resident has a right to personal privacy ...includes accommodations, medical treatment ...." This Federal tag related to Complaint IN00389598.			

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	3.1-37			
F 0728 SS=D Bldg. 00	483.35(d)(1)-(3) Facility Hiring and Use of Nurse Aide §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined			

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	competent as provided in §483.150(a) and (b). Based on interview and record review, the facility failed to ensure 2 of 10 employees reviewed for employee records (CNAs 49 and 50) had a current active licenses. Findings include: 1. Certified Nursing Assistant (CNA) 49 was hired by the facility as a CNA on 8/1/21. She had an active license in Florida with an expiration date of 5/31/2024. CNA 49 worked as a CNA on dayshift, 7:00 a.m. until 7:00 p.m., on the B wing unit on the following days in September: 9/2/22, 9/3/22, 9/4/22, 9/9/22, 9/10/22, and 9/11/22. 2. CNA 50 was hired by the facility as a CNA on 8/1/22. CNA 50 was considered PRN (as needed) and had not yet worked for the facility. During an interview on 9/19/22 at 12:22 p.m., the ED, VP of Clinical Operations and Senior VP of Clinical Operations indicated that CNAs 49 and 50 were hired during the COVID-19 waiver and they facility was under the understanding that the waiver was still active. CNAs 49 and 50 were scheduled to take state testing on 10/29/22. The Administrator notified CNAs 49 and 50 that they were no longer able to work until they gain a state license. 3.1-14(b)	F 0728	**F728 – Facility Hiring and Use of Nurse Aide** **SS=D** *"Based on interview and record review, the facility failed to ensure 2 of 10 employees reviewed for employee records (CNAs 49 and 50) had a current active license."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · CNA's 49 and 50 are no longer employed with the facility **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the deficient practice · All licensed staff files will be audited to ensure up to date license/certification is in place. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur** · BOM will be in-serviced on verifying license and certifications	10/21/2022

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			with the state of Indiana prior to employment offer. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · BOM/Designee will audit all newly hired licensed staff and 5 random, previously employed licensed staff employee files one time a week for 6 months to ensure up to date license/certifications are in place. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 1. **5. Date of completion:** 10/21/2022	
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental			

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	well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to ensure a resident on the behavior unit with Alzheimer's disease, psychotic disorder with delusions, and schizoaffective disorder was supervised and had interventions implemented to prevent resident to resident altercations which resulted in Resident D pushing Resident C, and Resident C breaking his arm for 1 of 2 residents reviewed for abuse (Residents D, C, 16, 17, and 83). Findings include: 1. On 9/15/22 at 11:50 a.m., Resident D's record was reviewed. Resident D was admitted on 10/15/21. His diagnoses included, but were not limited to, Parkinson's disease (progressive deterioration of motor function), Alzheimer's disease(progressive mental deterioration), Homicidal Ideations (thinking about, considering, or planning a homicide), Psychotic disorder with delusions (a mental disorder with a disconnection from reality with a belief in altered reality), anxiety disorder (mental health disorder of feelings of worry, or fear that interfere with daily activities), diabetes mellitus (blood sugar disorder), cognitive decline (reduction in cognitive ability such as memory, awareness, judgment and/or mental acuity), and Schizoaffective disorder, bipolar type (includes features of both schizophrenia, affects a person's thinking, sense of self, and perceptions, and a mood disorder such as bipolar disorder which includes mania and depression). He resided on the locked behavior unit. On 9/15/22 at 11:54 a.m., a review of Resident D's care plans was completed. They were created on	F 0740	**F740 – Behavior Health Services** **SS=G** *"Based on observation, interview, and record review, the facility failed to ensure a resident on the behavior unit with Alzheimer's disease, psychotic disorder with delusions, and schizoaffective disorder was supervised and had interventions implemented to prevent resident to resident altercations which resulted in Resident D pushing Resident C, and Resident C breaking his arm for 1 of 2 residents reviewed for abuse (Residents D, C, 16, 17, and 83)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D is currently receiving treatment in neuro psych unit. Care plan interventions implemented and will be further updated on resident's return to facility. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**	10/21/2022

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	5/4/22. The care plans lacked documentation of no revisions after the resident's 2 psychiatric hospital stays, 2/24 to 3/11/22 and 7/20 to 7/29/22, and 5 incidents with other residents. The care plan problems were: 1. Resident D had a diagnosis of homicidal behavior. 2. The resident uses anti-anxiety medication related to anxiety disorder. 3. The resident uses anti-psychotic medications related to schizoaffective disorder, bipolar type. Behavior management, Potential for injury to self or others. 4. Resident D exhibits restlessness, nervousness and/or other anxiety symptoms related to a diagnosis of anxiety. 5. Resident D had impaired cognitive function/impaired thought process related to diagnosis of Alzheimer's and is at risk for decline. 6. Impaired thought processes/altered mental status related to diagnoses of schizoaffective disorder, bipolar type and Psychotic disorder with delusions due to known physiological condition. A care plan, revised on 9/22/22, indicated the problem was Resident D had (Auditory, Visual) hallucinations (perception of something not present), delusional episodes, talking to himself in hallway and in his room, he had a history of threatening behaviors towards others, history of verbal aggression towards others, abusive language, history of throwing items, making statements about females and wanting a girlfriend. He was manipulative towards others, lunging at staff making threats, and making threatening gestures. The goal and interventions had not been updated since the care plan was created on 5/4/22. Resident D's reportable incidents to the Indiana		· All residents on Behavior unit have the potential to be affected by this alleged deficient practice. · All residents on Behavior unit are monitored and all resident care plans were audited and updated with individualized interventions to prevent resident to resident altercations. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff were educated on: o "Behavior Assessment/Monitoring" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/designee will audit 5 residents on the behavior unit three times a week x4 weeks, then twice a week x8 weeks, then weekly x3 months to ensure all behavior residents are being monitored and interventions are in place to prevent resident to resident altercations. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for	

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	Department of Health for the last 8 months were as follows: a. On 2/17/22, it was reported that Resident D wanted to borrow Resident 16's cell phone. She denied him and he called her a b***h. b. On 5/10/22, it was reported that Resident D made contact with Resident 17. Resident 17 was hallucinating and was sent to the hospital. c. On 5/17/22, it was reported that Resident 83 made racial comments to Resident D, and Resident D made contact with Resident 83. d. On 6/2/22, it was reported that Resident 17 made racial comments to Resident D, and Resident D pushed Resident 17. It was known that Resident 17 was in need of psych services. e. On 6/22/22, it was reported that Resident 83 made contact with Resident D for no reason. f. On 7/16/22, it was reported that Resident D pushed Resident C. Resident C fell and fractured his wrist. On 9/15/22 at 11:50 a.m., Resident D's "soft file" was provided by the SSD. These were dated paragraphs of information regarding Resident D and his progress to discharge. No times were noted. - On 2/23/22 with no time noted, the Social Services Director (SSD) indicated the resident had made sexual comments, verbal and physical aggression towards staff and peers, but was independent with all ADLs, scored high on BIMS (brief interview for mental status) and inquired about discharge to the local homeless shelter. -On 3/11/22 with no time noted, a care plan meeting was held with SSD, Assistant Director of Nursing (ADON) and Resident D. SSD discussed recently being readmitted to facility this morning from an inpatient psychiatric (psych) stay. SSD		patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 10/21/2022	

