STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELWOOD HEALTH AND LIVING	2300 PARKVIEW LN, ELWOOD, , 46036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
F 0000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00449079, IN00449973, IN00450517, and IN00452205. This visit included a State Residential Licensure Survey and the Investigation of Complaint IN00450475. Complaint IN00449079 - Federal/State deficiencies related to the allegations are cited at F584 and F921. Complaint IN00449973 - Federal/State deficiencies related to the allegations are cited at F584 and F921. Complaint IN00450517 - No deficiencies related to the allegations are cited. Complaint IN00452205 - Federal/State deficiencies related to the allegations are cited at F584 and F921. Complaint IN00450475 - No deficiencies related to the allegations are cited. Survey dates: February 10, 11, 13, 13, 14, and 17, 2025 Facility number: 000372	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegations in the survey report are accurate or reflect accurately the provisions of care and services to the residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegation of compliance.	

	Provider number: 155522 AIM number: 100289060 Census Bed Type: SNF/NF: 67 Residential: 16 Total: 83 Census Payor Type: Medicare: 5 Medicaid: 42 Other: 20 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 26, 2025.			
F 0584 SS = E	Safe/Clean/Comfortable/Homelike Environment 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 0584	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A recirculation line has been added to the affected hall on the 300 Unit. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)	03/07/2025

	(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to maintain water temperatures at a comfortable level for 4 of 7 residents reviewed for comfortable water temperatures on the 300 Hall. (Residents C, D, E, F) Findings include: On 2/10/25 at 11:28 a.m., the following was observed: The hot water in room 316's		will be taken: All resident's on the 300 long hall (20 residents) have the potential to be affected by this deficient practice. A recirculation line has been added to this hall to ensure that residents get hot water in a timely manner. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will record the time it takes water to reach appropriate temperature and the temperature of the water weekly as part of his TELS. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place: The Maintenance Director will record the time it takes water to reach appropriate temperature and the temperature of the water weekly as part of his TELS. Once one quarter of audits has shown 100% compliance, the Maintenance	

	bathroom sink reached a temperature of 96.8 degrees Fahrenheit (F) after it ran for five minutes. The hot water in room 320's bathroom sink reached a temperature of 100 degrees F after it ran for three minutes. During an interview, on 2/10/25 at 2:20 p.m., Resident E indicated the water from her bathroom sink was always cold, even after letting the water run for a while. It had been like that for the last 3-4 months. During an interview, on 2/11/25 at 10:32 a.m., Resident C indicated the water from her bathroom sink was cold all the time. During an observation, on 2/11/25 at 10:35 a.m., the hot water in Resident C's bathroom sink was turned on, and after letting the water run for three minutes, the water was lukewarm to touch. During an interview, on 2/11/25 at 10:59 a.m., Nurse Assistant 5 indicated some residents had complained of cold water in their bathrooms. Some rooms only had lukewarm even after running the water for a while. During an interview, on 2/11/25 at 11:03 a.m., the CNA Coordinator indicated residents had been complaining of cold water in their bathroom sinks. Further down the 300 hall you went, the colder the water was. She had to turn the water on and walk away for a while, so the water had time to warm up. She had waited over 20 minutes to get hot water in some of the resident rooms. Maintenance had been notified regarding the water being cold. During an interview, on 2/11/25 at 11:07 a.m., CNA 7 indicated the		Director may then ask the QAPI team to consider reduction of audit or potential discontinuation.	

bathroom sink water in room 312 only ever got lukewarm. You needed to let the water run a while before it would get warm. Maintenance had been notified regarding the cold water down the 300 hall.
During an interview, on 2/12/25 at 1:22 p.m., the Maintenance Supervisor indicated residents had complained about lack of hot water toward the end of 300 hall. He had performed temperature checks and the water did get above 100 degrees F. The other day, room 320 took eight minutes to get hot water. He told staff members, in order to get hot water, they needed to let the water run a while.
Weekly water temperature audit logs were obtained from the Maintenance Supervisor on 2/12/25 at 2:25 p.m., and indicated the following:
2/11/25:

Room 302 was 118 degrees F

Room 305 was 115 degrees F

Room 317 was 111 degrees F

Room 319 was 109 degrees F

The water temperature audit logs did not indicate how long the water had run to reach those temperatures.
2/4/25:

Room 306 was 114 degrees F

Room 312 was 116 degrees F

Room 319 was 109 degrees F

The water temperature audit logs did not indicate how long the water

had run to reach those temperatures.
1/23/25:

Room 309 was 116 degrees F

Room 312 was 117 degrees F

Room 320 was 114 degrees F

The water temperature audit logs did not indicate how long the water had run to reach those temperatures.
During an observation, on 2/13/25 beginning at 2:57 p.m. and ending at 3:28 p.m., accompanied by the Maintenance Supervisor, the following hot water temperatures were obtained:
The hot water in room 314's bathroom sink reached 97.8 degrees F after the water ran for 15 minutes.
The hot water in room 320's bathroom sink reached 97.7 degrees F after the water ran for 6 minutes.
Upon returning to room 314, the hot water in the bathroom sink reached over 100 degrees after four minutes.
Upon returning to room 320, with the water still running, the water reached 100 degrees F after running for over seven minutes.
During an interview, on 2/13/25 at 2:59 p.m., the Maintenance Supervisor indicated he had a plumber in the building earlier that morning to discuss adding a recirculating pump to the end of 300 hall to help with hot water circulation.
During an interview, on 2/17/25 at 2:23 p.m., the Administrator indicated they did not have a

	facility policy regarding environment and hot water. This citation relates to Complaints IN00449079, IN00449973, and IN00452205. 3.1-19(f)(5)			
F 0744 SS = D	Treatment/Service for Dementia 483.40(b)(3) §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 residents with dementia did not receive anti-psychotic medications without indication and individualized interventions for behavior expressions were implemented for 2 of 5 residents reviewed for dementia care (Resident 33 and Resident 61). Findings include: 1. During an observation, on 2/10/25 at 3:50 p.m., Resident 33 walked with a shuffling gait in the activity/dining area with his hands in his pockets. He was encouraged by a staff member to participate in an activity and was assisted to sit in a chair. On 2/12/25 at 10:09 a.m., Resident 33 shuffled up and down the hall with his hands in his pockets. On 2/12/25 at 12:40 a.m., Resident 33 talked nonsensically to his tablemate while sitting at a dining table. He moved food around on	F 0744	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Two resident's with a diagnosis of dementia and were taking antipsychotic medications were affected by this deficient practice. Those identified to not have appropriate behaviors (IE delusions or hallucinations that cause distress) were referred to their physicians with a request to gradually reduce this medication with a goal of discontinuation. **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 resident with a diagnosis of dementia that are also prescribed an antipsychotic	03/07/2025

