STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00415346, IN00415818, IN00419565, IN00419701, IN00420080, and IN00420942. Complaint IN00415346 - No deficiencies related to the allegations are cited. Complaint IN00415818 - Federal/State deficiencies related to the allegations are cited at F676, F677, F758, and F921. Complaint IN00419565 - Federal/State deficiencies related to the allegations are cited at F580, F610, and F689. Complaint IN00419701 - Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00420080 - Federal/State deficiencies related to the allegations are cited at F610, F676, F677, F757, and F921. Complaint IN00420942 - Federal/State deficiencies related to the allegations are cited at F676, F677, and F921. Unrelated deficiencies are cited. Survey dates: October 30 & 31, November 1, 2, & 3, 2023 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 124	F 0000	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **The facility respectfully requests a desk review for these alleged deficient practices.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Smith	Administrator	11/27/2023

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

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	Total: 124 Census Payor Type: Medicare: 15 Medicaid: 95 Other: 14 Total: 124 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/13/23.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on record review and interview, the facility failed to ensure a resident was thoroughly assessed for self-administration of insulin and received a Physician's Order that the resident was appropriate for self-administration for 1 of 1 resident reviewed for self-administration of medications. (Resident S) Finding includes: Resident S's record was reviewed on 11/2/23 at 1:11 p.m. The diagnoses included, but were not limited to, diabetes mellitus and congestive heart failure. An Admission Minimum Data Set assessment, dated 8/7/23, indicated an intact cognitive status an had no behaviors. The Physician's Orders, dated 8/1/23, indicated orders to monitor the blood sugar and Humulog	F 0554	**Tag number: F554 – Self Administration of Medications** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident S – Self Administration of Medications Assessment Completed by 11-22-2023** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with the potential to self-administer medications have the potential to be**	11/30/2023

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	insulin was to be administered with a dosage amount in relationship to his blood sugar result (sliding scale) before meals and an order on 8/7/23 for a routine dose of Lantus insulin, 15 units was to be administered nightly at bedtime. There was no Physician's Order for the resident to self-administer the insulin dosages. A Self-Administration Assessment, dated 9/12/23, indicated the resident was appropriate to self-administer medications. Insulin injections were not included in the Self-Administration Assessment. During an interview on 11/2/23 at 1:48 p.m., Employee 7 indicated the resident had always done his own insulin. It was stored in the refrigerator and the nurses took the insulin to his room. The resident would then draw up his own insulin. She indicated there was not a Physician's Order for the self-administration of the insulin, no care plan for the self-administration, and there was no self-administration assessment for the insulin injections. She indicated there had been no teaching or return demonstration to ensure the resident was able to draw the insulin up and given to himself. The nurses completed the blood sugar monitoring, they handed the insulin to him and he drew the insulin up and administered it while the nurse remained in the room. An undated Self-Administration of Medication Procedure, received from the Director of Nursing on 11/3/23 at 10:26 a.m., indicated a resident would be assessed to determine if they were safe and the results would be discussed with the attending Physician and an order was to be obtained. The Assessor was to document the resident's understanding of the use of the medication, signs,		**affected by the alleged deficient practice. The Director of Nursing/designee audited all facility residents and found no other resident has the ability to self-administer medications.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff by 11-30-2023 on evaluation/assessment of residents for Self-Administration of Medications.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. **DON/designee will conduct an audit of all new admissions and readmissions the next business day post admission to determine resident's ability to self-administer medications. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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	symptoms, and response to the use. They were to document the observation of the self-administration. 3.1-11(a)		**plan of correction as indicated.** V Date of Compliance: 11-30-2023	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or			

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	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify a Physician for a follow up consult/appointment as ordered and failed to notify a resident's responsible party in a timely manner about skin tear injuries for 2 of 13 residents reviewed for Physician notification. (Residents B and M) Findings include: 1) Resident B's record was reviewed on 10/31/23 at 11:55 a.m. The diagnoses included, but were not limited to, dementia and anxiety. A CT of the pelvis result, dated 9/15/23, indicated a chronic un-united fracture of the left hemipelvic and multiple compression fractures of the lumbar spine with severe spinal canal stenosis. A Nurse's Progress Note, dated 9/22/23 at 12:44 p.m., indicated Physician Orders were received for an Orthopedic Consult. An attempt was made to	F 0580	**Tag number: F580 – Notify of Changes** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident M – no longer a resident of the facility. Resident B – primary care physician discontinued ortho consult order as resident's compression fractures were related to diagnosis of osteoporosis and are chronic.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All**	11/30/2023

