DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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	03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00322783, IN00326203, IN00327628, IN00333072, IN00338469, IN00343711, IN00345238, IN00345349, IN00346611, IN00346771 and IN00349737. This visit included a COVID-19 Focused Infection Control Survey. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00322783 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00326203 - Unsubstantiated due to lack of evidence. Complaint IN00327628 - Substantiated. Federal/State deficiencies related to the allegation are cited at F921 and F925. Complaint IN00333072 - Unsubstantiated due to lack of evidence. Complaint IN00338469 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00343711 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Complaint IN00345238 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600 and F744. Complaint IN00345349 - Substantiated. No deficiencies related to the allegations were cited.	F 0000	Submission of this Directed Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted in accordance with requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance as of 4/12/2021.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Complaint IN00346611 - Substantiated. Federal/State deficiencies related to the allegations are cited at F744. Complaint IN00346771 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00349737 - Substantiated. Federal/State deficiencies related to the allegations are cited at F558. Survey dates: March 22, 23, 24, 25, and 26, 2021. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 7 Medicaid: 75 Other: 2 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 1, 2021.			
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and			

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	preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 7 of 9 dependent residents observed for call light placement (Residents U, V, AA, BB, CC, DD, and G). Findings include: 1. On 3/22/21 9:50 a.m., Resident U was observed lying in bed watching TV (television). The resident requested the call button and TV remote that were near his hip and under the bed rail on his right side be handed to him. Resident U indicated he was paralyzed and could not move his right arm from its resting position on his chest. He had no way to call for staff if the call light was on his right side. On 3/22/21 at 11:31 a.m., a second observation of Resident U, the resident was sitting up in a cardiac chair (a medical chair that allowed positioning from a fully flat position to a sitting position) approximately 4 feet from the bed, watching TV. The resident's call light was hanging on the bed rail out of reach of the resident. Resident U's record was reviewed on 3/22/21 at 2:46 p.m. Diagnoses on included, but were not limited to, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side, and speech and language deficit following cerebrovascular disease. Care Plans for Resident U included, but were not limited to, ADL's (activities of daily living) with total dependence, mechanical lift for transfers, 2 assistance for continence care, assistance for	F 0558	All concerns identified during the survey were immediately corrected. Clips were utilized, as necessary, to secure the call light to the bed or the resident's person. As all residents who use a call light have the potential to be affected by this alleged deficient practice, house-wide observations were conducted to identify other potential concerns; all concerns similar in nature were immediately remedied. All staff shall receive education related to ensuring call lights remain within reach of the residents. Clips may be utilized, as necessary, to secure the call light to the bed or the resident's person. To ensure ongoing compliance, the Administrator/Designee is responsible for conducting daily visualizations on his/her scheduled days of work to ensure all call lights are within resident reach. Daily observations shall continue for a period of three months and then three times weekly for a period of three months. Should concerns be identified, immediate corrective action shall be taken. The Quality	04/12/2021

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	nutrition, and total dependence for ambulation (wheelchair or cardiac chair) with fall risk. On 3/22/21 at 2:43 p.m., Licensed Practical Nurse (LPN) 20 indicated the resident required maximum assistance of staff for care, and he was a total transfer with a mechanical lift. The resident was right side affected, and if he wanted assistance, he would use his call light, bang on things, yell, or push things over. 2. On 3/22/21 at 9:58 a.m., Resident V was observed lying in bed with his eyes closed, the call light was tucked under the mattress at the head of the bed, out of reach of the resident. On 3/22/21 at 11:34 a.m., a second observation of Resident V, the resident was lying in bed, eyes open, the TV on, and his call light was tucked under the resident's back out of his reach. On 3/22/21 at 2:32 p.m., a third observation of Resident V, the resident was lying in bed, eyes open, the TV on, and his call light tucked under the resident's mattress at the top of the bed out of his reach. Resident V's record was reviewed on 3/25/21 at 10:04 a.m. Diagnoses of Resident V's profile included, but were not limited to, dementia with behavioral disturbance, and cognitive communication deficit. A Physician's order for Resident V indicated, up with assistance of wheelchair. Care Plans for Resident V included, but were not limited to, total dependence for ADL's, transfers with 1-2 staff assistance, total dependence of 2 for incontinence care, total dependence for		Assurance Committee will review the results of these audits, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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	diet/nutrition, and fall risk with total dependence for ambulation. 3. On 3/22/21 at 10:21 a.m., Resident AA was observed in a wheelchair at bedside watching TV, with the call light on the bedrail approximately 4 feet behind her, out of her reach. Resident AA's record was reviewed on 3/25/21 at 9:45 a.m. Diagnoses on Resident AA's profile included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, muscle weakness, and blindness of one eye. A Physician's orders for Resident AA indicated, up with assistance of 2 for transfers. 4. On 3/22/21 at 10:24 a.m., Resident BB was observed in a cardiac chair at the foot of her bed, eyes closed, and her call light was on the bedrail on the opposite side of the bed, out of her reach. There was no observation of any apparatus for the resident to contact staff. Resident BB's record was reviewed on 3/25/21 at 10:52 a.m. Diagnoses on Resident BB's profile included, but were not limited to, dementia with behavioral disturbance, difficulty walking, status post fall with fracture, and need for assistance with personal care. A Physician's order for Resident BB indicated, bedrest, limit chair time to 2 hours daily. 5. On 3/22/21 at 10:29 a.m., Resident CC was observed in a wheelchair at the foot of his bed, the TV was on, there was no call light or apparatus to call staff observed within 6 feet of the resident.			

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On 3/22/21 2:33 p.m., Registered Nurse (RN) 14 and Qualified Medication Aide (QMA) 22 were observed assisting Resident CC to lie down in bed. The staff indicated the resident was a known fall risk.

Resident CC's record was reviewed on 3/25/21 at 11:15 a.m. Diagnoses on Resident CC's profile included, but were not limited to, vascular dementia without behavioral disturbance, and difficulty in walking.

A Physician's order for Resident CC indicated up with assistance of 1.

6. On 3/22/21 at 10:29 a.m., Resident DD was observed in his wheelchair at bedside, TV on, and no call light or apparatus to call staff observed within 6 foot of the resident.

On 3/22/21 at 2:47 p.m., staff were observed assisting Resident DD, who had been asleep in a broad chair (a tilt in space positioning chair), back to his room and told him he would be the next to be laid down, they needed to wait on the machine to help him get into bed.

Resident CC's record was reviewed on 3/25/21 at 11:05 a.m. Diagnoses on Resident CC's profile included, but were not limited to, Alzheimer's disease, and blindness of both the right and left eyes.

A Physician's order for Resident CC indicated up with assistance.