	his plate, then poured water on it. He put small pieces of his pie in his water glass with his fork, then he ate small bites of the pie from his water glass. On 2/14/25 at 3:39 p.m., Resident 33 was lying in bed with his eyes closed. Resident 33's clinical record was reviewed on 2/13/25 at 2:03 p.m. Diagnoses included personal history of other mental and behavioral disorders, anxiety disorder, unspecified, primary insomnia, unspecified symptoms and signs involving cognitive functions and awareness, depression, unspecified, unspecified dementia, unspecified severity, with anxiety, and unspecified dementia, unspecified severity, with psychotic disturbance. A physician's order for quetiapine fumarate 12.5 mg daily was started on 7/13/21 and was discontinued on 8/31/24. Current physician's orders included venlafaxine (antidepressant) 75 milligrams (mg) daily (started 12/17/24), melatonin (sleep aid) 3 mg daily at bedtime (started 3/25/21), and quetiapine fumarate (antipsychotic) 25 mg daily (started 9/18/24). A quarterly Minimum Data Set (MDS) assessment, dated 9/12/24, indicated the resident was severely cognitively impaired. The resident did not experience hallucinations or delusions during the assessment period. The resident did not exhibit behavioral symptoms during the assessment period. The resident did not reject care or wander during the assessment period. An annual MDS assessment, dated		medications have the potential to be affected by this deficient practice. The DON has audited all residents and any that were found to have a dementia diagnosis that were also prescribed an antipsychotic medication were referred to their physician with a request to gradually reduce this medication with a goal of discontinuation. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** For all new orders of antipsychotic medications along with a diagnosis of dementia, the DON or designee will review for appropriateness of this medication. DON will audit all new orders daily (M-F) to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place:**	

	1/23/25, indicated the resident was severely cognitively impaired. The resident did not experience hallucinations or delusions during the assessment period. The resident did not exhibit behavioral symptoms during the assessment period. The resident did not reject care or wander during the assessment period. A current care plan, initiated on 3/30/21 and revised on 1/19/23, indicated the resident had impaired cognitive function and/or thought processes related to diagnoses of dementia and physical behaviors related to not understanding a situation or his peers' behavior who have dementia. He believed what he saw on television. Interventions included the following: Keeping the resident's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion (3/30/21) and providing a homelike environment (3/30/21). A current care plan, initiated on 4/20/21 and revised on 11/27/22, indicated the resident refused care at times. The resident picked at his food and declined to eat very much. Interventions included the following: Attempting to use a different staff member if the resident was uncomfortable with the current staff (4/20/21), educating the resident on the importance of care the staff were trying to provide (7/27/21), reapproaching the resident at a later time (4/20/21), and allowing the resident to assist with his care, by soaping up the wash cloth and handing it to him (10/15/24). A current care plan, created on 6/17/21 and revised on 5/2/24, indicated the resident may		DON or designee will audit all new orders, with focus of antipsychotic medications and appropriate diagnosis and behaviors for one quarter and results with be discussed in QAPI. After one quarter or when 100% compliance is reached, the DON or designee may request for this audit to be reduced or discontinued.	

	urinate/defecate in inappropriate places at times (trash can, dining room floor, dresser drawer). The resident stuck things in his pocket (i.e. butter knife) as if he is carrying a comb. He had a history of carrying a brush in his pocket. Interventions included the following: Assisting the resident with toileting before bed (11/25/24), assessing the resident for pain (initiated 6/17/21 and revised on 4/14/22), encouraging the resident to toilet frequently (initiated 6/17/21 and revised on 4/14/22), observing the resident meal tray after meals for all utensils (3/6/24), providing one on one reassurance and assistance (initiated 4/13/22 and revised on 6/28/22), and showing the resident the bathroom (initiated 6/17/21 and revised 4/14/22). A current care plan, created on 3/10/22 and revised on 1/23/23, indicated the resident may be verbally aggressive and may threaten to smack staff, cause harm to someone, talk about guns, and threaten to punch a peer. Interventions included the following: Assessing the resident for an unmet need (3/10/22), assessing the resident for pain (3/10/22), ensuring the resident is safe and ceasing interaction (3/10/22), redirecting the resident with conversation and activities he enjoys (3/10/22), and using a different caregiver if possible (3/10/22). A current care plan, created 12/26/22 and revised on 1/24/25, indicated the resident had threatened to hit staff and peers when he got agitated. He would raise his hand and shake it. He had not hit any peers. Interventions			

included the following: Allowing the resident to wash his own private parts assisting with putting soap on wash cloth and handing it to the resident and explaining what to do (7/3/24), allowing the resident to be up out of bed a bit before providing care when possible (1/10/25), assessing resident for a need that might be contributing to his behavior (12/26/22), redirecting the resident with activities such as listening to music he prefers like Elvis and Buddy Holly (11/21/24), intervening to make sure the resident and his peers are safe (12/26/22), walking away if resident is being physically aggressive with staff (11/8/23), and walking away from the resident and reapproaching after several minutes (6/10/24).

A current care plan, created and initiated on 9/17/24, indicated the resident walked up and down the hallway and hits the rails, the wall, and the nurse's cart. Interventions included the following: assess the resident for pain when he is hitting things (9/17/24), distract the resident with snack such as cookies and chocolate milk and cokes (initiated 9/17/24 and revised 1/23/25), the resident likes to listen to music and dance to the music this will redirect him at times (9/17/24), and try to distract the resident with activities of his choice when he is walking up and down the hall hitting things (9/17/24).