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	schedule an appointment and a voicemail with a detailed message was left for the Orthopedic Physician. A return call was requested. There was no further documentation the Orthopedic Consult had been completed or scheduled. During an interview on 10/31/23 at 4:13 p.m., the Director of Nursing (DON), indicated there was no follow up for the Orthopedic Consult . An appointment had not been made and the resident had not been seen for the consult. She indicated she notified the Primary Care Physician on 10/31/23 and was told the fractures were from 2018 and the Orthopedic Consult was not needed. She was unaware the resident was to be seen by the consult until 10/31/23. 2) Resident M's record was reviewed on 11/2/23 at 6:20 a.m. The diagnoses included, but were not limited to, dementia. An Admission Minimum Data Set assessment, dated 10/17/23, indicated a severely impaired cognitive status. A Nurse's Progress Note, dated 10/24/23 at 5:09 a.m., indicated three skin tears to the right forearm had been found after care was completed and the resident had been combative during care. The Physician had been notified and the Power of Attorney would be notified later in the morning. There was no documentation the Power of Attorney/Responsible Party had been notified of the skin tears the morning of 10/24/23. The Skin Condition Report, dated 10/24/23, indicated three skin tears to the right forearm,		**residents have the potential to be affected by the alleged deficient practice. All notifications of pertinent changes in condition will be communicated with all resident physicians and/or NPs, responsible parties moving forward from 11-30-2023 as our date of compliance.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff by 11-27-2023 on necessary notifications of changes in condition to resident physician/NP, responsible parties.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a notification of change audit to ensure notifications of changes are reported to physician/NP, responsible parties per regulation. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed**	

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	which measured 2.5 by 1 centimeters, 3 by 1.5 centimeters, and 3 by 2 centimeters. The family had not been notified. An investigation for the cause of the skin tears, received from the DON on 11/2/23, indicated the family was notified on 10/25/23 at 12:17 p.m. A request for a Physician and Family Notification policy was made on 11/2/23 at 3 p.m. and 11/3/23 at 8:45 a.m., no policy was received as of exit on 11/3/23 at 10:35 a.m. This citation relates to Complaints IN00419565 and IN00419701. 3.1-5(a)(1) 3.1-5(a)(3)		**in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V Date of Compliance: 11-30-2023	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on observation, record review, and interview, the facility failed to ensure injuries to residents were thoroughly investigated for the cause of the injury to rule out potential abuse for 2 of 4 residents reviewed for injuries and abuse. (Residents M and L) Findings include: 1) During an observation on 10/31/23 at 10:51 a.m., Resident M was lying in bed, the Wound Nurse and the Director of Nursing (DON) were in the room and the Wound Nurse had just completed the dressing change to the left arm skin tears. Resident M was unable to explain how he received the skin tears. The DON indicated an investigation for the cause of the skin tears was not completed. The nurse who had provided the care and found the skin tears had written a statement in the record and on the investigation on how the skin tears occurred. Resident M's record was reviewed on 11/2/23 at 6:20 a.m. The diagnoses included, but were not limited to, dementia. An Admission Minimum Data Set assessment, dated 10/17/23, indicated a severely impaired cognitive status and required maximum to dependent assistance with all activities of daily living. A Nurse's Progress Note, dated 10/24/23 at 5:09 a.m., indicated three skin tears to the right forearm had been found after care was completed and the resident had been combative during care. The Skin Condition Report, dated 10/24/23, indicated three skin tears to the right forearm, which measured 2.5 by 1 centimeters, 3 by 1.5	F 0610	**Tag number: F610 – Investigate/Prevent/Correct Alleged Violation** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident M – no longer a resident of facility. Resident L – skin tears have healed effective 11-14-2023 and investigation completed on 11-6-2023.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. The facility Interdisciplinary Team has investigated all skin tears and will ensure all are investigated as to our plan of correction date of 11-30-2023.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff by 11-27-2023 on initiating and completing skin tear investigations and therefore notifying**	11/30/2023

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	centimeters, and 3 by 2 centimeters. An investigation for the cause of the skin tears, completed by Employee 5 on 10/24/23 at 5:03 a.m. and received from the DON on 11/2/23, indicated the resident had been combative with care and received three skin tears. He was unable to give a description of the occurrence and was confused, on an anticoagulant, and had fragile skin. The predisposing situation factors indicated he had increased agitation, was resistive to care, combative, and had previous skin tears or bruises and no injuries were observed post incident. A typed notez, completed by the DON on 10/31/23, indicated the resident received multiple skin tears to the forearms while being resistant during care as documented by the Employee who had provided the care. There had been no witnesses to the occurrence and no further investigation was needed. During an interview on 11/2/23 at 10:07 a.m., the DON indicated Employee 5 was the only employee in the room. If the resident was agitated, combative, and/or resistant, the staff member should have stopped the care and re-approached. She indicated there was no description of the type of care the resident was receiving and what interventions the Employee completed when he became combative. She indicated Employee 5 had informed her when the resident was approached, he would become combative and he would try to fight the care. The Unit Manager indicated the resident understood very little English and staff were to move slowly with care due to his dementia and the language barrier. 2) During an observation on 11/1/23 at 4 p.m., Resident L's shower had just been completed.		**Physician/NP and responsible parties of investigation.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a resident skin tear audit to ensure all skin tears have investigations in place and subsequent notifications of changes are reported to physician/NP and responsible parties per regulation. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V Date of Compliance: 11-30-2023	