7. On 3/22/21 at 12:09 p.m., Resident G was observed lying flat in bed, immobile, eyes open, the bed was in high position, a mechanical lift at

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	bedside, and the call light was tucked under a transfer pad, out of reach of the resident. Certified Nursing Assistant (CNA) 8 was observed at end of hallway attempting to figure out how to maneuver Resident G's specialized electric wheelchair, he was unsuccessful and ultimately left the hallway to get assistance. Staff were not observed to return to the resident's room in excess of 20 minutes. Resident G's record was not available for review during the survey process. On 3/25/21 at 11:36 a.m., LPN 20 indicated, although Resident G was unable to transfers independently, he had the ability to speak and to use his hands. He used a call light to contact staff. On 3/25/21 at 2:30 p.m., the Regional Nurse Consultant provided a Call Light policy, dated 10/2014, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: Resident will have a call light to summon facility personnel to ensure the resident's needs will be met. Policy: Resident's call light is to be within reach and answered promptly by facility personnel ...8. Call lights must remain functional and within reach of each resident. Call lights must not be disabled. Call lights shall not be removed from resident's reach unless this is a therapeutic intervention documented in a resident specific behavior management plan...." This Federal tag relates to Complaint IN00349737. 3.1-3(v)(1)			

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F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on observation, interview, and record review, the facility failed to ensure a resident-to-resident altercation did not take place that resulted in (Resident S) pepper spraying (Resident L) in the eyes for 1 of 5 residents reviewed for behaviors. Findings include: During a random observation, on 3/23/21 at 2:07 p.m., Resident L was observed ambulating with a Certified Nursing Assistant (CNA) up and down the hall on the closed behavioral unit. During an observation, on 3/24/21 at 10:05 a.m., Resident L was observed in bed with his eyes closed. A CNA was present with the resident in his room. During an observation, on 3/25/21 at 1:30 p.m., Resident L was observed in bed. A CNA was	F 0600	Prior to the survey, Resident S discharged from the facility. Resident L remains on indefinite ongoing one-to-one supervision. All residents have the potential to be affected by this alleged deficient practice. All personnel shall receive education related to strategies to identify events/behaviors that have the potential to result in resident-to-resident altercations, including intrusive wandering, and interventions to prevent said events/behaviors and altercations. As a condition of admission to the Mental Wellness Unit, the facility shall conduct searches of the resident's personal items prior to enter the	04/12/2021

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	present with the resident in his room. Resident L's record was reviewed on 3/24/21 at 11:04 a.m. Diagnosis included, but were not limited to, dementia associated with cerebral anoxia, traumatic brain injury, bipolar, delusional disorder. An incident report, dated 1/1/21 at 2:40 p.m., indicated Resident L was ambulating in the hallway and complained he could not see, and his eyes burned. His eyes were flushed with eye solution at that time. An incident report, dated 1/1/20 at 2:45 p.m., indicated Resident L had reported to staff his eyes were burning. An investigation was conducted and found that Resident S had sprayed pepper spray in Resident L's eyes. Resident S had indicated Resident L had not done anything to him and that he did not like Resident L. He had brought pepper spray in with him upon admission and purposefully concealed it from staff. Resident S was informed at that time a member of the facility team would need to search both his belongings and physical person to confiscate inappropriate or potentially harmful materials. He asserted he would not answer any more questions and desired to leave the facility. The nurse notified him it was against medical advice and the resident still refused to stay at the facility and would not sign any paperwork. A nurse's note, dated 1/1/21 at 3:00 p.m., indicated staff remained with Resident L. Resident S's record was reviewed on 3/24/21 at 12:00 p.m. A personal inventory sheet, dated 12/24/20, indicated the resident refused staff to list his personal items brought into the facility		secure area in efforts to identify potentially dangerous possession(s) that may be used to cause harm to others. To ensure ongoing compliance, the Administrator/Designee is responsible for conducting daily observations of staff and utilization of person-centered interventions to prevent the potential for resident-to-resident altercations on his scheduled days of work. Daily observations shall continue for a period of three months and then three times weekly for a period of three months. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these observations, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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on 12/24/20 and 12/25/20.

A nurse's note, dated 1/1/21 at 2:42 p.m., indicated staff confiscated contraband from Resident S. The resident was verbally aggressive and indicated they could not keep him there and he wanted to leave. Resident refused to sign against medical advice (ama) paperwork. Resident ambulated out of the facility and the medical director was notified.

During an interview, on 3/24/21 at 2:37 p.m., the Infection Control Preventionist (ICP) indicated Resident S had brought pepper spray into the facility upon his admission and had admitted he hid it so staff would not know. After the incident with Resident L, they revised the facility policy that included, but was not limited to, a physical body search being conducted before they would be admitted onto the behavioral unit. Resident S was not in agreement to give up his pepper spray and discharged the same day against medical advice on 1/1/21.

On 3/25/21 at 12;00 p.m., the ICP provided a document, dated 5/2016 and titled, "Personal Belongings Inventory," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To maintain a record of each resident's personal items kept at the facility. Policy: the facility must inventory upon admission and at the time of discharge, the resident's personal belongings...."

This Federal tag relates to Complaint IN00345238.

3.1-27(a)(1)

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F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on record review and interview, the facility failed to ensure appropriate care and treatment were provided to a resident with head injuries, facial bruising, abnormal neurological checks, suspected internal/external rotation anomaly, and complaints of pain after a fall when the resident was moved prior to the arrival of Emergency Medical Services (EMS) for 1 of 3 residents reviewed for falls (Resident F). The immediate jeopardy began on 8/1/2020 when Resident F was found on the floor by the toilet. The resident was assessed to have sustained a concussion with injuries to the left head and forehead, and the neuro checks were positive with left eye drooping. Resident F was assisted into the wheelchair and taken to the nurses' station. 911 was called and the resident was transferred to a local hospital, then transferred to another hospital with a trauma unit. Resident F had a C7 cervical vertebrae fracture that was not treatable and later died at the hospital with the cause of death of "complications of a fractured C-7 vertebrae." The Administrator, Assistant Administrator, and Regional Nurse Consultant were notified of the immediate jeopardy at 2:54 p.m. on 3/25/21. This immediate jeopardy was removed on 3/26/21, but noncompliance	F 0684	Upon discovery, RN immediately received education related to ensuring a resident, having fallen or having been found on the floor who exhibits a head injury with change in mental status, neurological change(s), and/or who the RN suspects to have sustained a traumatic head injury and/or fracture upon immediate/initial assessment, is left in place and not moved until the arrival of EMS. All nursing staff on duty received in-service training related to the same. All residents, who have fallen or may have fallen in the future, have the potential to be affected by this alleged deficient practice. All incidents/accidents known to have occurred within the facility in the past 60 days have been reviewed. No concerns of a similar nature were discovered. The DON provided education to all staff, prior to their next tour of	04/12/2021