A current care plan, created and initiated 10/1/24, indicated the resident had a diagnosis of unspecified psychosis and took an antipsychotic medication for behaviors related to this condition. Interventions included the

following: Giving medication as ordered from physician (10/1/24), the resident enjoys Buddy Holly and Elvis Presley's music. Playing music for resident while being redirected from behaviors. (initiated 10/1/24 and revised 1/24/25), notifying the physician if the resident is having increased behaviors (10/1/24), and redirecting the resident from behaviors by engaging him in activities of his choice. He enjoys ball toss and listening and dancing to music (10/1/24).

A current care plan, created 10/23/24 and revised 2/13/25, indicated the resident may take other residents' food and drinks in the dining room and will sometimes swat at staff. Interventions included the following: Moving the resident to another table (10/23/24), giving the resident's drinks to him in a clear cup (10/23/24), and offering to refill the drink if the resident drinks all of his drink (initiated 10/23/24 and revised 1/2/25).

A current care plan, created and initiated on 11/26/24, indicated the resident receives psych services. Interventions included the following: Acting as a liaison between the facility, the resident, the psych personnel, and the family (11/26/24), encouraging the resident to express his feelings to the psych personnel (11/26/24), and introducing the resident to the psych personnel (11/26/24).

A current care plan, created 1/23/23 and revised on 1/23/23, indicated the resident had a decline in mental status related to dementia. Interventions included the following: Allowing the resident to voice his concerns and reassure

him (2/7/25), assisting the resident with tasks as needed (1/23/23), and redirecting the resident as appropriate (1/23/23).
A current care plan, created 12/17/24 and revised 12/17/24, indicated the resident had depression and received an antidepressant. Interventions included the following: Allowing the resident to express his feelings and provide emotional support as needed (12/17/24), giving medications as ordered (gradual dose reduction as appropriate) (12/17/24), and notifying the physician if the depression worsened or did not get better (12/17/24).
A current care plan, created 1/23/23 and revised on 5/2/24, indicated the resident walked about the unit and sometimes into other residents' rooms. He sometimes wandered and whistled because he forgot where his room was located related to his dementia. Interventions included the following: Allowing the resident to wander in a safe and unobtrusive way (1/23/23), encouraging the resident to participate or remain with the group providing him with structure (1/23/23), and engaging the resident in a functional appropriate exercise and activities. Keep the resident occupied in meaningful time pursuits (1/23/25).
A progress note, dated 8/17/24 at 4:01 a.m., indicated Resident 33 was assisted to the bathroom. The resident started to get agitated and started to push staff while staff were providing bowel incontinence care.
A Behavior Note, dated 8/19/24 at 8:57 p.m., indicated the resident

	growled, cussed, hit, pushed, and grabbed during a shower. Interventions attempted included played music, talked with the resident, approached the resident by different staff, and redirected the resident. The interventions were not successful. A Social Service Note, dated 8/20/24 at 1:37 p.m., indicated the resident had several behaviors that quarter including urinating and defecating in an inappropriate place and hitting staff during care. The resident had not experienced hallucinations or delusions during that quarter. A Behavior Note, dated 8/20/24 at 7:22 p.m., indicated the resident hit, kicked, pushed, grabbed, made loud disruptive noises, threatened others, and used foul language during personal care. Interventions included talked to the resident and finished his care. A Behavior Note, dated 8/23/24 at 7:18 p.m., indicated the resident was found lying in a female resident's bed watching television. He was redirected to the dining area for breakfast. A Behavior Note, dated 8/23/24 at 7:39 a.m., indicated the resident attempted to punch the CNA twice when the CNA tried to redirect the resident from urinating in the hall. The resident was redirected and encouraged to allow care. A Behavior Note, dated 8/23/24 at 12:27 p.m., indicated the resident punched the wall, the medication carts, and the handrails. The resident was redirected. A Behavior Note, dated 8/25/24 at 10:02 a.m., indicated the resident urinated on the doors, the walls, and the bedside tables. He			

	defecated in peers' closets, cussed, and tried to hit staff during care. The need to use the bathroom and perineal care triggered the behaviors. Interventions included talking with the resident which was unsuccessful and providing care and leaving the resident alone was successful. A Behavior Note, dated 8/25/24 at 5:00 p.m., indicated the resident paced the hall, pushed bedside tables and wheelchairs down the hallway, hit the walls as he paced the hall. He yelled and threatened staff. The resident was given snacks and toileted. The staff walked with him. The interventions were unsuccessful. A Behavior Note, dated 8/26/24 at 8:44 a.m., indicated the resident pulled back his fist towards the CNA who was providing his care. The provision of care triggered the behavior. The CNA disengaged with the resident and offered care at a later time. The resident was redirected. A Behavior Note, dated 8/26/24 at 3:53 p.m., indicated the resident was found in a female resident's bed eating candy he found in the room. The resident became agitated with attempts to redirect. The resident was redirected and offered a different snack. A Behavior Note, dated 8/26/24 at 4:30 p.m., indicated the resident was aggressive and combative with care. He hit the CNA during care. He was redirected, and staff disengaged when he became aggressive. A Nurses Note, dated 8/30/24 at 5:56 p.m., indicated the resident urinated on the floor in the hall.			

	The resident drew his fist when the staff attempted to redirect. A Behavior Note, dated 8/31/24 at 6:26 a.m., indicated the resident threatened staff, pulled back his fist at staff, and cursed at staff. The staff talked to the resident to intervene. A Behavior Note, dated 9/1/24 at 5:14 a.m., indicated the resident went into other residents' rooms. The resident became aggressive and held his fist up when the CNA attempted to redirect him. A Behavior Note, dated 9/3/24 at 12:17 p.m., indicated the resident wandered into other residents' rooms and urinated in trash cans and on different items in peers' rooms. The resident urinated in his closet, in the office, and in the lounge. Interventions included toileted the resident before and after meals and toileted the resident when he wandered. The interventions were not successful. A Behavior Note, dated 9/3/24 at 2:49 p.m., indicated the resident pushed hard on the exit door. He shook the door and told the staff he was trying to fix it. The staff talked with the resident and gave him a snack and coke. A Behavior Note, dated 9/4/24 at 9:39 a.m., indicated the resident threatened to kill the staff and swung at the staff. The staff were cleaning urine out of his closet which triggered the behavior. The staff talked with the resident and was unsuccessful at stopping the behavior. The cease of interaction with the resident was successful. A Behavior Note, dated 9/4/24 at 9:50 a.m., indicated the resident tried to hit staff with a lotion bottle. The CNA attempted to toilet the			