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	Employee 6 indicated there were skin tears on the right upper arm and the dressing would need to be changed due to the wetness from the shower. There was a dressing on the right upper arm with a date of 10/31/23. The skin tear on the right upper arm was clean and freshly attached. Employee 6 indicated she was unaware how the skin tear had occurred and the resident had fragile skin. Resident L's record was reviewed on 11/1/23 at 4:05 p.m. The diagnoses included, but were not limited to, dementia and fractured hip. A Quarterly Minimum Data Set assessment, dated 10/5/23, indicated a severely impaired cognitive status, maximum assistance with toileting, hygiene, bathing, lower body dressing, transfers, and has had no falls. A Nurse's Progress Note, dated 10/16/23 at 6 a.m., indicated around 5:50 a.m., there were two skin tears on the right posterior upper arm found. They were measured at 3 x 3.4 centimeters and 3 by 3 centimeters. During an interview on 11/2/23 at 10:21 a.m., the DON indicated there had been no investigation completed for the cause of the skin tears. A facility abuse prevention and reporting policy, dated 10/28/22 and received from Social Service as current, indicated for injuries not directly involving an allegation of abuse or neglect, the Administrator would appoint a person to gather further facts to make determination as to whether the injury should be classified as an injury of unknown source. This citation relates to Complaints IN00419565 and IN00420080.			

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	3.1-28(d)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document			

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	whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to ensure individualized Care Plans were developed and implemented related to behaviors and self-administration of medications, for 3 of 13 residents reviewed for care plan development and implementation. (Residents M, Q, and S) Findings include: 1) Resident M's record was reviewed on 11/2/23 at 6:20 a.m. The diagnoses included, but were not limited to, dementia. A Nurse's Progress Note, dated 10/24/23 at 5:09 a.m., indicated three skin tears to the right forearm had been found after care was completed and the resident had been combative during care. Cross Reference F610. There was no Care Plan developed and implemented for the resident's reported ongoing behaviors of agitation/ resistance/ combativeness when care was attempted. 2) Cross Reference F676.	F 0656	**Tag number: F656 – Develop/Implement Comprehensive Care Plan** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident M – no longer a resident in the facility. Resident Q – individualized care plan developed and implemented for the resident's behavior of placing his food in his napkin and not eating his meals; Speech Therapy to evaluate and treatment accordingly. Resident S – individualized care plan developed for resident's self-administration of his insulin.** II How other residents having the potential to be affected by the same deficient practice will	11/30/2023

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	155156	A. BUILDING 00 B. WING	11/03/2023

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	During an observation of the lunch meal on 11/1/23 at 12:08 p.m. Resident Q was served a soft taco, refried beans, green beans, lettuce, tomato, shredded cheese, and cake. He placed an unfolded napkin on the table, and placed the refried beans, the green beans, the lettuce, tomatoes, and shredded cheese on the napkin and twisted the napkin shut. Employee 7 asked the resident if he would like his taco cut into pieces and he stated he did. She cut up the taco. The resident then pushed the plate away and handed Employee 7 the napkin filled with the other food served. Employee 7 then offered a grilled cheese sandwich and he consumed 100% of the sandwich. Resident Q's record was reviewed on 11/2/23 at 11:35 a.m. The diagnoses included, but were not limited to, dementia and mild intellectual disabilities. An Annual Minimum Data Set assessment, dated 10/11/23, indicated a severely impaired cognitive status, no behaviors, required set up or clean up with eating, and had no significant weight gain or loss. There was no individualized Care Plan developed and implemented for the resident's behavior of placing his food in his napkin and not eating his meals. 3) Resident S's record was reviewed on 11/2/23 at 1:11 p.m. The diagnoses included, but were not limited to, diabetes mellitus. An Admission Minimum Data Set assessment, dated 8/7/23, indicated an intact cognitive status, no behaviors, and received insulin daily for seven		be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. All residents with the ability to self-administer medications will be assessed and care plan developed; facility will monitor dining services and resident behaviors during dining service to provide input to the Interdisciplinary Team to facilitate individualized interventions in the care planning process; any new onset of behaviors will be reviewed by the Interdisciplinary Team to determine if any interventions are to be placed in the individualized care plan.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate IDT by 11-27-2023 on the development of individualized care plans per observation based on self-administration and resident behaviors in dining service. Further, the DON/designee to educate nursing staff and Interdisciplinary Team regarding evaluating new onset of resident behaviors.**	