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	asked Resident D if he recalled the reason for the psych stay, Resident D indicated he got into a fight. SSD agreed and discussed behaviors of becoming very loud with threatening behavior yelling and screaming out. We discussed his ADL (activity of daily living) status of being independent with all ADLS except medication management., discussed his potential 30-day notice to Local homeless shelter due to safety concerns of other residents. Resident D became very agitated and began yelling and screaming at SSD and ADON, stated he's not leaving, and he wanted to stay at the facility. SSD had difficulty speaking to Resident D due to yelling, screaming out. SSD educated Resident D on current verbal behavior and disruption to other peers. Resident continued to yell and scream. SSD attempted to redirect him but was unsuccessful. He screamed at SSD and ADON to leave his room. - On 3/16/22 at 2:53 p.m., the SSD was notified by the DON of Resident D had become agitated with staff regarding the smoking time. He slammed his jacket on the chair in hallway. SSD spoke with Resident D this afternoon regarding his behaviors. He denied having these behaviors. SSD re-educated him on appropriate behaviors. He expressed understanding. No behaviors noted during this visit. - On 3/18/22 at 12:54 p.m., a Social Services (SS) note indicated Resident D was visited by Psych therapist on this day with no concerns regarding behavior, psychosocial well-being, or mood. The Social Service Director (SSD) also visited with Resident D who was pleasant. No signs or symptoms of psychosocial well-being, mood concerns, or behaviors noted. - On 3/21/22 with no time noted, the SSD was			

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	notified Resident D was upset with a female peer and told her she cannot have another boyfriend. SSD and ADON spoke with him. He admitted to having this behavior and state he was jealous. SSD educated Resident D of previous conversation of him having behaviors and the potential for a 30-day discharge. He expressed understanding that this behavior could cost him a 30-day notice. He asked for a second chance. SSD stated she would speak with the Executive Director (ED). They would speak to him again next week. - On 3/23/22 at 1:33 p.m., an SSD note indicated the SSD visited with Resident D who was in good spirits. He showed no behaviors, no signs or symptoms of psychosocial well-being or mood concerns. - On 3/24/2022 at 2:34 p.m., an SSD note indicated the SSD and ADON visited with Resident D. SSD discussed threatening behaviors towards staff with yelling and screaming out, his impulsive outbursts, and safety concerns. Resident D was educated on 30 Day Discharge Notice that was issued to him on this day. Resident D became agitated and began to raise his voice, he continued to ask for another chance. SSD educated Resident D again on his behaviors. -On 4/8/22 at 10:46 a.m., a nursing note indicated the Assistant Director of Nursing (ADON), currently the Interim DON, indicated Resident D scored at a high risk on an elopement assessment due to being independently mobile and having dementia. -On 4/22/22 12:21 a.m., the Nurse Practitioner (NP) 40 indicated in a late entry that she had a discharge visit with Resident D. She indicated he			

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	was being seen today for discharge planning to the local homeless shelter per the facility. He had a past medical history of psychotic disorder, Alzheimer's disease, Schizoaffective disorder, Parkinson's disease, diabetes mellitus type 2, age-related cognitive decline, anxiety disorder, tremor, muscle weakness, difficulty in walking, and insomnia. He did not appear to be in any acute distress at this time or during this visit. He was resting quietly in a chair. He was oriented to person and place with periods of confusion. He was pleasant and cooperative. Medications were sent with Resident D upon his discharge. - On 4/22/22 at 2:53 p.m., the Discharge Summary indicated the SSD had spoken with Resident D several times throughout this week regarding his upcoming discharge on 4/22/22. She informed Resident D of the clinic providing transportation from the facility to their clinic for an initial appointment on 4/22/22, then would be transported to the local homeless shelter. Resident D became agitated throughout these visits and asked on different occasions for another chance. SSD attempted to redirect Resident D by educating him but was unable to due to him yelling at writer. Staff members visited with Resident D on this day regarding his discharge to the local homeless shelter related to the 30-day discharge notice. Resident refused to leave facility. He was yelling and screaming, with threatening behaviors. He told the staff the only way he was leaving was if the cops were called. Non-emergency police were contacted to assist with escorting Resident D to an outpatient clinic's vehicle. The police escorted Resident D outside and into van. He was discharged with medications, contact numbers, and discharge information.			

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	- On 4/25/22 at 5:56 p.m., the Staffing Coordinator/Unit Manager indicated Resident D returned to facility at 5:15 p.m. today. Resident returned with medications and his belongings. He was placed in a room on the locked behavior unit. Physician's orders were received to give him his 9:00 a.m. medication now per NP 40. He was alert and oriented times 3. He ambulated on own without an assistive device. His gait was steady. - On 5/26/22 SSD was notified of Resident D "smacking" a Certified Nursing Aide (CNA) on the buttocks. SSD asked Resident D why he did it, educated him on appropriate behaviors and explained this behavior was inappropriate. Resident D apologized. - On 6/1/22 with no time noted, SSD was notified of Resident D becoming agitated and verbally aggressive as he stated he was jealous of the other peers wanting a girlfriend. SSD was able to redirect him with conversation, walking on the unit and offered activities of interest. He appeared in a better mood with no further behaviors noted. - On 7/20/22 with no time noted, the SSD, DON and the Rounding Psych physician denied him for inpatient psych stating medications would not help his behaviors. This was his personality and medication would not change or help him. - On 9/19/22 at 2:35 p.m., the ED indicated Resident D did not have a behavioral contract with the facility. On 9/19/22 at 2:36 p.m., the April MAR medications indicated Resident D took the following medications: 1. Aripiprazole tab 20 mg (milligram), take 1 tablet by mouth once daily for schizophrenia.			

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	2. Quetiapine fumarate (anti-psychotic) tab 50 mg, take 1 tablet by mouth every morning. 3. Quetiapine fumarate tab 300 mg, take 1 tablet by mouth every night at bedtime. 4. Buspirone Hcl (anti-anxiety) tab 5 mg, take 5 mg by mouth 3 times a day for anxiety. 5. Lactulose (laxative) 10 gr (grams)/15 mL, take 30 mL by mouth once daily for hyperammonemia (high ammonia). 6. Trazodone Hcl (antidepressant/sedative) tab 50 mg, take 1 tablet by mouth every night at bedtime for insomnia. 7. Carbidopa/Levodopa (dopamine promotor for Parkinson's disease) tab 25-100 mg, take 1 tablet by mouth once daily. 8. Amantadine Hcl (dopamine promotor) cap 100 mg, take 100 mg by mouth once daily at 9:00 a.m. for Parkinson's. 9. Amlodipine Besylate (calcium channel blocker for high blood pressure) tab 10 mg, take 1 tablet by mouth once daily for hypertension. 10. Donepezil Hcl tab 10 mg, take 1 tablet by mouth at bedtime for major depressive disorder. 11. Gabapentin cap 300 mg, take 1 capsule by mouth three times daily for bipolar disorder. 12. Hydrochlorothiazide tab 25 mg, take 1 tablet by mouth daily for hypertension. 13. Lamotrigine tab 200 mg, take 1 tablet by mouth once daily for bipolar disorder. 14. Vitamin D cap 1.25 mg (50,000 units), take q capsule by mouth every week for vitamin daily deficiency. 15. Acetaminophen tabs 325 mg, take 2 tablets by mouth every 6 hours as needed for pain. On 9/19/22 at 3:13 p.m., the Activity Director (AD) indicated Activity Aide 36 had a good relationship with Resident D and was able to redirect him. Resident D liked to do crafts, loved newspapers, and activity staff talked to him. She			