resident, and the resident picked up a lotion bottle and attempted to hit her with it. He told her to shut up and get out of there. The resident exited the shower room. The ceasing of interaction with the resident was a successful intervention.
A Behavior Note, dated 9/6/24 at 11:08 a.m., indicated the resident paced throughout the hall and into other residents' rooms. He pushed on the exit doors repeatedly. He hit his fist against the wall, the handrails, and the medication carts while he walked in the hall. He refused care. The resident was redirected and reapproached after refusals of care. He participated in an exercise activity on the unit. He was offered snacks and drinks. He was encouraged with toileting.
A Behavior Note, dated 9/8/24 at 5:53 p.m., indicated the resident threatened to hit and kill staff. The resident was digging in the trash, and a staff member told him to not do that and tried to redirect the resident. The resident then tried to swing at the staff member and told her he was going to kill her. Talking with the resident was unsuccessful for changing the behavior. Redirecting the resident was somewhat successful for changing the behavior.
A Behavior Note, dated 9/9/24 at 9:56 a.m., indicated the resident attempted to kick the staff member and threatened to kill the staff member when a bladder scan on the resident was attempted. The intervention was to disengage with the resident.
A Behavior Note, dated 9/9/24 at 5:27 p.m., indicated the resident pulled on the handrails in the hall.

	The resident was redirected with ice cream, drinks of choice and meal intake encouragement. A Behavior Note, dated 9/11/24 at 6:33 p.m., indicated the resident walked around with his drink. He was about to tilt and dump his drink on another resident when the CNA attempted to help him straighten his cup, the resident pulled away from the CNA and dropped the cup on the floor. When the CNA started to pick up the cup, the resident pushed the CNA out of the way. The staff attempted to talk to the resident to explain they were trying to help, this was unsuccessful to deescalate the behavior. The resident was left alone and walked away, which was a successful intervention to deescalate the behavior. A Social Service Note, dated 9/12/24 at 8:30 a.m., indicated the resident had several behaviors since the last assessment. He had hit, cursed, and threatened staff. He urinated in inappropriate places and took other residents' belongings. He had no hallucinations or delusions. A Behavior Note, dated 9/16/24 at 12:12 p.m., indicated the resident hit the nursing staff during care. He kicked the CNA while his wet pants were changed. He threatened to kill the staff. He was redirected and reassured while care was provided. A Behavior Note, dated 9/16/24 at 6:24 p.m., indicated the resident paced in and out of rooms. He removed papers from the wall and hit carts and the handrails. When the resident was questioned, he verbalized he was in pain. The resident was redirected. Activities and meal intake was encouraged.			

	The resident was assisted to bed. A Physician's Progress Note, dated 9/17/24 at 2:04 p.m., indicated the resident was being seen for an acute visit due to ongoing behaviors. The nursing staff had reported concerns about the safety of the staff, the resident, and the other residents. The resident was on lorazepam 0.5 mg twice a day and buspirone 10 mg twice a day. Buspirone was recently increased on 8/27/24. There had been an ongoing concern the behaviors could be due to pain. The nursing staff reported the resident occasionally admitted to lower extremity pain. The resident took scheduled acetaminophen twice a day since last year. He also had an order for acetaminophen as needed which was not taken very often. Assessment/Plan - For unspecified dementia, unspecified severity, with other behavioral disturbance the resident was having significant anxiety, agitation, and aggression. The resident had an increase in buspirone with not much changes. The resident did seem to have components of delusions and paranoia. It was difficult to assess for hallucinations. The physician suspected the changes were related to psychosis related to the progression of dementia. He started a trial of quetiapine. He also suspected a component of traumatic brain injury with apparent cognitive fluctuations and thought the quetiapine would help that component. Quetiapine 25 mg daily was ordered. A Nurses Note, dated 9/17/24 at 2:24 p.m., indicated a new order for quetiapine 25 mg daily was			

	received. The physician requested a psychological evaluation. A Behavior Note, dated 9/18/24 at 7:39 p.m., indicated the resident grabbed the staff and squeezed their hands hard. He cursed and hit the walls. The staff redirected and talked to the resident. A Behavior Note, dated 9/22/24 at 1:44 p.m., indicated the resident raised his fist behind another resident's back. The aide intervened. The resident then tried to go into another resident's room. The aide tried to get him to come out of the room, and the resident doubled his fist and told the aide he was going to kill the aide. The resident acted like his abdomen was bothering him. Interventions included distraction and one on one. A Nurses Note, dated 9/23/24 at 9:00 a.m., indicated the recent verbalizations and nursing assessments indicated the resident was in pain. The nurse practitioner ordered tramadol 25 mg twice a day. A Behavior Note, dated 9/23/24 at 3:14 p.m., indicated the resident raised his hand toward another resident when another resident touched him to get his attention. He was redirected. A Behavior Note, dated 9/23/24 at 5:24 p.m., indicated the resident hit the walls and medication carts. He paced. He was redirected, offered food and fluids, and medication. A General Progress Note, dated 9/24/24 at 6:40 p.m., indicated the resident went into another resident's room. He had a bowel movement on the floor and stepped in it. He got feces all over the room. He urinated on the floor			

by the bed and the other resident's shoes by the bed. He tore the toilet paper holder off the wall. He then put his hand inside the ice chest and got a piece of ice.
A Behavior Note, dated 9/25/24 at 10:42 a.m., indicated the resident tried to karate chop the staff during care when his clothes were being changed.
A Behavior Note, dated 9/26/24 at 7:21 a.m., indicated the resident started to squeeze the CNAs hands, hit and kick them while they changed his brief.
A Nurses Note, dated 9/30/24 at 12:20 p.m., indicated the resident's buspirone was to be gradually reduced from 10 mg bid to 5 mg bid for 7 days, then to 5 mg daily for 7 days, then to 5 mg every other day for 7 days, then discontinue.
A Behavior Note, dated 10/4/24 at 12:47 p.m., indicated the resident poured chocolate milk on another resident. Then, he attempted to pour milk on other residents as the staff intervened. The resident was trying to get himself between the dining chairs and the window. Other residents were seated in those chairs, eating lunch. The resident was redirected.
A General Progress Note, dated 10/4/24 at 7:30 p.m., indicated the resident urinated in the corner by the double doors and walked into other residents' rooms. When the staff attempted to redirect the resident he tried to hit them.
A Behavior Note, dated 10/5/24 at 12:22 p.m., indicated the resident was physically and verbally aggressive during care. Ceasing of the interaction with the resident was successful to deescalate the