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	days. A Care Plan, dated 8/1/23, indicated diabetes mellitus was diet and insulin managed. The interventions included medication would be administered as ordered by the Physician. The Physician's Orders, dated 8/1/23, indicated he received a Humulog insulin dosage in relationship to his blood sugar result (sliding scale) before meals and on 8/7/23 a routine dose of Lantus insulin of 15 units was to be administered nightly at bedtime. During an interview on 11/2/23 at 1:48 p.m., Employee 7 indicated the resident had always administered his own insulin. He drew the insulin up in the syringe and administered it himself. She indicated there was no Care Plan for the self-administration of his insulin. 3.1-35(a)		IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will monitor for behavior alerts to ensure behaviors are being assessed and care planned. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V Date of Compliance: 11-30-2023	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility			

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	ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, record review, and interview, the facility failed to ensure a resident who required set up assistance with eating was assisted with his supper meal for 1 of 6 residents reviewed for meal assistance. (Resident Q) Finding includes: During an observation on 10/31/23 at 5:40 p.m., Resident Q received his evening meal, which consisted of breaded fish, spinach, rice, a dinner	F 0676	**Tag number: F676 – Activities of Daily Living** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident Q – resident is being assisted with meal set-up and meals per resident need.**	11/30/2023

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	roll and a health shake in a milk carton container. He received butter and tarter sauce on the side of his plate. His plate was removed from the tray and placed in front of him. The staff had not offered to place tartar sauce on the fish nor butter on the roll. The health shake was opened, the shake had not been poured into a glass, nor was a straw provided. The resident opened his napkin up on the table and he used his spoon to scoop the spinach onto the napkin. He took two bites of rice and spit the bites out. He then scooped the rice on top of the spinach in the napkin and half of the dinner roll. Staff were walking by the table and no one stopped to assist him, cue him, or to offer him an alternate meal. He then took his knife and cut a piece of fish, took one bite then spit the bite out and placed the rest of the fish into the napkin. He placed the napkin onto his empty plate. He attempted to drink the health shake from the opened carton and was unable to the fluid out of the carton. He used his knife to open the carton opening further and was still unable to get a drink. Employee 1 picked up the carton of health shake, then placed it back on the table and indicated the health shake was frozen. The Dietary Manager indicated the shake was a milk shake thickness and then indicated she could warm a new carton up in the microwave and place another carton in the microwave then handed the carton to Employee 1. Employee 1 then opened the carton and placed it in front of the resident on the table and the resident consumed the shake. On 10/31/23 at 5:55 p.m. Resident Q then propelled himself in the wheelchair from the Dining Room		II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents requiring assistance with meal set-up have the potential to be affected by the alleged deficient practice. Facility will monitor dining services and resident behaviors during dining service to provide input to the Interdisciplinary Team to facilitate individualized interventions and appropriate meal set-up. Resident interventions to be therefore put in place.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff by 11-27-2023 on the need to assist those residents requiring meal set-up and assistance with meals.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will**	

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	without consuming any of his evening meal. When Employee 2 was informed the resident had not eaten any of his meal, nothing further was done. Resident Q's record was reviewed on 11/2/23 at 11:35 a.m. The diagnoses included, but were not limited to, dementia and mild intellectual disabilities. An Annual Minimum Data Set assessment, dated 10/11/23, indicated a severely impaired cognitive status, no behaviors, required set up or clean up with eating, and had no significant weight gain or loss. A Care Plan, revision date of 10/31/23, indicated a potential for a nutritional problem and was at risk for fluctuations in his weight. The interventions included the diet as ordered would be provided. A Care Plan, revision date of 7/19/23, indicated assistance was required for activities of daily living. The interventions included set up assistance with meals would be completed. This citation relates to Complaints IN00415818, IN00420080, and IN00420942. 3.1-38(a)(2)(D)		**monitor for behavior alerts to ensure behaviors are being assessed and care planned. Audits will be completed 7 meals/week for 1 month, 5 meals/week for 5 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V Date of Compliance: 11-30-2023	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure a resident	F 0677	**Tag number: F677 – Activities of Daily Living**	11/30/2023