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	indicated she did not know if the evening/night shift or weekends had special activities for him, but they did know where the activity room key was kept so they could have had access to supplies for his leisure. The facility also bought him cigarettes when he was out. Activity personnel were in the building 7 days a week until 7:00 p.m. On 9/19/22 at 3:14 p.m., the SSD indicated Resident D loved cleaning and organizing things in his room. The staff knew the resident very well. He liked to talk about cars. He liked to compare prices. The AD indicated she would take a computer to him to look at ads. The SSD indicated she was looking into making a binder of activities of interest for him. On 9/19/22 at 3:19 p.m., the ED indicated the Staff Coordinator was trained to run the locked behavior health unit and for the most part there was a dedicated staff on the behavioral health unit. The ED provided the specific training the Staff Coordinator did to be over the locked behavior unit. She watched 6 YouTube videos, totally 62.5 minutes. Then, she educated the behavioral health staff, who also watched the 6 videos. The YouTube videos were provided online by BJC Behavioral Health. They were called, Do This Not That: Providing Care for Medical Patients with Psychiatric Issues. 1. The video to educate about anxiety issues was 9:09 minutes long. 2. The video to educate about anger and aggression issues was 11:57 minutes long. 3. The video to educate about delusions issues was 9:37 minutes long. 4. The video to educate about suicide risk issues was 11:52 minutes long. 5. The video to educate about depression issues			

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	was 10:15 minutes long. 6. The video to educate about hallucination issues was 9:47 minutes long. During an interview, on 9/20/22 at 10:11 a.m., Resident D indicated the SSD did not like him. He came in from outside and the SSD indicated to him he needed to go to the local homeless shelter for no reason. He indicated he was given documents that were a 30 day notice and a right to appeal. He provided the documents to review. Resident D began shaking badly and indicated this conversation was upsetting to him. He said he received the papers but did not understand what the notice of discharge or request for a hearing meant. On the day of his discharge, he was in his room at the facility and the SSD indicated it was time to go. He had just been laying down. He indicated he was sent to the local homeless shelter and the staff at local homeless shelter indicated the facility had no right to send him there. He indicated the SSD used to say that she would send him to the local homeless shelter as "a threat" to get him to go the psych hospital. On the local homeless shelter day, he was mad and he faced the wall. The police came and got him to go to the front door. The police said if he didn't go to the local homeless shelter then he would go to jail in the police car. He had 3 or 4 big bags of clothes and medications. He indicated he did not know how to take medications or when. The people at local homeless shelter told him they do not dispense medications. One resident at local homeless shelter tried to "start something with him," he just turned and walked away. Resident D indicated with his occasional severe shaking he was unable to read.			

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	He indicated he did not try to read the medication packaging. He did not know how to take the medication, he did not know what kind of medications he takes now, so he left them alone. He indicated sometimes he thought about killing people. He had never killed anyone or tried to kill anyone. He only thought about killing his brother and sister because they took his money and threw him out. He indicated he was mad at the SSD but had not thought about killing her. Sometimes he felt like fighting, but not fighting to kill them. During an interview on 9/20/22 at 10:47 a.m., the ED and SSD indicated they were trying to discharge Resident D from the facility because of his behaviors. The psych physician indicated he had a personality disorder, not behaviors. His behaviors were at a very high level compared to the other residents. The facility was trying to care for his needs. They were able to care for his needs. But this was a personality disorder. He did not "need to be around other people." On 9/20/22 at 10:53 a.m., the SSD indicated the psych physician indicated to the facility to send Resident D to the local mental health outpatient center emergency room and not accept him back. They did not follow these instructions. 2. Resident C was interviewed on 9/13/22 at 11:35 a.m. He wanted to speak in private about a situation that occurred in the facility. He indicated that Resident D had gotten in his face. He had asked Resident D to get out of his personal space when Resident D pushed him down and broke his wrist. The police came and told Resident C that they could not arrest Resident D. He indicated that it happened in the hallway, just outside his room. The nursing staff arrived and told him to stay on the ground. The			

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	ambulance was notified, and he was taken to the emergency room for evaluation and treatment of his left wrist. Resident C pointed to a splint on his arm and indicated that he must wear it to help the fracture heal. He indicated that incident had had no effect on him. Since the incident, he did not do anything except play his video game system and smoke. The staff gave him "nerve pills." On 9/13/22 at 3:00 p.m., Resident C's record review was completed. Resident C had the following diagnoses but not limited to schizophrenia, bipolar disorder, anxiety disorder, hypertension, and GERD (gastroesophageal reflux disease). A progress note, dated 7/16/22, indicated that Resident C and Resident D had an altercation on 7/16/22 resulting in Resident C being pushed down. Resident C had orders to send him to the emergency room for left arm evaluation. A note, dated 7/16/22 at 9:41 p.m., indicated Resident C returned from the emergency room with a new diagnosis of fracture of left ulnar, distal radius, and a splint to his left arm. A radiology report was reviewed from the emergency room. It indicated that there was a comminuted fracture of the distal radial surface and nondisplaced ulnar styloid fracture on 7/16/22 at 11:33 a.m. Resident C had orders, dated 7/21/22, for a left arm immobilizer to be on except for skin checks, OT (Occupational Therapy) services 5 days per week for 60 days for ADL (Activities of Daily Living) retraining, therapeutic exercise, therapeutic activity, patient/caregiver education, and group			

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	therapy due to decline in function following a fall with left wrist fracture. Resident had a care plan, dated 7/19/22. It indicated that resident had a wrist fracture with a goal of returning to his prior level of function after healing and rehabilitation. A policy title "Behavior Assessment/Monitoring" with a date of 8/2022 provided by the ED on 9/19/22 at 3:45 p.m. indicated, " ...The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities ...." 3.1-37(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a			

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	month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record reviews and interviews, the	F 0756	**F756 – Drug Regimen Review,**	10/21/2022