behavior.
A General Progress Note, dated 10/8/24 at 6:30 p.m., indicated the resident looked like he was going to urinate in the hallway, and the staff member took him to toilet him. The resident hit the staff member on the shoulder during the care
A Behavior Note, dated 10/9/24 at 12:36 p.m., indicated the resident wandered into other residents' rooms, destroyed the other residents' items and threw them in the trash. He banged his head on the bathroom door. He punched and hit the staff member while the staff member tried to redirect the resident out of the other residents' rooms. The staff member ceased interaction with the resident, and the resident calmed down.
A Social Service Note, dated 10/9/24 at 3:40 p.m., indicated the resident was seen by the physician regarding the increased behaviors. He received a new order to increase the tramadol to three times a day.
A General Progress Note, dated 10/16/24 at 6:30 p.m., indicated the resident urinated in the hall by the double doors. The aide attempted to assist him to the bathroom, and he began urinating on the floor.
A General Progress Note, dated 10/18/24 at 5:53 p.m., indicated the resident tried to hit and kick the staff and called them names during toileting and changing of his clothes
A Behavior Note, dated 10/18/24 at 6:19 p.m., indicated the resident got into another resident's bed. He yelled and threatened the staff when they tried to get him out of the bed. The staff talked to the resident. The behavior stopped

when the staff got the resident to his own bed.
A Social Service Note, dated 11/21/24 at 1:19 p.m., indicated the resident had several behaviors in the past quarter. He cursed at staff, hit staff during care, hit the walls as he walked down the wall, hit a peer when he stepped on his foot, threw milk in a peer's face, got into other residents' beds, and urinated in inappropriate places. He experienced no hallucinations or delusions during the quarter.
A Social Service Note, dated 1/23/25 at 12:41 p.m., indicated the resident had multiple behaviors during the quarter. He hit the walls and medication carts, urinated in the hallways, bent the staff's fingers back, wandered in and out of other residents' rooms, and was combative with care. He had no delusions or hallucinations in the quarter.
During an interview, on 2/14/25 at 9:22 a.m., QMA 11 indicated the resident had mentioned a fire the other day which was new. She did not know what he meant. Usually, he just became agitated during care. He generally just walked back and forth a lot. They met his needs the best they could. They gave him snacks and tried to redirect him.
During an interview, on 2/14/25 at 2:14 p.m., CNA 16 indicated his psychosis was shown in his behaviors. Most of his aggression was with his care or also when the staff redirected him. He did not like showers. He tried to lie in other residents' beds. When assisting him with toileting, the staff did care in pairs (they use two people at least). The resident would

occasionally walk by a wall and punch it. When the staff talked throughout his care telling him each step of the way, that seemed to help with his agitation.
During an interview, on 2/14/25 at 3:51 p.m., the Unit Manager indicated the resident's dementia had progressed significantly in the last six to eight months and had become more violent. His psychotic behaviors are throwing milk at others, mostly the staff. Everyday he changed. The staff were having him sleep in and wake up naturally and that seemed to help some. She assisted with his care, and sometimes he was fine then other times he swatted at her. When the resident was admitted he took quetiapine. The medication had been reduced then discontinued a few years ago. All of sudden recently, it seemed like his dementia had gotten worse and his agitation had gotten worse.
During an interview, on 2/14/25 at 4:24 p.m., the Social Services Director (SSD) indicated the resident had started on quetiapine because he had a lot of behaviors like aggression towards staff, especially during care. He had been on quetiapine when he was admitted. The facility had tried other medications, but they were not helping control his aggressive behaviors towards others.
During an interview, on 2/17/25 at 4:31 p.m., the DON indicated the medical director had ordered the quetiapine for the resident. She knew the resident had increased aggression.
2. During an observation, on 2/10/25 at 10:44 a.m., Resident 61 ambulated in the hall wearing his

	coat and carrying a drink. During an observation, on 2/12/25 at 8:33 a.m., Resident 61 stood in the doorway of his room. He had a pull-up brief on his right hand, wore his coat, and was looking around. His speech was nonsensical. During an observation, on 2/13/25 at 3:54 p.m., Resident 61 ambulated in the hall with his hands in his pockets. He walked by the entrance doors with no attempt to leave. During an observation, on 2/14/25 at 11:34 a.m., Resident 61 was ambulating in his room. His roommate told the resident that he was not going to see well with those glasses because they were his (the roommate's). During an observation, on 2/14/25 at 3:21 p.m., Resident 61 was standing up in his room, looking at the bed. Resident 61's clinical record was reviewed on 2/13/25 at 2:45 p.m. Diagnoses included anxiety disorder, unspecified, cerebral infarction, unspecified, dementia in other diseases classified elsewhere, unspecified severity, with anxiety, delusional disorders, unspecified psychosis not due to a substance or known physiological condition and hallucinations, unspecified. Current physician's orders included ciprofloxacin (antibiotic) 500 milligrams (mg) twice a day for urinary tract infection (UTI) for 7 days (started 2/11/25), lorazepam (antianxiety) 1 mg at bedtime daily (started 11/26/24), quetiapine fumarate (antipsychotic) 12.5 mg twice a day (started 2/4/25), and quetiapine fumarate 12.5 mg every 24 hours as needed for			