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	remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During a confidential interview, it was indicated Resident F died because of her falls at the facility. Resident F had dementia, was confused, she was not able to use her call light, and was not capable of understanding she needed to use the call light for help before trying to go to the bathroom. On 8/1/20, Resident F had a fall and was sent to the hospital. When Resident F arrived at the hospital, her face was black and blue, and looked like she had been "hit by a truck." Resident F was taken to the closest local hospital, but they transferred her to another hospital who admitted her as a trauma patient. Resident F had an x-ray which indicated a new fracture of her C-7 cervical vertebra. She was not a candidate for surgery, and a decision was made to place her on inpatient hospice. All they could do was keep her comfortable until she died. During that time, she had to wear a stabilizing neck collar. She died 10 days later, and her cause of death was deemed an accident, as complications from fractured C-7 vertebrae. On 3/24/21 at 2:20 p.m., Resident F's medical record was reviewed. Resident F's most recent comprehensive nursing assessment was a discharge MDS (minimum data set) assessment dated 8/1/2020. The MDS indicated Resident F was moderately cognitively impaired and needed extensive assistance for all ADLs (activities of daily living to include, but were not limited to transfers, toileting, walking in her room, and walking on her unit). She was frequently		duty. To ensure ongoing compliance, the on-call nursing administrative staff shall be notified of all falls/incidents to confirm appropriate action was taken by the licensed nurse on duty. Should any concern be identified with adherence to appropriate assessment and action taken, immediate corrective action shall be taken. It shall be the responsibility of the Administrator/Designee to meet with the nursing administrative staff each morning on days of work, to further confirm compliance with the immediate corrective action plan, confirming appropriate steps taken following the incident and to receive updates on residents who have recently fallen. Should any concern be identified, immediate corrective action shall be taken. As means of quality assurance, the Registered Nurse Consultant shall conduct bi-weekly audits of all incidents/accidents known to have occurred within the facility for a minimum of six months to confirm continued compliance. Should non-compliance be identified, immediate corrective action shall be taken, including, but not limited to re-education and disciplinary action, up to and including termination, if warranted. The	

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	incontinent of bowel and bladder. She had active diagnoses to include, but were not limited to, muscle weakness, difficulty in walking, dementia, Alzheimer's disease, and osteoarthritis. The MDS indicated Resident F was at risk for falls and had experienced one fall in the prior seven days, with no injuries. Resident F's physician orders, current from 8/1/2020 through 8/31/2020, indicated the resident had additional diagnoses to include, but were not limited to: Osteopetrosis, history of falls, history of femoral neck fracture, right 4th and 5th rib fracture, and vertebral compression fracture. Resident F had a comprehensive care plan titled, "Falls," initiated 1/17/19, and most recently revised 8/1/20. The care plan indicated Resident F had multiple risk factors for falls which included, but were not limited to, impaired cognition, unsteady balance, dementia, and weakness. Interventions for this care plan included but were not limited to monitor the resident frequently when the call lights were not available, ensure that resident was using assistive devices, ensure walker/rollator and wheelchair were within reach, offer to use the toileted every two hours, and 30 minute visual checks. A document titled, "Accident & Incident Report and Investigation," dated 7/30/2020, indicated Resident F fell at 5:20 a.m. She was found on the floor in the hallway by a CNA (Certified Nursing Assistant). The resident stated she did not know what she was doing but fell on the floor. No suspected injuries were noted, her vital signs, and neuro (neurological) checks were within normal limits. Immediate action taken at the time of this fall was to place Resident F on visual safety		Quality Assurance Committee will review all results of the audits, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance. *The facility does not agree that it failed to ensure appropriate care and treatment were provided to a resident after a fall. While the documentation did not exhibit a chronological account of the presentation of resident symptoms warranting transfer for evaluation, the nurse's interviews provided the chronological account of the nurse's initial assessment, continued observation, and subsequent action, which provided explanation of those actions, per his professional judgment.*	

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	checks every 30 minutes, and to offer her the toilet every two hours. A document titled, "Post Fall Thirty (30) Minute Observations," dated 7/30/2020 at 5:30 p.m., indicated 30-minute visual checks were initiated at this time. The Post Fall Thirty Minute Observations Check tool indicated Resident F was observed walking by herself in the hallway at 5:30 p.m. on 8/1/20, with no complaints of pain, and had been offered to go to the bathroom. A document titled, "Accident & Incident Report and Investigation," dated 8/1/2020 and documented by Registered Nurse (RN) 25, indicated Resident F fell at 5:30 p.m. She was found on the floor of the bathroom and stated she was trying to use the bathroom. She sustained a skin bruise, concussion injuries on left head and forehead, and neuro checks were positive with her left eye drooping. The NP (nurse practitioner) was notified, and a new order was received to send the resident out to the Emergency Department (ED). The incident report indicated Resident F's most recent BIMS (Brief Interview for Mental Status) score was 2 (out of 15) indicating severe cognitive impairment. Her vital signs at the time of the fall included blood pressure 158/93, heart rate 109, and respirations were 24 breaths per minute. Staff suspected she hit her head and had a change in her cognition as noted by confusion. An anomaly of internal/external rotation of her extremities was suspected. She sustained a skin tear to her left hand that measured 1.5 cm (centimeters) and was administered Norco 5/325 (a narcotic pain medication). Resident F was assisted to the wheelchair and taken to the			

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nursing station.

A nursing progress note, dated 8/1/20 at 5:30 p.m. and documented by RN 25, indicated Resident F was found on the floor, she stated she was trying to go use the restroom and then lost balance with the walker. Resident sustained injuries of a skin tear to her left hand, hematoma on the left forehead and on the center of head. She also had a formed hematoma. NP notified and ordered the resident to be sent out emergently.

A document titled, "Post Fall Investigation," dated 8/1/20 and documented by RN 25, indicated Resident F was incontinent at the time of her fall, and stated she was trying to get to the bathroom and fell. The report indicated the resident usually put herself to bed anytime she wanted, but that evening she had been assisted to bed at 4:00 p.m.

The record lacked documentation that Resident F tried to get up by herself or was being uncooperative, not following commands, nor assessment or vitals within normal limits after the fall.

A document titled, "ED Physician Progress Note," from the local hospital, dated 8/1/20 at 6:25 p.m., indicated Resident F was admitted with a chief complaint of face pain after a fall at the long term care facility. She was complaining of right shoulder pain, neck pain, and face pain. She arrived in a cervical neck collar, her right shoulder was tender, and she had a left face abrasion. The attending physician consulted with a trauma surgeon from a different hospital and agreed to have her transferred there and admitted as a trauma patient. A CT Cervical Spine without

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IV contrast was taken on 8/1/20 at 7:43 p.m., and indicated Resident F sustained a new fracture of the C-7 superior facet. Left frontal and left parietal scalp hematomas were noted.