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	facility failed to timely respond to the pharmacist's monthly drug regimen review recommendations for 2 of 5 residents reviewed for unnecessary medications (Residents 57 and 36). Findings include: 1. On 9/15/22 at 2:01 p.m., Resident 57's record was reviewed. He had the following diagnoses but not limited to type 2 diabetes, schizoaffective disorder, seizures, depression, hyperlipidemia, hypotension, anemia, and gastro-esophageal reflux disease. On 1/31/22 the pharmacist recommended to consider decreasing Lexapro to 5 milligrams (mg) from 10g due to duplicate therapy. Resident was also prescribed Zoloft. Both medications were used to treat depression. On 3/4/22, the IDT (interdisciplinary team) met, and Lexapro was discontinued on 3/4/22. 2. On 9/15/22 at 2:53 p.m., Resident 36's record was reviewed. He had the following diagnoses but not limited to tremors, vascular dementia, delirium, chronic kidney disease, anorexia, anemia, unspecified psychosis, insomnia, and hyperlipidemia. On 12/26/21 the pharmacist recommended to consider an increase in Aricept (a medication used to treat dementia) from 5 mg to 10 mg for a maintenance dose for his diagnosis of vascular dementia. During an interview on 9/16/22 at 10:00 a.m., the VP of Clinical Operations indicated that the physician responded to the recommendation on 2/9/22 and denied the request to increase the		**Report Irregular, Act On SS=D** *"Based on record reviews and interviews, the facility failed to timely respond to the pharmacist's monthly drug regimen review recommendations for 2 of 5 residents reviewed for unnecessary medications (Residents 57 and 36)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 57 and 36 have had all pharmacy monthly drug regimen review recommendations reviewed with MD and any new order implemented per MD. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents with monthly pharmacy recommendations have the potential to be affected by deficient practice. · All Pharmacy recommendations over last 6 months have been reviewed for all current residents and any outstanding issues will be addressed immediately with MD.	

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	dosage. During an interview on 9/16/22 at 2:05 p.m., the DON indicated that pharmacy recommendations were expected to be responded to within 7 days. On 9/19/22 at 3:45 p.m., the Administrator provided a copy of the current facility policy. The policy was titled, "Medication Regimen Review" dated 9/2022. The policy indicated " ...if the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the Administrator ..." 3.1-25(h)		**3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · DNS will be in-serviced on: o "Medication Regimen Review" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/designee will audit all outstanding pharmacy recommendations weekly x6 months and ongoing to ensure recommendations are reviewed by MD/NP and completed timely. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5. **Date of completion:** 10/21/2022	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to label medications, destroy expired vials and solution of medications, and monitor the temperature of refrigerators used to store medications and vaccinations for 3 of 4 units with medication storage. (Residents 71, 33, 52, 5, and 64) Findings include: On 9/19/22 at 2:50 p.m. medication carts and medication storage rooms were observed with the Director of Nursing (DON). B wing front medication cart was observed to have the following unlabeled medications:	F 0761	**F761 – Label/Store Drugs and Biologicals** **SS=E** *"Based on observation, interview, and record review, the facility failed to label medications, destroy expired vials and solution of medications, and monitor the temperature of refrigerators used to store medications and vaccinations for 3 of 4 units with medication storage. (Residents 71, 33, 52, 5, and 64)."* **1. What corrective action(s) will be accomplished for those residents found to have been**	10/21/2022

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	1. Resident 71's albuterol inhaler that was opened 1/25/22. The order read 2 puffs inhale orally every 6 hours as needed for shortness of breath/wheezing. Resident 71 had dorzolamide eye drops with no date to indicate when the bottle was opened. Resident 71 had latanoprost solution 0.005% solution with no date to indicate when the bottle was opened. 2 . Resident 33 had an open bottle of tears eye drops with no date opened on the bottle. She had another bottle of tears eye drops with no date open on the bottle. A bottle of ciprofloxacin eye drops was in the cart for Resident 33. The order was times and ended on 7/20/22. 3. Resident 52 had a bottle of artificial tears in the medication cart with no label to indicate when the bottle was opened. Resident 52 had a bottle of pilocarpine solution 4% in the cart with no date to indicate when it was opened. Resident 52 had a combivent inhaler with no date to indicate when it was opened. 4. Observed a container of breo in the medication cart. There was no label on the medication to indicate who the container belonged to. The C wing medication cart contained his artificial tears in its original box along with another bottle of artificial tears. One was opened and lacked a		**affected by the deficient practice?** · Residents 71, 33, 52, 5 and 64 have had all medications audited for appropriate labels and expirations dates, any issues noted were immediately addressed. If medications needed replaced, they were replaced at no cost to resident. Medication storage rooms/carts were audited for appropriate labels and expired medications were destroyed. Refrigerator temperature monitoring is in place. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected be deficient practice. · Medications rooms, medication carts and medication refrigerators have had 100% audit and any issues were immediately addressed. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed staff will be	

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	date to indicate when it was opened. The C wing medication room observed. The refrigerator had a temperature log with the date of June 2022. It contained tuberculin serum sent from the pharmacy on 7/29/22. The bottle lacked a date when it was opened and had expired. The B wing medication room was observed to have no temperature log present on the refrigerator. Inside the refrigerator contained Engerix B (hepatitis B vaccination) that expired on 4/3/20. Resident 64 had 2 containers of clorpactin solution in the refrigerator. One bottle was opened on 9/20/22 and another bottle was opened on 8/18/22. On 9/20/22 at 3:00 p.m., a policy for medication storage was requested. It was not provided by exit on 9/20/22 at 4:00 p.m. 3.1-25(j) 3.1-25(m) 3.1-25(n)		in-serviced on: o "Medication Storage" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/Designee will complete 5 random audits weekly in medications rooms and medications carts for 6 months to ensure medications have appropriate labels, are destroyed timely and refrigerator temperatures are monitored and within range. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5. **Date of completion:** 10/21/2022	
F 0802 SS=F Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses			

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	of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation, interview, and record review, the facility failed to ensure the kitchen staff were knowledgeable of the daily tasks and responsibilities required to maintain the kitchen in a clean and safe operating condition which had the potential to effect 82 of 83 residents served from the kitchen. Findings include: 1. Upon entrance into the facility, an initial, and subsequent kitchen visits were conducted. The facility's industrial dish washing machine was observed to only reach a wash temperature of 80 degrees Fahrenheit (F). When asked, the kitchen staff were unaware if the machine was a high or low temperature machine and were unaware they should test the chemical concentration of the dishwasher water to ensure proper sanitation was attained. The kitchen staff indicated cloth dish towels were used to wipe off and dry dishes as they came out of the dishwasher because the serving-ware took too long to air dry due to the cool water temperatures. The 3-compartment wash sink was observed to be missing the chemical disinfectant solution and lacked the tubing hook-up which should connect to a pump to	F 0802	**F802 – Sufficient Dietary Support Personnel** **SS=F** *"Based on observation, interview, and record review, the facility failed to ensure the kitchen staff were knowledgeable of the daily tasks and responsibilities required to maintain the kitchen in a clean and safe operating condition which had the potential to effect 82 of 83 residents served from the kitchen."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · All Dietary Staff have been in serviced about the daily tasks and responsibilities required to maintain the kitchen in a clean and safe operating condition which includes cleaning dishes and maintaining the dish machine.	10/21/2022