	hallucinations, delusions, and paranoia until 2/18/25 (started 2/12/25). An admission 8/9/24 Minimum Data Set (MDS) indicated the resident was cognitively intact. He had no delusions, hallucinations, behaviors, wandering, or rejection of care during the assessment period. A significant change 12/2/24 MDS indicated the resident was moderately cognitively impaired. He had no delusions, hallucinations, behaviors, wandering, or rejection of care during the assessment period. The resident's behavior status was the same as the prior assessment. A quarterly 12/28/24 MDS assessment indicated the resident was cognitively intact. He had no delusions, hallucinations, behaviors, wandering, or rejection of care during the assessment period. A current care plan, initiated 8/7/24, indicated the resident had impaired cognitive function or impaired thought processes related to dementia. Interventions included discussing concerns about confusion (8/7/24), disease process and nursing home placement (8/7/24), needing supervision with all decision-making (8/7/24), and keeping routine consistent with consistent caregivers as much as possible in order to decrease confusion (8/7/24). A current care plan, initiated 8/7/24 and revised on 1/21/25 indicated the resident had a diagnosis of delusional disorder, hallucinations, and psychosis. The resident took an anti-psychotic medication for			

	those diagnoses. At home the resident would see things in the yard that weren't there. He often at the facility talked about things and saw things that did not make sense or were not present. Interventions included allowing adequate time to voice feelings and frustrations (8/7/24), never arguing with the resident about delusions/hallucinations (8/7/24), and providing psychological services as ordered (8/7/24). A current care plan, initiated 8/7/24, indicated the resident had a diagnosis of anxiety disorder and took an anti-anxiety medication for increased anxiety, pacing, fidgeting, and voicing increased anxiety/shakiness. Interventions included allowing adequate time to voice feelings and frustrations (8/7/24), reducing the medication as ordered (8/7/24), and observing and reporting increased signs and symptoms of anxiety to the physician (such as fidgety, wandering, statements of feeling anxious, shaking, shortness of breath, and change in appetite/sleep) (8/7/24). A current care plan, initiated 1/8/25, indicated the resident used psychotropic medications related to hallucinations and delusions. The goals were to remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the review date and to reduce the use of psychoactive medications through the review date (both initiated 1/8/25). Interventions included consulting with pharmacy, considering by			

	physician of dosage reduction when clinically appropriate and observing and recording of target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others) and document per facility protocol (1/8/25). A current care plan, initiated 1/21/25, indicated the resident frequently packed his belongings and asked when/where he was supposed to be going to. He rummaged through his roommate's belongings at times. Interventions included offering the resident the activity of conversation to redirect him from behavior (he enjoys talking about his past work as a policeman/mayor, he enjoys going outside when the weather is nice) (1/21/25), offering the resident a snack or drink (he likes suckers) (1/21/25), and offering the resident to call his son (1/21/25). A current care plan, initiated 1/21/25, indicated the resident wandered in the hallways with no concrete destination. Interventions included assessing the resident for basic needs, assessing the resident for pain, offering the resident an activity to occupy time, and offering to call the resident's son (1/21/25). A Nurses Note, dated 11/23/24 at 4:14 p.m., indicated the resident was in his room packing his bags and packing his roommate's items with his belongings. The resident was agreeable to putting the roommate's belonging back after the staff talked with the resident. A Behavior Note, dated 11/24/24 at 12:44 a.m., indicated the resident was going through his roommate's			

	dresser and belongings. The resident was easily redirected. A Nurses Note, dated 11/24/24 at 6:42 a.m., indicated the resident was exit-seeking and pushing buttons on the doors trying to open them. The resident was placed on 15-minute checks. The nurse practitioner was notified. A Nurses Note, dated 11/24/24 at 10:58 a.m., indicated the resident had received a new order for quetiapine 50 mg one time, then 25 mg twice a day. A Nurses Note, dated 11/24/24 at 11:00 a.m., indicated the resident was placed on the memory care unit for daily activities. The resident read the paper and interacted with other residents. A Nurses Note, dated 11/24/24 at 7:16 p.m., indicated the resident went to the memory care unit because of exit-seeking. The resident did not exit seek for a short time. The resident read a newspaper, played cards with staff, interacted with other residents and went outside into the gated patio with staff. The resident then wanted to come back inside and started to exit seek. The resident then began telling the other residents that they had a way to leave and upset them. The resident was taken back to his room to lie down. A Nurses Note, dated 11/25/24 at 1:39 p.m., indicated the resident received a new order for routine acetaminophen (for pain) and an as needed order for acetaminophen. A Nurses Note, dated 11/26/24 at 1:57 p.m., indicated the resident complained of low back pain with an 8/10 rating.			

	A Nurses Note, dated 11/26/24 at 2:28 p.m., indicated the physician saw the resident and changed the lorazepam to 1 mg at bedtime, quetiapine 25 mg at bedtime, and increased the acetaminophen to 1000 mg three times a day. A Nurses Note, dated 11/27/24 at 2:05 p.m., indicated the resident was on antibiotic therapy for pneumonia. A Nurses Note, dated 11/30/24 at 4:39 a.m., indicated the resident was restless and rummaged through his belongings. He came out into the hall wearing only a brief. He was easily redirected. A Social Service Note, dated 12/2/24 at 10:26 a.m., indicated the resident's brief interview for mental status indicated he was moderately cognitively impaired. He had behaviors since the last assessment which included going through his roommate's belongings and was easily redirected. Later, the same day, he was exit seeking. He was taken to the memory care unit to deter his exit seeking. He later was taken back to his room and lied down and took a nap. A Nurses Note, dated 12/3/24 at 5:00 p.m., indicated the physician saw the resident and changed the quetiapine order from 25 mg to 12.5 mg at bedtime. He ordered doxycycline (antibiotic) 100 mg for 5 days and prednisone 20 mg daily for 5 days for chronic obstructive pulmonary disease (COPD) exacerbation. A Behavior Note, dated 12/8/24 at 1:16 p.m., indicated the resident was going through his and his roommate's belongings. The resident was hallucinating about bugs in bed with him. The resident			

reminded it was 1 am in the morning and cold outside. The resident lied down.
A Nurse Note, dated 12/13/24 at 3:58 a.m., indicated the resident was up and down throughout the night looking for his car keys, his wallet, and his phone. He wanted to go and get donuts. He was redirected multiple times.
An IDT Note, dated 12/16/24 at 1:49 p.m., indicated the IDT (Interdisciplinary Team) met to review the resident's psychoactive medications. The resident's quetiapine was scheduled to be reviewed for potential reduction. The IDT did not feel it would be in the resident's best interest to make a reduction at this time as the resident was still showing psychotic symptoms at times. The nurse practitioner agreed the reduction attempt should not be made at that time.
A Nurses Note, dated 12/26/24 at 11:26 a.m., indicated the resident's representative had concerns over the quetiapine order. During a visit the previous day, the resident had said he was getting kicked out and arrested. He also spoke to another family member and said he did not know who was trying to vote him out of the building. The family felt the resident was not at his previous baseline.
A Social Service Note, dated 12/27/24 at 8:24 a.m., indicated the resident's quetiapine was decreased on 12/2/24. He was seen by the psychiatrist on 12/14/24. He was seen by the primary care physician on 12/24/24. The resident's brief interview for mental status indicated he was cognitively intact.