A document titled, "ED Physician Progress Note," from the second hospital, dated 8/2/2020 at 1:05 a.m., indicated Resident F was admitted as a trauma patient with C-7 fracture. Her thoracic and lumbar spine was tender to palpation. An abdominal/pelvis CT scan was completed on 8/2/20 at 4:34 a.m., and indicated, a compression deformity of the T-12 (thoracic spine vertebrae) superior endplate which was new from her prior examination on 6/29/20. An x-ray of her spine was completed on 8/2/20 at 11:40 a.m. and confirmed the C-7 fracture.

A document titled, "Death Summary," from the second local hospital, dated 8/11/2020 at 11:09 a.m., indicated Resident F was on comfort care with morphine as needed for pain control. She passed away on 8/10/2020 at 11:15 p.m.

A document titled, "Certificate of Death," dated 8/10/2020, indicated Resident F passed away on 8/10/2020 at 11:15 p.m., and the immediate cause of death was, "complications of a fractured C-7 vertebrae."

During an interview on 3/24/21 at 2:49 p.m., RN 25 indicated he was the nurse on shift at the time of Resident F's fall on 8/1/20. He indicated, around 5:00 p.m. that evening, CNA 90 notified him that Resident F was on the floor. He went to assess her and found her on the floor of her bathroom. Resident F was "fine" on the floor and following commands. RN 25 assessed the resident on the bathroom floor and did all the vital signs and neuro checks there in the room

which were documented on the Fall Incident Report. RN 25 then wanted to put her in the wheelchair and go to the nurses' station to monitor her because he noticed increased confusion, her eye was drooping, and she had pain. Resident F was unable to verbally tell where she was hurting, but indicated it was all over. She did get a Norco pill (pain medication) while she was waiting and took a cup of water. RN 25 had a CNA sit with her at the nurses' station while he called 911 and the family. When EMS arrived RN 25 informed them that Resident F was indicating her back and neck area were hurting, and EMS immobilized her neck and back to take her to the ED via ambulance.

During an interview on 3/24/21 at 2:21 p.m., LPN 19 indicated if a CNA found a resident on the floor, they were to keep the resident safe, and not move the resident until the nurse assessed the resident. The nurse should call the physician immediately, identify injuries if any, and send the resident out to the ED as needed. If the resident was assessed, and found to have abnormal neuro checks, the resident should immediately be sent to the ED. The nurse should make sure the resident was safe, leave the resident on floor, and call 911 to come transport. The DON (Director of Nursing) should be notified, and the family should be notified after resident care had been completed. A Post Fall Investigation should be filled out with the incident report, and both documents should be given to the unit manager.

During an interview on 3/24/21 at 2:22 p.m., LPN 20 indicated if a nurse found a resident on the floor, it should automatically be treated as an unwitnessed fall incident. The nurse should immediately assess the resident for injuries. If head injuries were suspected either by

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	lacerations, bruises, or hematomas, and if neuro checks were abnormal the resident should be sent to ED immediately. In order to call 911, the nurse should ensure the resident was safe and comfortable on the floor and let EMS move them. During an interview on 3/25/21 at 9:39 a.m., the Regional Nurse Consultant indicated when the resident fell on 8/1/20 in the bathroom, the documentation indicated the resident sustained injuries, which included concussion injuries to the head, a formed hematoma, and positive neuros (neurological checks) with left eye drooping. The nurse should have secured the resident's safety, assessed the resident, notified the physician, and the resident should have been sent out of the building to the ER. Whether the resident should have been gotten up off the floor into a wheelchair versus leaving her on the floor for EMS to move, would have been dependent on the conversation with the physician, even with documentation of injury per the nurse. The Regional Nurse Consultant indicated the fall documentation did not indicate what orders the physician may have given for care, other than the NP ordered the resident to be sent out to ED. RN 25 administered Norco 5/325 to the resident for pain after the fall and review of the fall documentation, did not clarify how much pain the resident was experiencing. The Regional Nurse Consultant indicated, if he had been in the same situation, he would have assessed the resident, left a CNA with the resident in order to place an emergent call to the physician for any orders and to ensure it was safe to assist the resident off the floor. The Regional Nurse Consultant's expectation would have been for staff to follow the facility fall policy and leave the resident in place and call 911 unless further instruction had			

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	been received from the physician to move the resident. During a second interview with RN 25 and the Regional Nurse Consultant on 3/25/21 at 1:38 p.m., RN 25 indicated after Resident F fell on 8/1/20, he and CNA 90 assisted the resident off the floor because she was trying to get herself up. The resident had been lying on her back on the bathroom floor when RN 25 got to her, she was bending her back and struggling to get up, so he and CNA 90 assisted her into a seated position where he completed an initial set of vitals and neuro checks which were within normal limits, and then helped her into the wheelchair, and brought her to the nurses' station for observation. After being placed at the nurses' station, the resident began to complain of pain. A second set of vitals was taken, and her neuro checks became abnormal to include drooping of her left eye and increased confusion. At this time, he called 911 which took approximately 20-30 minutes to arrive. RN 25 indicated he would not have gotten the resident off the floor if she had not been trying to get herself up. Resident F's record lacked documentation of an assessment and neuro checks after the fall that were within normal limits. The resident's record only contained documentation of one set of vitals and one assessment after the fall. Contact information for CNA 90 was requested multiple times during the survey but not provided by the exit of the survey on 3/26/21. On 3/26/21 at 10:30 a.m., the Regional Nurse Consultant indicated CNA 90 had been contacted several times in attempts for the facility to interview the CNA regarding the fall, but the CNA had not been available.			

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	On 3/24/21 at 2:09 p.m., the Regional Nurse Consultant provided copies of current facility policies. A policy titled, "Internal Fall Investigation Process," dated 3/2019, indicated, " ...the following is to be completed by the licensed nurse on duty: resident is reported as observed on the ground; OR resident witnessed to have fallen, resident is left as found (not moved) until licensed nurse assessment is conducted. NOTE: If during review, it is determined the staff moved the resident prior to assessment, education must be conducted and documented, as well as disciplinary action taken, if warranted ... If the fall was unwitnessed, or if resident states he/she struck his/her head, the licensed nurse must initiate neurological checks using the NEUROLOGICAL CHECK FLOWSHEET. Following assessment, physician is contacted and resident is either transported via EMS for ER evaluation; or deemed with no apparent injuries and assisted to bed or chair. Physician contact must include informing the physician if the resident is on an anticoagulant (due to potential bleeding tendencies), and if the resident is believed to have struck his/her head. This notification should be clearly documented in the nurse's notes...." A policy titled, "Fall emergency, First Aid," dated10/2014, indicated, "Purpose- to ensure a resident who sustains a fall will be assessed and treated to prevent complications. Policy- Any resident who sustains a fall will be assess for injury at the time of the fall and will receive first aid treatment promptly. Licensed nurse will notify physician to ensure proper treatment is administered. Procedure- Certified Nursing Assistant: 1. If a resident falls, call for nurse and stay with resident. 2. Check if resident is			