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	dispense the sanitizing solution. The 3-compartmnet sink was not observed to be utilized, despite the dishwasher being too cold. A blank dishwashing monitor log was observed posted on the front of the machine for the month of September. Dishwashing logs from June-August were reviewed and lacked documentation that the chemical concentration had been monitored and there were multiple days with low temperature readings. Large serving trays were observed to be in use in transmission-based precaution (TBP) isolation rooms which were returned to the kitchen to be cleaned in the dishwasher. During a follow up observation on 9/13/22, the dishwashing machine was observed to not reach the required temperature. The 3-compartment sink was observed to be filled and in use with dishes soaking but was not at the proper concentration of sanitizing solution. These deficient practices resulted in an immediate jeopardy which was removed during the survey period. Cross Reference F812. 2. Upon entrance into the facility for the annual recertification survey, an initial kitchen tour was conducted with the Dietary Manager (DM). the employee sink was out of soap, and the paper towels sat on top of the soap dispenser. The DM indicated it ran out sometimes and she needed to call Housekeeping to restock the soap. In the meantime, she and her staff were observed to use an alcohol-based hand gel instead of soap and water. Three bulk storage bins were observed in use for flour, sugar and thickener. The bins were not		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All Dietary Staff have been in serviced about the daily tasks and responsibilities required to maintain the kitchen in a clean and safe operating condition which includes cleaning dishes and maintaining the dish machine. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All dietary employees will be in-serviced on: o "Food Receiving and Storage Policy" o "Preventing Foodborne Illness – Food Handling Policy" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · BOM/Designee will audit all new dietary employee files within 2 weeks of hire for 6 months to ensure job specific orientation has	

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	dated or label so that substances could be easily identified, and the DM was unaware why the scoops should not be left in the bins. Cross reference F812. 3. During an interview on 9/13/22 at 9:46 a.m., the DM indicated she and her staff were still on a big learning curve since almost everyone was pretty new. She had taught herself a lot of things, most recently, she had "googled" research about checking the PPM (parts per million- a concentration level of sanitizer in water). She trained her staff to what she knew. Upon hire, orientation was just a checklist they signed, then learned as they went. On 9/12/22 at 4:54 p.m., the Administrator (ADM) provided copies of the kitchen staff's job-specific orientations and they were reviewed at this time. The document was titled, "Dietary Aid/Server/Cook Job Specific Orientation." The orientation was 6-page packet with a 90-day timeframe (from the date of employment) to complete the skills check off. The packet was divided into three sections: 1. Facility Orientation, 2. General Food Service and 3., Dining Room. At the end of each section, there was a place for the initials or signature of the supervisor confirming the orientation items and the date those items were reviewed. Dietary aid 12 was hired on 3/15/22. His job-specific orientation was dated and signed as completed the same day as his hire on 3/15/22. The three sections for supervisor/trainer initials and dates of completion were blank. Dietary Aid 16 was hired on 5/20/22. Her job-specific orientation was dated and signed as		been completed including daily task and responsibilities to maintain a clean and safe operating condition. This will include the “Food Receiving and Storage Policy” and “Preventing Foodborne Illness – Food Handling Policy”. · Dietary Director/ Designee will audit/quiz 2 random dietary employees weekly x6months to ensure staff are knowledgeable of the daily tasks and responsibilities required to maintain the kitchen in a clean and safe operating condition. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 10/21/2022	

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	completed the same day as her hire on 5/20/22. The three sections for supervisor/trainer initials and dates of completion were blank. Dietary Aid 18 was hired on 3/14/22. Her job-specific orientation was dated and signed as completed the same day as her hire on 3/14/22. The three sections for supervisor/trainer initials and dates of completion were blank. Dietary Aid 20 was hired on 8/15/22. Her job-specific orientation was dated and signed as completed the same day as her hire on 8/15/22. The three sections for supervisor/trainer initials and dates of completion were blank. Dietary Aid 21 was hired on 5/11/22. Her job-specific orientation was dated and signed as completed the same day as her hire on 5/11/22. The three sections for supervisor/trainer initials and dates of completion were blank. On 9/17/22 at 3:45 p.m., the Administrator provided a copy of current facility policy titled, "Food Receiving and Storage," dated 8/2022. The policy indicated, " ...Foods shall be received and stored in a manner that complies with safe food handling practices ...Dry foods that are stored in bins will be removed from original packaging, labeled and dated ("use by" date). Such foods will be rotated using a "first in - first out" system ...." On 9/17/22 at 3:45 p.m., the Administrator provided a copy of current facility policy titled, "Preventing Foodborne Illness - Food Handling," dated 8/2022. The policy indicated, " ...Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness ... Antimicrobial hand gel CANNOT be used in place			

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	of handwashing in food service areas ... food service employees will be trained in the proper use of utensils such as tongs, [scoops], gloves, deli paper and spatulas as tools to prevent foodborne illness ... All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents ...." 3.1-20(h)			
F 0812 SS=K 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. A. Based on observation, interview, and record	F 0812	**F812 – Food Procurement, Store/Prepare/Serve-Sanitary**	10/21/2022

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	review, the facility failed to ensure dishes, trays, and pots and pans (serving- ware) were cleaned and sanitized as directed by the dishwasher instructions and dried according to regulation which resulted in 82 of 83 residents who received food from the kitchen being at risk of contamination from improperly cleaned serving-ware including the potential of exposure from kitchen serving trays being cleaned from isolation rooms. The immediate jeopardy began on 9/12/22 when the facility's industrial dishwashing machine was observed to only reach a wash temperature of 80 degrees Fahrenheit (F). When asked, the kitchen staff were unaware if the machine was a high or low temperature machine and were unaware they should test the chemical concentration of the dishwasher water to ensure proper sanitation was attained. The kitchen staff indicated cloth dish towels were used to wipe off and dry dishes as they came out of the dishwasher because the serving-ware took too long to air dry due to the cool water temperatures. The 3-compartment wash sink was observed to be missing the chemical disinfectant solution and lacked the tubing hook-up which should connect to a pump to dispense the sanitizing solution. The 3-compartment sink was not observed to be utilized, despite the dishwasher being too cold. A blank dishwashing monitor log was observed posted on the front of the machine for the month of September. Dishwashing logs from June-August were reviewed and lacked documentation that the chemical concentration had been monitored and there were multiple days with low temperature readings. Large serving trays were observed to be in use in transmission-based precaution (TBP) isolation rooms which were returned to the kitchen to be		**SS=K** *"A. Based on observation, interview, and record review, the facility failed to ensure dishes, trays, and pots and pans (serving-ware) were cleaned and sanitized as directed by the dishwasher instructions and dried according to regulation which resulted in 82 of 83 residents who received food from the kitchen being at risk of contamination from improperly cleaned serving-ware including the potential of exposure from kitchen serving trays being cleaned from isolation rooms. The immediate jeopardy began on 9/12/22 when the facility's industrial dishwashing machine was observed to only reach a wash temperature of 80 degrees Fahrenheit (F). When asked, the kitchen staff were unaware if the machine was a high or low temperature machine and were unaware, they should test the chemical concentration of the dishwasher water to ensure proper sanitation was attained. The kitchen staff indicated cloth dish towels were used to wipe off and dry dishes as they came out of the dishwasher because the serving-ware took too long to air dry due to the cool water temperatures. The 3-compartment wash sink was observed to be missing the chemical disinfectant solution and lacked the tubing hook-up which should connect to a pump to dispense the sanitizing*	