	A Behavior Note, dated 1/15/25 at 4:24 p.m., indicated the resident asked the activity director when he would be receiving a paycheck. The resident indicated he had been at the facility for a long time helping all those old people and had not yet gotten a paycheck. He was invited to attend an activity and agreed. He did not mention it again. A Behavior Note, dated 1/20/25 at 11:38 a.m., indicated the resident entered the front office and asked if his ex-wife was there. He also asked if he had money that someone he knew needed. The office manager was able to redirect the resident by speaking to him about his family. A Behavior Note, dated 1/21/25 at 1:40 p.m., indicated the resident entered the front office and asked why his ex-wife was in the building and why she was in his room visiting him. He also asked where he was going to go since he was being kicked out of the place. The office manager told the resident he had a room at the facility and was not being kicked out. The office manager redirected the resident by changing the conversation. A Nurses Note, dated 1/23/25 at 4:43 p.m., indicated the resident asked a staff member who was in charge. He wanted to know if there were any cops there. The resident said he had a couple of hostages and thieves in the building that were his family. The staff member told the resident he would check on this. The resident told the staff member his room number and went to his room. A Nurses Note, dated 1/23/25 at 4:50 p.m., indicated the staff			

member went to check on the resident. The resident asked if the staff member had any warrants. The staff member told the resident he did not, then asked if the resident had slept any through the night. He had not been able to get any sleep, and his roommate indicated the resident had been keeping him (the roommate) from sleeping too.
A Nurses Note, dated 2/2/25 at 1:20 p.m., indicated the resident said he was leaving to go back home, but he didn't have a car here. He asked what would happen if he took a car that was parked outside. He paced up and down the halls. The resident was redirected several times and encouraged him to get some rest. The resident was placed on 15-minute checks and the physician was notified.
A Nurses Note, dated 2/2/25 at 1:33 p.m., indicated the resident wandered in and out of other residents' rooms. He was easily redirected.
A Physician's Progress Note, dated 2/4/25 at 1:38 p.m., indicated the resident was seen for an acute visit due to a change in his behaviors. The nursing staff reported the resident was having psychotic behaviors. The resident was convinced he was leaving the facility, and there was a bus coming. The resident went into another resident's room and laid down on the bed which upset the other resident's roommate. The resident had a history of hallucinations, and he was on a chronic antipsychotic for this. The resident had difficulty explaining how he felt due to his cognition. He

admitted "something is off in my head." Assessment/Plan indicated for the resident's hallucinations the resident had several gradual dose reductions of psychoactive medications in the past couple of months. His psychosis symptoms were worsening. The physician indicated he suspected the change in behaviors was due to a failed gradual dose reduction attempt. Quetiapine was increased to twice a day and daily as needed for the next two weeks. He indicated psycho must not be following the resident as no notes are in the resident's electronic clinical record.
A Nurses Note, dated 2/4/25 at 3:23 p.m., indicated the primary care physician saw the resident and changed the quetiapine 12.5 mg daily to twice a day and ordered a quetiapine 12.5 mg daily as needed for 14 days.
A Nurses Note, dated 2/7/25 at 1:35 p.m., indicated the resident was continually going through his roommate's belongings.
A Nurses Note, dated 2/8/25 at 11:12 a.m., indicated the resident continued to go through the resident's belongings, go in and out of other residents' rooms, and packing his belonging to go home. He was easily redirected. Brown urine was found on his bed. He was typically continent of urine. The resident indicated he was having trouble urinating when asked to void in a cup.
A Nurses Note, dated 2/8/25 at 1:09 p.m., indicated the resident received a new order for a urinalysis with a culture and sensitivity.
A Nurses Note, dated 2/11/25 at 5:27 a.m., indicated the resident

paced throughout the night, wandering in and out of other residents' rooms. He was easily redirected out of rooms. He packed his bags and placed dresser drawers on the bed. He was redirected multiple times.
A Nurses Note, dated 2/11/25 at 5:30 a.m., indicated the resident was placed on 15-minute checks.
A Nurses Note, dated 2/11/25 at 1:57 p.m., indicated the resident was seen in the hallway without his shirt. He was redirected to his room. He had episodes of exit seeking and wanted to pack his belongings. Staff was able to redirect.
A Physician's Progress Note, dated 2/11/25 at 2:05 p.m., indicated the resident was seen for an acute visit due to change in his behaviors. The resident was seen last week, and his quetiapine was increased from daily to twice a day. The resident has continued to have significant delusions - he was thinking he was in another city, and he had been trying to elope. The facility had to place him in the memory care unit for a short time due to elopement risk. Nursing notes indicated the resident had been wandering and pacing at nights into other residents' rooms, he stood behind a door when it opened on 2/10 and was hit in the head, he had brown urine, and he packed things to go home. Assessment/Plan for microscopic hematuria - the resident had increased confusion and delusions, and he also had significant microscopic hematuria. His increasing white blood cell count was borderline leukocytosis. A course of ciprofloxacin (antibiotic)

would be started. For hallucinations - if behaviors don't improve with the antibiotic need to consider further increases in the quetiapine.
A Nurses Note, dated 2/11/25 at 4:53 p.m., indicated the resident received a new order for an antibiotic for a recent diagnosis of UTI.
The Medication Administration Record for 2/2025 indicated the resident received an as needed (PRN) quetiapine on 2/13/25 at 9:38 a.m. and was effective.
The clinical record lacked documentation of interventions utilized prior to administration of the PRN quetiapine.
A facility document, titled "GDR and Behavior Tracking," provided by the Social Services Director (SSD) on 2/17/25 at 2:40 p.m., indicated the resident had behaviors on 2/11/25 and 2/15/25. No behaviors were listed for 2/13/25.
During an interview, on 2/14/25 at 4:15 p.m., CNA 18 indicated the resident had been wandering a lot more lately. He had become much more confused. He had not tried to go outside, though he did sometimes close other residents' doors.
During an interview, on 2/14/25 at 4:17 p.m., LPN 12 indicated the resident had become more confused lately. She had not heard of him having hallucinations. She knew he had been taken back to the memory unit the other day, and he had not slept much that night. She was uncertain what his baseline behavior was because he always seemed to be changing.
During an interview, on 2/14/25 at