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	breathing. 3. Do not move resident. Leave in same position until the nurse examines resident. 4. Talk to resident in a calm and supportive manner ... Licensed Nurse: 1. Respond immediately to call. 2. Do not move resident prior to completion of a thorough assessment ... 4. Assess resident from head to toe for any injuries. 5. Assess for pain immediately. 6. Assess extremities for injury noting any rotation inward or outward, any shortening of the limbs and/or any complaints of pain. 7. If there is any evidence of a fracture, do not move resident until EMS arrives. 8. Assess for injury to head. If noted, begin neurological checks immediately. 9. Assess for injury to other parts of the body (e.g. cuts, skin tears, abrasions, hematomas, etc.) ...." The immediate jeopardy that began on 8/1/20 was removed on 3/26/21 when the facility had educated nursing staff regarding leaving a resident in place until EMS arrived when a resident has a fall with a change in mental status, neurological change(s), and/or who the nurse suspects the resident to have sustained a traumatic head injury and/or fracture upon immediate assessment. All incidents and accidents known to have occurred within the facility in the past 60 days were reviewed. Plans were implemented for the on-call nursing administrative staff to be notified of all falls/incidents to confirm appropriate action was taken by the licensed nurse on duty, and for the Registered Nurse Consultant to conduct bi-weekly audits of all incidents/accidents known to have occurred within the facility for a minimum of six months to confirm continued compliance. The noncompliance remained at the lower scope and severity level of isolated, no actual harm with the potential for more than minimal harm that is not immediate jeopardy			

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	because of the facility's need for continued monitoring. This Federal tag relates to Complaint IN00338469. 3.1-37(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.			
	Based on observation, interview, and record review, the facility failed to ensure an intrusive wandering resident was free from resident-to-resident altercations for 1 of 1 randomly observed wandering residents (Resident L) and affected for 4 of 4 residents (Resident K, M, D, and SS) reviewed for dementia. Findings include: During a random observation, on 3/23/21 at 2:07 p.m., Resident L was observed ambulating with a Certified Nursing Assistant (CNA) up and down the hall on the closed behavioral unit. During an observation, on 3/24/21 at 10:05 a.m., Resident L was observed in bed with his eyes closed. A CNA was present with the resident in his room. During an observation, on 3/25/21 at 1:30 p.m., Resident L was observed in bed. A CNA was present with the resident in his room.	F 0744	Resident L remains on indefinite ongoing 1:1 supervision. All other residents related to these occurrences continue to reside within the facility, and no further incidents have occurred. As all residents who have been diagnosed with dementia have the potential to be affected by this alleged deficient practice, patient-centered interventions to reduce the incidence of behaviors, such as intrusive wandering, were reviewed and plans of care updated. Personalized interventions were also reflected on the applicable CNA assignment sheet. All personnel shall receive education related to strategies to identify events/behaviors that have the potential to result in	04/12/2021

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	Resident L's record was reviewed on 3/24/21 at 11:04 a.m. Diagnosis included, but were not limited to, dementia associated with cerebral anoxia, traumatic brain injury, bipolar, delusional disorder. A care plan, updated 3/18/21, indicated Resident L had a diagnosis of anxiety with symptoms of pacing, restlessness, irritability, fear, and physician behaviors. Interventions included, but were not limited to, ensure calm environment. A care plan, updated 3/18/21, indicated Resident L exhibited verbal behavioral symptoms directed towards others such as threatening and screaming at others, resident would talk to himself. A care plan, updated 3/18/21, indicated Resident L presented with bipolar disorder and may exhibit explosive behaviors, physical behaviors such as hitting, verbal behaviors, anxiety, agitation, pacing, restlessness. Interventions included, but were not limited to, 1 to 1 supervision. 1. An incident report, dated 9/12/20 at 6:30 p.m., indicated Resident L engaged in a verbal altercation with Resident K. As a result of the altercation Resident L struck Resident K. Both residents were separated at this time and psychiatric services were notified. A nurse's note, dated 9/14/20 at 2:00 p.m., indicated the psych provider was notified and the resident was placed on 1 to 1 observation for safety. A nurse's note, dated 9/19/20 at 12:30 a.m., indicated the resident exhibited increased		resident-to-resident altercations, including intrusive wander, and interventions to prevent said events/behaviors and altercations, when risks have been identified. To ensure ongoing compliance, the DON/Designee is responsible for conducting daily observations of staff and utilization of person-centered interventions to prevent the potential for resident-to-resident altercations on scheduled days of work. Daily observations shall continue for a period of three months and three times weekly for three months. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these observations, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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	restlessness and agitation and put him at risk for injury to self and others within the unit which required a psychiatric evaluation. The resident was transported to the psychiatric unit. A nurse's note, dated 10/9/20 at 1:35 p.m., indicated the resident returned to the facility. Resident was resting quietly in bed and was pleasant and smiling. A timeline note indicated the resident had received medication changes while at psych stay and there was no longer need for 1 to 1 supervision. 2. A nurse's note, dated 10/24/20 at 12:00 p.m., indicated Resident L was fighting with Resident M in the hallway. Both residents fell to the floor as the writer had approached. Resident L climbed over Resident M and struck him twice in the face with a closed fist. Both residents were separated and assessed. Resident L was observed to have several scratches to his neck. He was placed on 1 to 1 monitoring. A nurse's note, dated 10/24/20 at 6:15 p.m., indicated Resident L received physician orders for Ativan (anti-anxiety) and Haldol and they had been effective. Resident remained on 1 to 1 monitoring. Resident M's record was reviewed, on 3/23/21 at 12:01 p.m., an initial assessment of non-pressure related skin condition, dated 10/24/20, indicated the resident had an area to the right eye. a. On 10/24/21 a 2-centimeter (cm) length (l) x 4 cm width (w) area to the left eye that was red. b. On 10/25/21 the area measured 2x4 with a purple wound bed. c. On 10/26/21 the area measured 2x4 with a purple wound bed. d. On 11/2/21 the area measured 2.1x4 with a			

blotchy purple wound bed noted.
e. On 11/9/21 the area was resolved.