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	cleaned in the dishwasher. During a follow up observation on 9/13/22, the dishwashing machine was observed to not reach the required temperature. The 3-compartment sink was observed to be filled and in use with dishes soaking but was not at the proper concentration of sanitizing solution. The Administrator, Regional Director of Clinical Operations, and Chief Operations Office were notified of the immediate jeopardy at 2:33 p.m. on 9/13/22. The immediate jeopardy was removed on 9/14/22, but noncompliance remained at a lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. B. Based on observation, interview, and record review, the facility failed to ensure the employee handwashing sink in the kitchen was supplied with soap, bulk items in food storage were labeled and dated to be easily identified and failed to ensure long-handled scoops were not left in bulk storage bins which had the potential to effect 82 of 83 residents who were served from the kitchen. Finding include: A. During an initial kitchen tour on 9/12/22 from 9:15 a.m., until 9:45 a.m., the following was observed: There was a standing puddle of water near the dishwashing area. The Dietary Manager (DM) indicated the water was leaking from the dishwasher, which had been giving them problems on and off again for several months. A dishwasher monitoring log for the month of September was posted on the front of the machine but was observed to be blank. The DM indicated		*solution. The 3-compartment sink was not observed to be utilized, despite the dishwasher being too cold. A blank dishwashing monitor log was observed posted on the front of the machine for the month of September. Dishwashing logs from June-August were reviewed and lacked documentation that the chemical concentration had been monitored and there were multiple days with low temperature readings. Large serving trays were observed to be in use in transmission-based precaution (TBP) isolation rooms which were returned to the kitchen to be cleaned in the dishwasher. During a follow up observation on 9/13/22, the dishwashing machine was observed to not reach the required temperature. The 3-compartment sink was observed to be filled and in use with dishes soaking but was not at the proper concentration of sanitizing solution. The Administrator, Regional Director of Clinical Operations, and Chief Operations Office were notified of the immediate jeopardy at 2:33 p.m. on 9/13/22. The immediate jeopardy was removed on 9/14/22, but noncompliance remained at a lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.* *B. Based on observation,*	

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	the log had not been filled out because the dishwasher had not been getting up to temperature and the temperatures varied too widely. She was unsure if the dishwasher was a high or low temperature machine. The DM ran several wash cycles back-to-back. The wash temperature was monitored by an external thermometer that never read more than 80 degrees Fahrenheit (F). No dishes were in the wash cycle for the observation, so the water tested by physical touch was lukewarm. The water ran clear. No detergent, or disinfectant was observed to be dispensed from the tubing into the front drain compartment which allowed it to be cycled through the machine. When asked how the dishes were sanitized if the dish machine did not get up to temperature, the DM indicated the 3-compartment sink was rarely used and the sanitizer was not even hooked up. She did not know what parts per million (PPM) (a measurement of the mass of a chemical or contaminate per unit volume of water) was or how to check the concentration. The DM indicated because the water was too cold during the wash cycle the dishes took too long to air dry, so the staff used cloth towels to wipe off and dry any equipment out of the machine as needed. After the dishwasher cycles were observed, Cook 12 loaded the dishwasher with serving-ware to include a large cooking pot and several burgundy trays. As he ran the dishes through the cycle, the machine did not reach temperature. Cook 12 indicated the dish machine had been having problems since he started in March, specifically that the water was always cold, and they had to use cloth towels to dry the serving-ware. He did		*interview, and record review, the facility failed to ensure the employee handwashing sink in the kitchen was supplied with soap, bulk items in food storage were labeled and dated to be easily identified and failed to ensure long-handled scoops were not left in bulk storage bins which had the potential to effect 82 of 83 residents who were served from the kitchen."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Dishwashing machine is a low temperature machine and is operating properly at correct temperature. · Chemical concentration of the dishwasher water is within normal range. The 3-compartment wash sink is repaired and operating properly. · Employees educated on not using large serving trays in transmission based precaution isolation rooms. · Dishwashing log is up to date. · The employee handwashing sink has full supply of soap. · Bulk food storage items are labeled and dated with no long-handled scoops left in bins. **2. How other residents having the potential to be**	

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	not know what PPM was or how to check the concentration. On 9/12/22 at 9:50 a.m., a rolling cart with breakfast trays was observed on the A-hall. All food items and beverages were observed to be plated on regular, reusable serving-ware and set on top of large plastic burgundy food trays. Meal tickets which remained on the trays included the names of residents in isolation as new admission for COVID-19 precautions. During an interview on 9/12/22 at 9:50 a.m., Qualified Medication Aide (QMA) 14 indicated there was one resident who had admitted and was COVID-19 positive (Resident 286) but he was out of the facility at that time for Dialysis. When asked how he was served meals, she indicated all his food was prepared and served in Styrofoam containers but brought in on a burgundy tray. The tray was returned to the kitchen like all the others. During an interview on 9/12/22 at 9:55 a.m., QMA 15 indicated there was one resident who was COVID-19 positive on the D-hall (Resident 4). Her food was served in all paper containers but taken into the room on a regular tray. At this time, she donned the appropriate PPE (personal protective equipment) and entered the room. Through the open door, Resident 4 was observed sitting in a chair, with her over-bed table in front of here where she ate her breakfast off a Styrofoam plate that rested on one of the burgundy food trays. During a follow up visit to the kitchen on 9/12/22 from 11:53 a.m., until 12:15 p.m., the following was observed: Dietary Aide (DA) 16 was observed at the		**affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by this alleged deficient practice. The Following were evaluated, repaired and monitored. · Dishwashing machine is a low temperature machine and is operating properly at correct temperature. · Chemical concentration of the dishwasher water is within normal range. The 3-compartment wash sink is repaired and operating properly. · Dishwashing log is up to date. · The employee handwashing sink has full supply of soap. · Bulk food storage items are labeled and dated with no long-handled scoops left in bins. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** All dietary staff will be educated on: o "Cleaning Dishes and Dish Machine" o "Kitchen Culinary Sanitation Facts" o "American Dish Service (ADS) Low Temperature Dishwasher	