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	who was dependent for dietary and fluid intake was assisted with the evening meal and was fed slowly and in an enjoyable manner, for 1 of 2 dependent residents observed during meal times. (Resident H) Finding includes: During an observation on 10/30/23 at 6:16 p.m., Employee 3 entered Resident H's room to assist her with her supper meal. The resident was in bed with the head of the bed elevated. She began to feed the resident the puree meal of macaroni and beef, peas, and mandarin oranges. There was also thickened punch drink. Employee 3 fed the resident quickly with one bite after another until the meal was 100% consumed at 6:19 p.m. She then gave the resident a drink of her fluid on the tray. During an interview on 10/30/23 at 6:21 p.m., Resident H indicated she had been fed too quickly. Resident H's record was reviewed on 10/1/23 at 2:18 p.m. The diagnoses included, but were not limited to, dementia and severe intellectual disabilities. A Quarterly Minimum Data Set assessment, dated 8/1/23, indicated a severely impaired cognitive status and required extensive assistance of one for eating. A Care Plan, dated 6/28/21, indicated a nutritional risk related to a mechanically altered diet with thickened liquids due to dysphagia. The interventions included the diet would be provided as ordered.		I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident H – resident is being assisted with meal service at a moderate pace; Speech Therapy to eval and treat accordingly.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents requiring assistance with meals have the potential to be affected by the alleged deficient practice. Facility will provide education to nursing staff on the need to assist those residents requiring assistance with meals.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff by 11-27-2023 on the need to assist those residents requiring assistance with meals.** IV How the corrective action(s) will be monitored to	

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	A Care Plan dated 1/5/22, indicated assistance was required for activities of daily living. The interventions included, the staff would assist the resident with eating. A Physician's Order, dated 4/18/22, indicated a regular pureed diet with nectar consistency fluids. A Speech Therapy Discharge Summary, dated 2/23/23, indicated eating strategies of sitting in an upright position, small bolus presentations, fluids and food were to be alternated and consumption time was to be increased. This citation relates to Complaints IN00415818, IN00420080, and IN00420942. 3.1(a)(3)		ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct audit to ensure residents needing assistance with meal set-up and/or assistance with meals is achieved through observation of meal times. Observation audits will be completed 7 meals/week for 1 month, 5 meals/week for 5 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V Date of Compliance: 11-30-2023	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided to a resident during a transfer related to a mechanical lift transfer (Resident H). The facility also failed to ensure a Care Planned intervention was in place to prevent injury to the skin related to geri-sleeves (skin protector) for 2 of 4 residents reviewed for injuries and assistive devices. (Resident L) Findings include: 1) During an observation on 10/31/23 at 1:45 p.m., Employee 4 was in Resident H's room. Resident H had been lifted up with the assistance of a mechanical lift and was positioned in the sling on the lift and was above the reclining chair where she had been sitting. Employee 4 then transferred the resident into her bed with the mechanical lift. She indicated she should have had another staff member assist her with the transfer. The nurse had asked her to transfer the resident to bed before her shift ended. She indicated there were three other staff members assigned to the unit and they must had been with other residents when she looked for someone to assist her with the transfer. During an interview on 10/31/23 at 2:30 p.m., the Director of Nursing (DON), indicated two staff were to assist with transfers using the mechanical lifts. Resident H's record was reviewed on 10/31/23 at 2:18 p.m. The diagnoses included, but were not limited to, dementia and severe intellectual disabilities. A Quarterly Minimum Data Set assessment, dated 8/1/23, indicated a severely impaired cognitive status and required extensive assistance of two	F 0689	**Tag number: F689 – Free of Accident Hazards/Supervision/Devices** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident L – resident's care plan was reviewed by the Interdisciplinary Team to ensure interventions in place to prevent injury to skin related to the use of geri-sleeves (skin protectors) and/or long sleeve clothing. In addition, as of 11-3-2023 resident H had adequate supervision during transfers utilizing a mechanical lift.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected the alleged deficient practice. The facility Interdisciplinary Team has investigated all skin tears and will ensure all are investigated as to our plan of correction date of 11-30-2023. All residents needing a mechanical lift were reviewed for proper transfer with equipment.**	11/30/2023