An initial assessment of non-pressure related skin condition, dated 10/24/20, indicated the resident had an area to the left hand.
a. On 10/24/21 a 1.5-centimeter (cm) length (l) x 2 cm width (w) area to the left hand that was red.
b. On 10/25/21 the area measured 2x2 with a purple wound bed.
c. On 10/26/21 the area measured 2x2 with a purple wound bed.
d. On 11/2/21 the area measured 2x1.8 with a blotchy purple wound bed noted.
e. On 11/9/21 the area measured 2.2x with a blotchy purple/blue wound bed noted.
f. On 11/16/21 the area was resolved.

An initial assessment of non-pressure related skin condition, dated 10/24/20, indicated the resident had an area to the right hand.
a. On 10/24/21 a 3-centimeter (cm) length (l) x 2 cm width (w) area to the left hand that was red.
b. On 10/25/21 the area measured 2.5x3 with a purple wound bed.
c. On 10/26/21 the area measured 2.5x3 with a light purple wound bed.
d. On 11/2/21 the area was resolved.

3. A nurse's note, dated 10/29/20 at 6:00 p.m., indicated Resident L had physical contact with Resident D with no injuries noted. The incident was witnessed by staff and Resident L was easily redirected and escorted to his room. The physician was notified, and resident was sent to the emergency room for evaluation and treatment for safety of others. The resident returned from emergency room and continued 1 to 1 supervision.

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A physician's order, dated 11/24/20, indicated to discontinue 1 to 1 supervision.

4. An incident report, dated 1/6/20 at 6:01 a.m., indicated Resident L struck Resident SS with no injury noted. Resident L was placed on 1 to 1 supervision.

A nurse's note, dated 1/6/21 at 6:20 a.m., indicated Resident L had struck Resident SS. Resident L was pacing the floor and came upon Resident SS in his wheelchair at the nurse's station and struck him without being provoked. Both residents were immediately separated, and Resident L was placed on 1 to 1 supervision.

A nurse's note, dated 1/6/21 at 8:45 a.m., indicated a new order was received to send Resident L for psychiatric evaluation.

A nurse's note, dated 1/6/21 at 11:30 a.m., indicated Resident L was denied admission for psychiatric evaluation.

During an interview, on 3/24/21 at 2:37 p.m., the Infection Control Preventionist (ICP) indicated they had investigated all incidents Resident L had when they occurred. Due to the safety of other residents the facility had determined the resident would be better suited at a facility with less stimulation and was currently in the process of the resident being discharged to another facility that could provide an environment more suitable to meet the resident's needs.

On 3/25/21 at 12;00 p.m., the ICP provided a document, dated 5/2016, and titled, "dementia, aggression/anger," and indicated it was the policy currently being used by the facility. The policy

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	indicated, "Purpose: To identify, understand, and respond to aggressive behavior exhibited by the resident with dementia...environmental factors: The resident may be overstimulated by loud noises, an overactive environment or physical clutter...." This Federal tag relates to Complaints IN00345238 and IN00346611. 3.1-37(a)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

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and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure a staff member performed hand hygiene and infection control practices during a medication administration observation of 3 of 3 random residents (Resident M, PP, and QQ), failed to ensure a staff member performed hand hygiene before touching a resident (Resident TT) for 1 of 1 random observation, and failed to prevent the possibility of contamination of resident respiratory equipment for 4 of 7 random observations of uncovered respiratory equipment (Residents U, Y, AA, and NN). Findings include: 1. During a continuous medication administration observation on 3/25/21 from 7:56 a.m. to 8:40 a.m. the following was observed. At 7:56 a.m., an observation of Qualified Medical Assistant (QMA) 22, she pulled one medication cup from a stack of medication cups inverted on D Hall medication cart 1. She put the end of her finger with a polished artificial nail inside the medication cup. Then, she placed Resident M's medications in it. His medications were as follows: a. Aspirin 81 mg (non-steroidal anti-inflammatory) b. Lisinopril 5 mg (anti-hypertensive) c. Vitamin D3 50 mcg (supplement) d. Olanzapine 15 mg (treatment for schizophrenia) e. Senna 8.6 mg (stimulant laxative)	F 0880	All staff members who were identified throughout the survey to have breached infection control standards were immediately re-educated. Contaminated respiratory equipment was immediately discarded, replaced, and new items stored appropriately. All residents have the potential to be affected by this alleged this deficient practice. In efforts to further identify residents who have to increased potential to be affected, the facility conducted house-wide observations for all residents who receive supplemental oxygen via nasal cannula and/or receive nebulizer treatments. All personnel shall receive education related to hand hygiene and the appropriate storage, maintenance/cleaning, and storage of respiratory equipment. All personnel shall be required to successfully return demonstrate hand hygiene competency. All licensed nursing staff shall receive education related to medication administration and infection control standards throughout the medication administration process.	04/12/2021

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	Resident M refused to take his medication. QMA requested several times, but he continually refused. She indicated he usually did not take his medications until after he went outside to smoke around 9:30 a.m. She placed the unlabeled medication cup in the D Hall medication cart 1. At 9:35 a.m., Resident M returned from smoking and took his medications. He put his lips on the soiled medication cup and swallowed his pills. At 8:15 a.m., QMA was observed to pull another medication cup for Resident PP. She put her finger with a polished artificial fingernail inside the medication cup. She needed a second medication cup for his liquid medication, when she picked it up, she dropped it on the floor. She picked it up from the floor with her bare hands and threw it away. She did not wash or gel her hands after picking it up from the floor. When, she got another medication cup for the liquid medication, she put her finger with a polished artificial fingernail inside the medication cup again. She poured some liquid medication into the soiled medication cup and drew up 1.67 mL with a syringe, then poured the remaining medication from the soiled medication cup back into the original container from the pharmacy. She provided Resident PP with his medication, and he put his lips on the soiled medication cup and swallowed the medication. Resident PP had saline nasal spray ordered. She donned gloves and sprayed one spray in each nostril as ordered. When she removed her gloves, she did not do hand hygiene and signed off on his medications in the medication administration binder. Resident PP's medications were as follows: a. Digoxin 125 mg (anti-arrhythmic) b. Oxcarbazepine 1.67 mL (liquid anti-convulsant)		To ensure ongoing compliance, the DON/Designee is responsible for conducting daily observations related to the storage, maintenance/cleaning, and storage of respiratory equipment, adherence to infection control practices throughout the duration of medication administration, and the appropriate performance of hand hygiene on scheduled days of work. Daily observations shall continue for a period of three months and then three times weekly for a period of three months. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these audits, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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c. Pantoprazole 40 mg (treats gastric reflux disease)
d. Tradjenta 5 mg (anti-diabetic medication)
e. Sertraline 50 mg (treats depression)
f. Eliquis 5 mg (anti-coagulant)
g. Metformin 850 mg (anti-diabetic medication)
h. Gabapentin 300 mg (anti-convulsant)
i. Potassium Cl ER 10 mEq (electrolyte and mineral)
j. Carbidopa levo 25-100 (treats Parkinson's disease)
k. Tramadol 50 mg (treats pain)
l. Saline nasal spray, one spray in each nostril (moisture for inside the nose)

QMA 22 did not do any hand hygiene between Resident PP and Resident QQ.