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	dishwasher running equipment and serving-ware through. She indicated the dishwasher had been broken for a while, and because it did not dry the dishes well, the staff used cloth towels to wipe off and dry dishes after the wash. The dishwasher was observed for several more cycles. There was an instructional panel on the top right corner of the machine which indicated the dish washer was a low temperature machine and should reach a minimum of 120 degrees F for both the wash and rinse cycles. Additionally, the wash water should be tested to ensure a minimum of 50 PPM of chlorine sanitizer was concentrated into the water. The DM indicated she had not been testing for PPM. She was observed to get a small container of test strips and dip the strip into the water reserve as the dishwasher was running. She removed the strip and compared it to the guide on the side of the strip container. The side of the testing strips had PPM concentrations to match the testing strip with, but 50 PPM was not listed on the side of the bottle. The strip was not observed to change colors. The DM indicated she may need to prime the tubing and she held the control on the machine to prime the tubing. No liquid was observed to be dispensed into the dishwasher water reservoir. The DM attempted to the prime the machine multiple times without liquid being dispensed. She retested the concentration of the water, and the strip did not change colors. During an interview on 9/12/22 at 12:05 p.m., the dish washing machine logs from June through August of 2022 were reviewed with the DM. At this time, she indicated the logs were temperature recordings, even though the log was for PPM		Manual" o "American Dish Service, Installation Instructions" o "Food Receiving and Storage" o "Preventing Foodborne Illness – Food Handling" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · Dietary Manager /Designee will audit the following twice a week x8 weeks then weekly x4 months and monthly ongoing to ensure residents are not at risk of contamination: o Dishwashing machine will be audited for proper operation and temperature per manufacturer guidelines. o Chemical concentration of the dishwashing water will be audited to ensure concentration is within normal range and the 3-compartment wash sink is functioning properly. o Dishwashing log will be audited to ensure the log is up to date. o The employee handwashing sink will be audited for full supply of soap. o Bulk food storage items will be audited for labels and dates with no long-handled scoops left in bins. o Employees not using large serving trays in TBP isolation rooms.	

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	monitoring. She did not know the staff should be checking the PPM ,so she has instructed them to record temperatures only. Upon review of the logs, the following days were recorded below the required minimum of 120 F. a. June 12, 13, 14, 16, 18, 19, 21, 22, 23 and 31, 2022. b. July 1, 3, 5, 7, 9, 11, 12, 17, 18, 24, 25, 26, 27, 29 and 30, 2022. c. August 2, 3, 4, 5, 7, 8, 10, 16, 17, 18, 20, 28 and 29, 2022. During an interview on 9/12/22 at 12:09 p.m., the Maintenance Director indicated the kitchen staff had let him know that the dishwasher was not getting up to temperature. He suspected the hot water heater was the problem. They had previously had other issues with the dishwasher related to plumbing and leaking so they had a contracted company come out for repairs. Other than small, simple technical repairs, the Maintenance Director was not qualified or certified to service the dishwasher when it broke which was why he needed to call someone else to come look at it. When he went to assess the machine after the DM let him know it was not up to the correct temperature, he observed that the temperature did not get over 80 degrees F. During an interview on 9/12/22 at 12:17 p.m., the Administrator indicated she had been informed of concerns with the dishwasher from earlier that morning. The dishwasher had issues that "come and go," and were repaired as needed. During an interview on 9/12/22 at 12:33 p.m., the DM indicated she had repeatedly reported concerns about the disrepair of the dishwasher to the Administrator and knew that the Administrator had contacted cooperate about the issues. She had even witnessed the Administrator		The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5. **Date of completion:** 10/21/2022 Reason for IDR request: There was no resident harm due to this alleged deficiency. There is no precedent of F812 ever being cited at a K level. While we do not dispute the citation, we do dispute the scope and severity.	

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	calling corporate and had not been given a final answer on repairs. When asked about the burgundy trays serving trays that meals were sent out on, the DM indicated every room received their meals on the serving trays except the two COVID-19 positive rooms. On 9/12/22 at 12:56 p.m., a rolling cart with lunch trays was observed on the A-hall. All food items and beverages were observed to be plated on Styrofoam or plastic disposable serving-ware but were placed on top of large plastic burgundy food trays. Meal tickets which remained on the trays included the names of residents in isolation as new admission for COVID-19 precautions. On 9/12/22 at 1:00 p.m., an unidentified Certified Nursing Assistant (CNA) delivered a Styrofoam lunch box to Resident 4, who was COVID-19 positive. After she donned the appropriate PPE, she entered the room, and through the open door, she was observed to set the lunch box on top of a burgundy serving tray that was on Resident 4's over-bed table. During an interview on 9/12/22 at 1:25 p.m., the Administrator indicated staff had been instructed to wipe off the burgundy serving trays before taking them out of the COVID-19 positive rooms. During an interview on 9/12/22 at 3:07 p.m., the Maintenance Director indicated he had determined that the kitchen staff had accidently turned off a switch under the dishwashing sink, that turned the hot water off. He had already called and gotten someone out to check the hot water heater which was being repaired as well. Additionally, he identified the tubing on the dish machine was not properly dispensing chemicals into the tank, so he needed to contact someone			

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	else to come and get that fixed. There was no way to determine how long the tubing had been compromised and not properly dispensing the dishwashing chemicals. During a follow-up observation of the dish washing machine on 9/12/22 at 4:47 p.m., a Contracted Technician was observed as he put final pieces of a repair on the dishwashing machine. At this time, he indicated the "squeeze tubes" for the chloride and rinse solutions had worn to disrepair and needed to be replaced. Upon replacement, the dish washer cycle was observed. Steaming hot water poured into the water basin, and bubbles gathered on the top of the water which indicated soapy water was present. The technician had tested the water and it was coming out to the correct PPM. He indicated he replaced the pump and chemical disinfectant solution for the 3 compartment sink as well as it had been missing. The DM who was present at that time, indicated she had no idea the squeeze tubes were able to be replaced, who, or how often they should be replaced. On 9/13/22 from 9:14 a.m., until 9:40 a.m., a return visit was conducted in the kitchen to observe the dishwashing machine. The DM indicated she had been instructed to let the machine run 5-6 times to ensure it got up to temperature before running dishes through it. She began the machine. After 10 back-to-back cycles, the machine only reached 112 degrees F. The DM indicated she did not know why it was "acting up" again. It had been fixed the previous night. While the dish machine ran, the DM used a purple PPM test strip to dip in the wash water. The test strip turned to indicate the appropriate amount of			

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	disinfectant had been dispensed into the dish machine wash water and it was 50 PPM. The DM indicated someone from corporate had come in and explained the repairs, but she had gone home and "Googled some research" on PPM testing and figured it out on her own. She had used the incorrect test strips on 9/12/22. While still waiting for the dish machine to get up to temperature, it was requested to test the PPM of the 3-compartment sink, as dishes were observed in the wash sink soaking. The DM used several of the same purple test strips she had used for the dishwasher. The strip did not turn colors. The DM indicated she needed to add the disinfectant and explained that two new hoses had needed to be installed last night to hook the pump back up properly. She pressed a button which started the pump to dispense the chemical sanitizer. She dipped a purple strip in the water several more times, but the strip did not turn colors. When prompted to test the water with a different type of test strip that the PPM strip registered and changed color to indicate the water was 100 PPM. The Dietary Manager was unaware this PPM was not appropriate for the 3 compartment sink. During an interview on 9/13/22 at 9:29 a.m., DA 18 indicated she had not received any new education or in-service the day before. The DM added at this time, she was in the process of getting her DAs re-educated. The DM indicated she had not signed any in-service material either, but she had been present for the repairs and had been told by the technicians what to do. On 9/13/22 at 9:46 a.m., the Administrator was notified that the dishwashing machine was still not getting to the correct temperature. Copies of			