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	for bed mobility and transfers. A Care Plan, last revised on 10/23/23, indicated a risk for falls. The interventions included the staff were re-educated on the use of the mechanical lift on 1/5/23. A Care Plan, last revised on 10/23/23, indicated assistance was needed for activities of daily living. The interventions included two staff members were to used for transfers with a mechanical lift. A mechanical lift policy, dated 1/19/18 and received from the DON as current, indicated two caregivers were to be used with the mechanical lift. 2) Resident L's record was reviewed on 11/1/23 at 4:05 p.m. The diagnoses included, but were not limited to, dementia and fractured hip. A Quarterly Minimum Data Set assessment, dated 10/5/23, indicated a severely impaired cognitive status, maximum assistance with toileting, hygiene, bathing, lower body dressing, transfers, and has had no falls. A Physician's Order, dated 7/24/23, indicated geri-sleeves were to be worn on both arms. A Fall Occurrence Assessment, dated 10/8/23 at 4 p.m., indicated an unwitnessed fall occurred and she received a skin tear on the the right posterior forearm which measured 3 by 2.4 centimeters. The assessment had not indicated the geri-sleeves were worn at the time of the fall. The Medication Administration Record (MAR), dated 10/2023, indicated the geri-sleeves had not		III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The DON/designee to educate nursing staff on the need to ensure residents' injury prevention interventions are in place. Further, DON/designee to educate nursing staff by 11-27-2023 on the need to ensure proper use of mechanical lifts and adequate supervision during resident transfers for those residents needing mechanical lift transfers.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct visual audits to ensure residents' skin prevention interventions are in place according to the care plan as follows: Intervention audits will be completed 5x/week for 4 weeks, 3 x/week for 4 weeks then weekly. Audit to confirm staff competencies for use of mechanical lifts for 5 residents per week x4 weeks, 3 residents per week x4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting**	

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	been placed on the resident's bilateral arms during the evening shift on 10/8/23. The MAR, dated 10/2023, indicated the geri-sleeves were not applied to both arms on the evening shift on October 12, 14, 18, and 26, 2023 and the night shift on October 5, 10, and 27, 2023. During an interview on 11/2/23 at 10:21 a.m., the DON indicated the geri-sleeves were not on at the time of the fall. This citation relates to Complaint IN00419565. 3.1-45(a)(2)		**monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V Date of Compliance: 11-30-2023	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			

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	Based on observation, record review, and interview, the facility failed to ensure a resident who had a Physician's Order for a dietary supplement to assist with caloric and protein needs, received the supplement as ordered for 1 of 4 residents reviewed for nutritional status. (Resident Q) Finding includes: During an observation of the lunch meal on 11/1/23 at 12:08 p.m., Resident Q was served a soft taco, refried beans, green beans, lettuce, tomato, shredded cheese, and cake. A nutritional health shake supplement was not served. He received an alternate meal of grilled cheese sandwich due to not eating the taco. He consumed 100% of the grilled cheese sandwich and cake then left the Dining Room at 12:30 p.m. Resident Q's record was reviewed on 11/2/23 at 11:35 a.m. The diagnoses included, but were not limited to, dementia and mild intellectual disabilities. An Annual Minimum Data Set assessment, dated 10/11/23, indicated a severely impaired cognitive status, no behaviors, required set up or clean up with eating, and had no significant weight gain or loss. A Care Plan, dated 12/12/22, indicated a potential for a nutritional problem. The interventions included supplements would be provided and served as ordered by the Physician. A Physician's Order, dated 10/7/23, indicated a house nutrition supplement was to be given four times a day.	F 0692	**Tag number: F692 – Nutrition/Hydration Status Maintenance** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident Q – resident has been receiving the dietary supplement as ordered by a physician.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with orders for dietary supplements have the potential to be affected by the alleged deficient practice. Facility to conduct house-wide audit to ensure all resident meal tray tickets correctly identified dietary supplements.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff and dietary staff by 11-27-2023 on the need of ensuring residents are receiving dietary supplements as ordered by a physician.**	11/30/2023

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	155156	A. BUILDING 00 B. WING	11/03/2023

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	A Nutritional Assessment, dated 10/6/23, indicated a history of weight loss. Intakes had slightly decreased in the previous month and received a house supplement three times a day that helped increase the calories and protein. The recommendation was to increase the house supplement to four times a day. His weight on 4/3/23 was 97.2 pounds, 9/29/23 was 105 pounds, and 10/23/23 was 100.5 pounds. During an interview on 11/2/23 at 12:53 p.m., the Dietary Manager indicated the nutritional supplement was on his dietary card and he should have received the supplement with his meal. 3.1-46		IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct audit to ensure residents are receiving dietary supplements as ordered by physician. Audits will be completed at random meals 5x/week for 4 weeks, 3x/week for 4 weeks, then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V Date of Compliance: 11-30-2023	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to manage medications appropriately, related to missing medication doses, not administering or ensuring insulin was administered, and blood sugar monitoring not completed as ordered for 1 of 4 residents reviewed for unnecessary medications. (Resident S) Finding includes: During an interview on 10/31/23 at 5:30 p.m., Resident S indicated he was not receiving his medications as ordered by the Physician. Resident S's record was reviewed on 11/2/23 at 1:11 p.m. The diagnoses included, but were not limited to, diabetes mellitus and congestive heart failure. An Admission Minimum Data Set assessment, dated 8/7/23, indicated an intact cognitive status an had no behaviors. A Physician's Order, dated 9/30/23, indicated	F 0757	**Tag number: F757 – Unnecessary Drugs** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident S – the facility is performing regulatory monitoring of medications, administration of insulin and blood sugar monitoring for resident.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. The facility clinical team – DON, ADON X 3 – will conduct an audit of**	11/30/2023