At 8:33 a.m., QMA 22 pulled a medication cup and put her finger with a polished artificial fingernail in the medication cup for Resident QQ's medication. His medications were as follows:
a. Amantadine 100 mg (treats Parkinson's disease)
b. Vitamin B1 100 mg (supplement)
c. Stool softener
d. Risperone 1 mg (treats schizophrenia)
e. Divalproex 250 mg (treats bipolar disease)
f. Clonipin 1 mg (treats seizures)
g. Lactulose 15 mg (laxative)

A current policy, titled, "Medication Administration," dated 4/2017, was provided by the Regional Nurse Consultant on 3/23/21 at 9:15 a.m. A review of the policy indicated, " ...Use alcohol gel or foam before between each resident unless using soap and water ...Never touch the inside of med cups ...Never pour medications back into the bottle ... Destroy

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	(according to facility policy and procedure) any medication that has been prepared but not ingested due to refusal, inability to wallow, or contaminated, etc. (medication that have been removed from the unit dose packaging or poured from a bottle, cannot be replaced to [sic] the medication cart for later use.) ...." 2. On 3/25/21 at 11:03 a.m., Unit Manager (UM) 26 was observed washing her hands in the nurse's station sink. She turned the faucet off with her bare hands and left to get paper towels. When she came back with paper towels, she did not rewash her hands and was observed touching Resident TT. She combed his hair back with her artificial fingernails, touched the lower part of his beard, and re-adjusted his mask by putting the fingers of both hands inside his mask. Then, she combed back his hair again with her artificial fingernails. On 3/25/21 at 11:57 a.m., UM 26 indicated she would educate her staff on hand hygiene to use paper towels to turn on the water, use soap and water with friction while singing the happy birthday song all the way through. Then, dry hands on paper towels and turn the water off with new paper towels. She indicated she should have re-washed her hands as soon as she brought the paper towels back to the nurse's station sink, and not touched Resident TT with dirty hands. A current policy, titled, "Handwashing/Hand Hygiene," dated 10/2014, was provided by the Regional Nurse Consultant, on 3/25/21 at 9:15 a.m. A review of the policy indicated, "...Hand hygiene is the single most important measure for preventing the spread of infection ...Situations that require hand hygiene include, but are not limed [sic] to: ...before and after direct resident contact ...upon and after coming in contact with a			

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	resident's intact skin ...Handwashing Procedure ...Rinse hands with water down from wrists to fingertips. Dry hands thoroughly with a single use towel. Use towel to turn off faucet and discard towel...." 3a. On 3/22/21 at 2:34 p.m., Resident U's oxygen nasal cannula was observed unbagged and hanging among electrical wires at the top of his bed. On 3/23/21 at 10:07 a.m., Resident U's nebulizer tubing was observed unbagged and hanging over the arm of the resident's wheelchair. 3b. On 3/22/21 at 10:15 a.m., Resident Y's oxygen nasal cannula was observed unbagged and laying among the soiled bedding on his bed. On 3/22/21 at 11:38 a.m., Resident Y was observed laying on his bed watching TV and wearing oxygen per nasal cannula. 3c. On 3/22/21 at 10:21 a.m., Resident AA's oxygen nasal cannula was observed unbagged laying on her bed. On 3/22/21 at 2:57 p.m., 2 sets of oxygen nasal cannulas were observed unbagged on Resident AA's bed. 3d. On 3/23/21 at 2:56 p.m., observation of Resident NN's oxygen nasal cannula hanging unbagged on the doorknob in his room. On 3/24/21 at 3:03 p.m., the Southern Nurse Consultant indicated, Resident NN's nasal cannula should not have been hanging on the doorknob, and she was observed to remove it. On 3/25/21 at 11:12 a.m. observation of			

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	Resident NN's oxygen nasal cannula hanging unbagged on the doorknob in his room. Resident NN indicated, staff had told him not to hang the nasal cannula on the doorknob, but he would forget. On 3/26/21 at 11:51 a.m., the Regional Nurse Consultant provided a Nasal Cannula Care policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To provide clean equipment for oxygen administration...." This Federal tag relates to Complaint IN00343711. 3.1-18(b)(1) 3.1-18(l)			
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 maintain safe and sanitary resident rooms for 7 of 8 random resident rooms observed for environment (Residents U, Y, RR, LL, MM, HH, and KK), and the facility failed to ensure a resident's room had an intact wall around the PTAC (self-contained heating and air conditioning system) unit for 1 of 8 random resident rooms observed for environment (Resident JJ). Findings include: On 3/22/21 at 10:35 a.m., observation of only 1	F 0921	All concerns identified during the survey were immediately corrected. As all residents have the potential to be affected by this alleged deficient practice, house-wide observations were conducted to identify any additional concerns, and, if necessary, the appropriate corrective action was taken. All personnel shall receive education related to monitoring for	04/12/2021

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	housekeeper who was in training during the initial facility tour. She was running the vacuum in a lounge on the behavioral care unit. On 3/22/21 at 11:45 a.m., there had been no observation of a housekeeper on the A or B hallways during the survey process. 1a. On 3/22/21 9:50 a.m., Resident U's room was observed with a copious amount of debris on the floor around and under the bed to include, but not limited to, paper, plastic medication tube pieces, and unidentified food on and pressed into the carpet. On 3/22/21 at 11:31 a.m., a second observation of Resident U's room indicated, the floor continued to be littered with food and debris. 1b. On 3/22/21 at 10:15 a.m., Resident Y's room was observed with a copious amount of paper and plastic debris, unidentified food on the floor around the bed, and pillows without pillowcases on the floor among the debris and food. On 3/22/21 at 11:38 a.m., a second observation of Resident Y's room, the resident was laying on the bed watching TV, most of the large pieces of paper debris were off the floor. 1c. On 3/22/21 at 10:22 a.m., Resident RR's room was observed to have white batting/stuffing covering the entire visualized walking area of the carpet in her room. 1d. On 3/23/21 at 9:37 a.m., Resident LL's room was observed with magazines, bits of paper and debris, trash, and candy wrappers on the floor. 1e. On 3/23/21 at 9:45 a.m., Resident MM's		and reporting potential maintenance/repair issues immediately and maintaining a clean, home-like environment. To ensure ongoing compliance, the Administrator/Designee will complete daily visual rounds throughout the facility ensure rooms are clean, well-maintained, free from debris and in good repair on his scheduled days of work. Daily observations shall continue for a period of three months and then three times weekly for a period of three months. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these audits, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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	room was observed with cardboard boxes on the floor, and 3 rows of cardboard boxes stacked, for a total of 10 boxes. On 3/26/21 at 10:44 a.m., the Regional Nurse Consultant indicated, the boxes on Resident MM's floor should not obstruct the pathway, pathways should be clear for exit, but residents have the right to have their personal items in their rooms. 1f. On 3/24/21 at 10:03 a.m., Resident HH's room was observed to have a large amount of powder ground into the carpet and trash on the floor. The resident indicated it was baby powder on the floor. Certified Nursing Assistant (CNA) 11 indicated, the baby powder was from changing the resident's disposable brief. 1g. On 3/24/21 at 10:13 a.m., Resident KK's room was observed with a cracker wrapper and crumbs on the floor, cup lids, and other unidentified debris on floor. 2. On 3/24/21 at 2:56 p.m., Resident JJ's room was observed was an approximate 2-inch area of wall board missing from under the PTAC (self-contained heating and air conditioning system) unit, and all the way around the electrical plug that led to the PTAC unit. The previous attempt at repairs with wall mud were cracked. There were in excess of 20 dead insects on the windowsill above the PTAC. A Resident Room Inspection Schedule, dated 2021, indicated resident rooms were assigned to be inspected in January, April, July, and October. On 3/23/21 at 10:02 a.m., Housekeeper 24 and Housekeeper 13 indicated they were contracted			