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	the in-service and/or education that was provided the day before were requested at this time. During an interview on 9/13/22 at 10:11 a.m., the DM indicated the Administrator had just asked her to have the kitchen staff sign an in-service sheet and to provide education on the dishwasher temperatures, so she had called all her kitchen staff to come in to receive the education. On 9/13/22 at 10:37 a.m., the DM provided a copy of an in-service sign-in and a current policy titled, "Cleaning Dishes and Dish Machine." She was in the process of educating her staff. A corporate consultant came last night and educated her and the staff that were present. On 9/13/22 at 10:40 a.m., the above policy was reviewed [and detailed below] and lacked information/instruction on low versus high temperature dish machines, PPM sanitizing procedure, and referred to the dish washing manufacture's recommendations, but no manufacture's recommendations were included. On 9/13/22 at 11:12 a.m., the dish washer was observed with the DM, the Regional Director of Maintenance (RDM) and two other technicians. During the wash and rinse cycle the internal thermometer registered 130 degrees F. The RDM indicated an electric valve to the hot water tank had gone bad and was replaced, which was different than the repair the Maintenance Director had completed the previous day. On 9/13/22 at 12:13 p.m., the previously mentioned policy was reviewed with the Administrator. She was notified at this time, that the policy lacked information/instruction related to the sanitation intent/specifications/requirements. Additionally,			

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	as the provided policy referred to the dish machine manufacture's recommendations and the dish washing manual, those documents were requested at this time as well. The Administrator indicated she had looked for the manual, but the machine was "so old," and had had so many repairs, they did not have a copy of the manual so she would look online. On 9/13/22 at 1:50 p.m., the Administrator provided typed instructions, which were noted to have been copied onto a policy template, titled, "Kitchen Culinary Sanitation Facts." The Administrator also provided a copy of the dishwashing manual and indicated she had printed a copy from online. The "Kitchen Culinary Sanitation Facts," dated 8/2021, indicated, " ...to test a sanitation bucket OR to test the 3-compartment sink, use the Hydrion Quat strips. Peel off a strip and immerse it in the sanitizer being tested for ten (10) seconds. Compare the strip to the key on the outside of the strip container while wet. Sanitizer concentration is read in parts per million (ppm). Ideal concentration is 200 ppm, but concentration is acceptable between 150-400 ppm ... low temperature dish machines should have a chemical chlorine concentration of 50 ppm...." The dishwashing manual provided by the ADMINISTRATOR on 9/13/22 at 1:50 p.m. was titled, "American Dish Service [ADS] Low Temperature Dishwasher Model: 5-AG-S Parts Manual," dated 7/2013. The manual indicated, " ...NOTICE: before you begin ... keep all instructions for future reference ... should you desire to make sure that you have the most up-to-date information, we would direct you to the appropriate document on our website: www.americadish.com... it is your obligation as the customer to ensure that the replacement parts			

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	for the machine are installed safely and properly, and when completed, the machine is left in proper and safe working order ... failure to provide adequate water quantity, pressure and temperature to the machine will cause the machine to function improperly ... On 9/14/22 at 7:50 a.m., additional recommendations for the 5-AG-S dish machine model were reviewed on the manufactures' website at: https://www.americandish.com/WhatsNew/Installation%20Manual%205-AGS.pdf. A document titled, "American Dish Service, "INSTALLATION INSTRUCTIONS Model 5-AGS or 5-AG," dated 5/2017 indicated, " ...Water heaters or boilers must provide the minimum temperature of 120F for this model of machine, which demands an hourly minimum of 118.4 GPH. Temperatures above 150F degrees exceed the operational design limits for this model. While the supply water must have a minimum of 120F degrees, 130/140F degrees is recommended for best results. ... CHEMICAL FEEDER PUMPS ADS provides three (3) peristaltic pumps to dispense liquid chemicals Chemical feed lines are color coded "Red" Detergent , "Green" Sanitizer, "Blue" Rinse aid ...Pick up tubes are provided for chemical product containers Sanitizer (chlorine) concentrations should be set at 50 parts per million. Inspect the transfer tubing for any cuts or holes, keep them protected and secured ... CHEMICAL LINES - Squeeze tubes should be replaced at least every six months...." On 9/13/22 at 10:35 a.m., the DM provided a copy of the in-service material and sign-in sheet she had provided to her staff. A current facility policy titled, "Cleaning Dishes and Dish Machines," dated 8/2022. The policy indicated, "Dishes and			

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	cookware will be washed and sanitized after each meal ... make sure detergent and sanitizers are properly loaded ... check temperatures and pressure. Follow manufactures' recommendations ... air dry all items ... Keep your ware washing machine in good repair...." The immediate jeopardy that began on 9/12/22 was removed on 9/14/22 when the facility had the water heater and dishwasher repaired by outside companies, the Dietary Manager and dietary staff were educated on how to use and monitor the temperature and chemical concentration of the dishwasher and the chemical concentration of the 3 compartment sink, and a process to monitor the dishwasher was implemented, but the noncompliance remained at a lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy because the need for additional monitoring of dishwasher temperatures, chemical concentrations of the dishwasher and 3 compartment sink, and ongoing training of kitchen staff. B. Upon entrance into the kitchen, for an initial kitchen tour on 9/12/22 at 9:15 a.m., the employee handwashing station was observed. The soap dispenser was out of soap, and the paper towels were set horizontally on top of the paper towel dispensing box. The Dietary Manager (DM) came over and indicated she was unaware that the station was out of soap. She did not have a replacement and would call Housekeeping to replace it. Instead, the DM grabbed a bottled of alcohol-based hand rub from her office desk, used it, and placed it on the sink for employee use. The DM indicated all the staff had hand gel as needed. The dry storage area was observed. There were			

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	three extra-large, standing plastic tubs. The tubs were not labeled or dated and the substance inside could not easily be identified. The DM indicated there was one tub each of flour, sugar and thickener. There were large, long-handled scoops laying on top of the substances inside each tub. When asked about scoops being left in bulk storage, the DM indicated she did not know that should not be allowed and asked why. It was explained, the scoop handles could be a potential source of contamination after being handled by several different kitchen staff members. On 9/17/22 at 3:45 p.m., the Administrator provided a copy of current facility policy titled, "Food Receiving and Storage," dated 8/2022. The policy indicated, " ...Foods shall be received and stored in a manner that complies with safe food handling practices ...Dry foods that are stored in bins will be removed from original packaging, labeled and dated ('use by' date). Such foods will be rotated using a 'first in - first out' system ...." On 9/17/22 at 3:45 p.m., the Administrator provided a copy of current facility policy titled, "Preventing Foodborne Illness - Food Handling," dated 8/2022. The policy indicated, " ...Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness ... Antimicrobial hand gel CANNOT be used in place of handwashing in food service areas ... food service employees will be trained in the proper use of utensils such as tongs, [scoops], gloves, deli paper and spatulas as tools to prevent foodborne illness...." 3.1-21(i)(1) 3.1.21(i)(3)			