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	furosemide (diuretic) 20 milligrams was to be given once a day for congestive heart failure. The Medication Administration Record (MAR), dated 10/2023, indicated the furosemide had not been administered on October 1 and 2 at 9 a.m. as ordered by the Physician. Physicians Orders, dated 8/1/23, indicated orders to monitor the blood sugar and Humulog insulin was to be administered with a dosage amount in relationship to his blood sugar result (sliding scale) before meals and an order on 8/7/23 for a routine dose of Lantus insulin, 15 units was to be administered nightly at bedtime. There was no Physician's Order for the resident to self-administer the insulin dosages. The October 2023 MAR indicated the blood sugars were not completed and the Humulog insulin had not been administered on October 13 at 7:30 a.m., October 4 and 21 at 11 a.m., and October 16 and 26 at 4 p.m. The October 2023 MAR indicated the Lantus insulin had not been given on October 16, 2023 at 9 p.m. During an interview on 11/2/23 at 1:48 p.m., Employee 7 indicated the resident had always administered his own insulin. The nurses would hand the insulin to him and he would draw the insulin up and administer it. There was no Physician's Order for self-administration of his own insulin. The nurses were to complete the blood sugar checks. This citation relates to Complaint IN00420080.		**diabetic residents to ensure that any resident with insulin ordered has blood sugar monitoring being conducted.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on 5 Rights of Medication Administration and following physician orders.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit 5 diabetic residents for blood glucose records for accuracy of entry into the eMAR and insulin administration. 5 residents per week for 6 month. Each business day for 6 months to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	3.1-48(a)(6)		V Date of Compliance: 11-30-2023	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and			

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	§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure residents were free from unnecessary psychotropic medications related to a lack of a GDR (Gradual Dose Reduction) for anti-anxiety and antidepressant medications completed for 2 of 4 residents reviewed for unnecessary medications. (Residents B and H) Findings include: 1. Resident B's record was reviewed on 10/31/23 at 11:55 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 10/4/23, indicated an intact cognitive status, no behaviors, and received anti-anxiety medication and antidepressant medications. The Physician's Orders, indicated the following: - 1/5/22 Ativan (anti-anxiety) 0.5 mg (milligrams) twice a day for anxiety - 10/19/22 sertraline HCL (Zoloft) (antidepressant)	F 0758	**Tag number: F758 – Unnecessary Psychotropic Meds - GDRs** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B and H - Resident's **medications were reviewed by Guidestar Psych NP and progress notes written by Guidestar. Care plans to be updated as appropriate.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with psychotropic medications have the potential to be affected by the alleged deficient practice. Social**	11/30/2023

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	150 mg daily for depression. An Encounter Progress Note (Psychiatry Progress Note), dated 7/12/22, indicated A GDR of the "...Ativan was contraindicated at this time...." There was no further documentation another GDR of the Ativan had been attempted or a rationale for why it was contraindicated. There was no documentation a GDR of the sertraline HCL had been attempted. During an interview on 10/31/23 at 3:10 p.m., the Social Service Director indicated there had not been another GDR attempted nor a contraindication indicated for the GDR of the Ativan. During an interview with the Social Service Director, on 11/3/23 at 8:50 a.m. she indicated there had not been a GDR attempt nor documentation of a contraindication for the GDR on the sertraline HCL. 2. Resident H's record was reviewed on 10/1/23 at 2:18 p.m. The diagnoses included, but were not limited to, bipolar, anxiety dementia, and severe intellectual disabilities. A Quarterly MDS assessment, dated 8/1/23, indicated a severely impaired cognitive status, no behaviors, and received anti-anxiety and antidepressant medications. The Physician's Orders indicated the following: - 4/19/22 Paxil (antidepressant) 20 mg daily for depression - 9/13/22 Ativan 0.5 mg twice a day for anxiety A Psychiatry Progress Note, dated 10/17/23,		**Service Director to perform 100% audit of long-term care residents with psychotropic medications to ensure all resident medications have been reviewed in a timely manner.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Social Service Department on the need to ensure appropriate and timely Gradual Dose Reductions are performed for each resident psychotropic medication.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **Social Services Director/designee will conduct a GDR audit for all residents with psychotropic medications. Audits will be completed 1x/week for 6 months. The facility Social Services Director will review and complete 5 resident charts per week and continue until all residents are reviewed and in compliance. The results of these audits will be reviewed in Quality**	