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housekeeping workers for the management company of the facility. The housekeepers were observed to have cleaning supplies, and indicated they cleaned room by room, and spot checked as needed. Handrails were to be wiped down throughout the day, and deep clean of the resident rooms should have included all surfaced and the floors. Housekeeper 24 and Housekeeper 13 indicated, they were newer employees, had not seen any bugs, and did not know of any problems with bugs.

On 3/24/21 at 3:01 p.m., the Southern Nurse Consultant indicted, the wall area under Resident JJ's PTAC unit should have been repaired.

On 3/24/21 at 3:06 p.m., the Administrator indicated, the wall board in Resident JJ's room should have been repaired.

On 3/26/21 at 10:34 a.m., the Regional Nurse Consultant indicated, preventive maintenance should have been done on Resident JJ's wall.

On 3/25/21 at 12:30 p.m., the Regional Nurse Consultant provided a Resident Room Cleaning, Daily policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "The resident's room is that resident's home, it is to be treated and cleaned as such ...Procedure: Prior to entering, announce yourself. Do a quick straighten up. Complete the following 5-step cleaning method ...get the trash out of all the rooms first ...wipe all horizontal [flat] surfaces ...spot clean all vertical surfaces ...use the dust mop to gather all trash and debris from the floor ...damp mop the floor working from the back corner to the door...."

On 3/25/21 at 12:30 p.m., the Regional Nurse

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	Consultant provided a Room Cleaning policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "Completing a Room Cleaning ensures that every bed, closet and drawer is disinfected. A Room Cleaning must be completed at least once a month...." On 3/25/21 at 12:30 p.m., the Regional Nurse Consultant provided a Preventative Maintenance Program policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "Resident Room Observations: Each resident room should be inspected for potentially needed repairs on a quarterly basis ...One should note that the room inspection includes inspection of the resident bathroom. Also included is inspection of any equipment used by the resident [e.g., wheelchair/brakes, cane, walker, electrical equipment/cords, etc.] ...." This Federal tag relates to Complaint IN00327628. 3.1-19(f)(5)			
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to the building was free of insects in a residents' room for 2 of 2 days of random observation. Findings include: On 3/23/21 at 9:45 a.m., a large gnat-like flying	F 0925	All concerns identified during the survey were corrected immediately. As all residents have the potential to be affected by this alleged deficient practice, house-wide observations were conducted to	04/12/2021

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	insect was observed on the wall outside of room C-15. On 3/23/21 at 9:46 a.m., a dead flying insect was observed stuck to the wall by a hanging activity calendar at the back of C hall. On 3/23/21 at 9:47 a.m., a large gnat-like flying insect was observed on the wall outside of room C-17. On 3/23/21 at 9:53 a.m., a large flying insect was observed on the wall, and then buzzing around the TV room at the back of the C hall. On 3/23/21 on 9:55 a.m., 60-80 dead, small black insects were observed on the windowsill by the vending machine at the back of C hall. On 3/23/21 at 9:57 a.m., another insect was observation on the wall outside of room C-7. During an interview, on 3/23/21 at 10:02 a.m., Housekeepers 13 and 24 indicated there was no problem with insects in the building. On 3/24 at 10:19 a.m., dead bugs and live ants were observed on the windowsill by the vending machine in the TV room at the back of C hall. On 3/24 at 10:20 a.m., more than 60 dead insects were observed in the windowsill on the TV side of the TV room. During an interview, on 3/25/21 at 1:25 p.m., the exterminator from a local extermination company, indicated he did not do any treatments for the facility today. The "Catchmaster glue board," he put down on February 24, 2021, were to identify insects that would need to be		identify any additional concerns, and if necessary, the appropriate corrective action was taken. Furthermore, the facility contacted the pest control vendor to arrange for additional treatments in addition to the monthly scheduled visits as deemed necessary. All staff shall receive education related to monitoring for and reporting of potential pest control concerns to the maintenance team or members of the administrative staff. All staff received education related to maintaining a clean, home-like environment. To ensure ongoing compliance, the Administrator/Designee is responsible for completing daily visual rounds throughout the facility to ensure rooms are clean, well-maintained, and free of pests on scheduled days of work. Daily observations shall continue for a period of three months and then three times weekly for a period of three months. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these audits, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of	

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	03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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	eradicated. During an interview, on 3/26/21 at 10:43 a.m., the Regional Nurse Consultant indicated once insects were identified in the building, and one bug was not an infestation, it should have been brought to the attention of the administrator. Then, the administrator could have called for a one-off additional extermination treatment. A document, titled, "Maintenance Requisition," dated 3/17/21, was provided by the facility. A review of the document indicated, Certified Nursing Aide (CNA) 18 reported, in Room B-24, " ...Ants everywhere, mostly on the window side of the room, call light, and on fridge ...." A current policy, titled, "Pest Control Program," dated 1/2015, was provided by the Administrator on 3/25/21 at 12:20 p.m. A review of the document indicated, " ...It is the policy of this facility to maintain an effective pest control program to ensure to the facility is free of pests and rodents ...should a staff member observe a concern with the presence and/or sighting of a pest/rodent (e.g., whether alive, carcass, or evidence of presence via droppings, etc.), the same shall be reported to the Department Head and/or Administrator for further action, as warranted. The contracted exterminator shall be notified as warranted in an effort to provide consultation and/or additional service in response to the identified concern. This Federal tag relates to Complaint IN00327628. 3.1-19(f)(4)		compliance.	