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	indicated a GDR had been completed on the Ativan on 9/13/22 and was tolerated well. A GDR had been discussed for the Paxil and was contraindicated on 10/11/22 due to yelling out behaviors and recent death of a roommate. There was no documentation a GDR had been completed or was contraindicated for the Ativan since 9/13/233 or for the Paxil since 10/11/22. During an interview on 11/1/23 at 3:36 p.m., the Social Service Director indicated the GDR's had not been completed. A Psychotropic Medication Gradual Dosage Reduction policy, dated 2/1/18 and received from the Social Service Director as current, indicated a gradual dose reduction and behavior interventions, unless clinically contraindicated, would be completed. A GDR would be encouraged at least twice yearly unless previous attempts were unsuccessful or the reduction was clinically contraindicated. This citation relates to Complaint IN00415818. 3.1-48(a)(6)		**Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V Date of compliance: 11/30/2023	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was sanitary and comfortable, related to dirty bathrooms, broken and chipped toilets, dirty walls, debris on the floor, unsanitary storing of	F 0921	**Tag number: F921 – Safe/Functional/Sanitary/Comfortable Environment** I What corrective action(s) will be accomplished for	11/30/2023

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	personal use items, holes in the walls, unmade beds, a dirty fan, over the bed table veneer loose and coming off, flooring coming up in the bathroom, and tears on the wheelchair arms for 11 of 24 rooms observed on 4 of 4 units (100, 200, 300, and 400) Findings include: During an Environmental Tour observation on 10/31/23 from 5 p.m. through 6:13 p.m. the following was observed: a. 300 Hall Room 303, there was debris under the bed by the window, a dried dark liquid spot on the toilet seat, a black substance on the wall by the toilet, and a hole in the wall behind the bed by the door. Room 306, the bathroom light was dim, the toilet seat was broken, the floor was sticky, there was dirt in the corners, and the linoleum was coming unglued on the floor in the bathroom. The room walls had scrapes and were dirty with a food like substance. Room 310 had chair pads with an uncovered, unmarked bath basin and bedpan setting on top of the pads on the floor of the bathroom. The toilet seat was chipped and dirty. Room 309 had a urinal on the floor in the bathroom and two holes in the wall in the room. Room 302 had a gash on the closet door. b. 400 Hall Room 439 had one resident in the room with two		those residents found to have been affected by the deficient practice; **The following has been completed:** **100 Unit – Resident D's wheelchair arms were replaced** **200 Unit – Room 203's bathroom was deep cleaned; Room 206 room fan was cleaned; Room 210's over the bed table was replaced** **300 Unit – Room 303 was deep cleaned and the hole behind Bed A was repaired; Room 306 was deep cleaned, walls repaired, bathroom light bulb replaced, toilet seat replaced, flooring repaired; Room 310 was deep cleaned, toilet seat replaced, bedpan removed and appropriately bagged in resident bathroom; Room 309 was deep cleaned, walls repaired, and urinal properly bagged in resident bathroom; Room 302 had closet door repaired** **400 Unit – Room 439 was deep cleaned and beds made; Room 438 was deep cleaned and bath basin properly stored in resident bathroom; Room 435 was deep cleaned and beds made; wall was repaired across from the 300 Unit Nurses' Station** II How other residents having the potential to be affected	

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	beds. The bed by the door had no linens and was unmade Room 438, there was an uncovered/unlabeled bath basin stored on the back of the toilet. There were two residents who resided in the room. There were spoons and crumbs of food on the floor under the window bed. Room 435 , there was a soiled brief in the waste basket in the bathroom and bowel movement on the toilet seat. At the time of the observation, Employee 8 indicated the resident required assistance with toileting. There was an unmade bed in the room. The room housed one resident. There was a hole in the wall and chipped plaster on the corner across from the 300 Unit Nurses' Station. c. 200 Hall Room 203 had wet paper towels spread out on the floor by the toilet. There was a black substance on the wall across from the toilet. Room 206 had a fan that was dusty and dirty. Room 210's over the bed table had the veneer coming off with roughness underneath it. d. 100 Hall Resident D resided on the 100 Unit. The wheelchair arms were torn and frayed. An Environment Tour was completed with the Director of Maintenance on 11/2/23 from 2 p.m. to 2:40 p.m. with acknowledgement of the above.		by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director/Housekeeping Supervisor performed a 100% audit of the facility regarding any needs for wall repair, cleaning of tube feeding spillage, and overall condition of each room.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director/Housekeeping Supervisor on ensuring Comfortable environment for all residents to include wall repairs, painting, cleanliness.** IV How the corrective action(s) 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 conduct an Environmental Audit as follows: Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks**	

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	This citation relates to Complaints IN00415818, IN00420080 and IN00420942. 3.1-19(e)		**then weekly.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** V. Date of compliance: 11/30/2023	