4:28 p.m., the SSD indicated the resident had been admitted to the facility taking quetiapine. When he was at home he had delusions and hallucinations. The recent delusions were his wanting to go home and packing his bags. He had been worried about his wife visiting him as he was currently in the middle of a divorce. He has been anxious and nervous. He hadn't been sleeping well recently. He had been anxious about being kicked out. His representative thought the resident was getting worse.

During an interview, on 2/17/25 at 4:31 p.m., the DON indicated when the resident first arrived at the facility he saw things through the windows and thought the police were there. The resident's physician, who was the medical director, had ordered the increase in the quetiapine and the PRN quetiapine. He had instructed the staff to give the PRN when he was there.

The black box warning for quetiapine was retrieved on 2/17/24 from The guidance indicated " ...WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS ...." The indications for use for quetiapine included schizophrenia, bipolar I disorder manic episodes, and bipolar disorder, depressive episodes.

A current policy, dated 11/28/17, provided by the Administrator on 2/17/25 at 1:30 p.m., titled "Dementia Services," indicated the following: " ...The facility will ensure 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, psychosocial well-being ...." A current policy, revised 10/2022, provided by the Administrator on 2/17/25 at 2:40 p.m., titled "Psychotropic Medication Policy," indicated the following: " ...Based on a comprehensive assessment of a resident, the facility must ensure: ...Residents do not receive psychotropic drugs on a PRN basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record ...Residents must not receive any medications which are not clinically indicated to treat a specific condition. The clinical record must show documentation of the diagnosed condition for which a psychotropic medication is prescribed ...." 3.1-37(a)			
F 0758 SS = D	Free from Unnec Psychotropic Meds/PRN Use 483.45(c)(3)(e)(1)-(5) §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;	F 0758	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** One resident was found to be affected by this deficient practice. All residents on antipsychotic medications were reviewed for proper diagnosis and indicator of medication usage. Residents found to not have appropriate diagnosis or indication were referred to their	03/07/2025

	(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 §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		physician with a request to gradually reduce this medication with a goal of discontinuing use. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents on antipsychotic medications were reviewed for proper diagnosis and indicator of medication usage. Residents found to not have appropriate diagnosis or indication were referred to their physician with a request to gradually reduce this medication with a goal of discontinuing use. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** DON or designee will review all medication orders daily (M-F) with a focus on antipsychotic medications. For any new order for	

	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure an antipsychotic medication was not initiated without indication for 1 of 5 residents reviewed for unnecessary medications. (Resident 15) Findings include: Resident 15's clinical record was reviewed on 2/17/25 at 9:32 a.m. Diagnoses included generalized anxiety disorder, alcohol dependence (in remission), hypertension, sedative, hypnotic, or anxiolytic dependence (uncomplicated), cognitive communication deficit, and unspecified dementia (unspecified severity - with other behavioral disturbance). A quarterly MDS, dated 1/21/25, indicated the resident had active diagnoses of anxiety, depression, and a psychotic disorder (other than schizophrenia). Current orders included buspirone (anti-anxiety) 5 mg tablet give 1 tablet by mouth three times a day, tramadol (opiate pain reliever) 50 mg tablet give 1 tablet by mouth every 8 hours as needed, quetiapine fumarate (anti-psychotic) 25 mg give 1 tablet by mouth at bedtime, and behavior assessment to be performed every shift due to psychotropic medications. A current, 3/20/22, care plan indicated the resident had a diagnosis of insomnia. She had daytime tiredness, irritability, depression and/or anxiety. Interventions included gradual		antipsychotic medications, the DON or designee will review for an appropriate diagnosis and indication for this medication prior to the initiation of medication. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place:** DON or designee will review all medication orders daily (M-F) with a focus on antipsychotic medications. For any new order for antipsychotic medications, the DON or designee will review for an appropriate diagnosis and indication prior to the initiation of medication. Audit results will be discussed in QAPI. After one quarter or when 100% compliance is reached, the DON may discuss potential to decrease or discontinue this audit.	

dose reductions (GDRs) as ordered, medications as ordered, observe for signs and symptoms of adverse reactions to medications and notify they physician of any concerns, provide a relaxing environment for the resident, and psych services as ordered.
A current, 3/30/22, care plan indicated a diagnosis of generalized anxiety disorder, described as persistent worrying or anxiety about a number of areas that were out of proportion to the impact of the events, restlessness, fatigue, crying, verbal behaviors, difficulty concentrating, irritability, multiple health complaints, and tearfulness. The resident worried about her husband and daughter when unable to reach them by phone. Interventions included medications as ordered, the nurse(s) were to assess health complaints, observe and document resident for signs and symptoms of increased anxiety, offer medications for health complaints when available, provide a calm, relaxing environment for resident, and provide reflective listening and reassurance to the resident.
A current, 3/30/22, care plan indicated a diagnosis of major depressive disorder, described as feelings of sadness, tearfulness, emptiness or hopelessness, fatigue, lack of energy, loss of appetite or overeating, loss of interest, and lack of concentration. Interventions included allowing the resident time to voice feelings and frustration, GDRs as ordered, medications as ordered, observe the resident for signs and symptoms of increased depression (and document), and observe for

	signs and symptoms of adverse reactions to medications as listed on the behavior/intervention monthly flow record. A current, 3/30/22, care plan indicated the resident had the potential for increased signs and symptoms of depression related to her diagnoses of depression, alcohol dependence, and depression assessment indicators. Interventions included allowing the resident to vent her feelings, using good listening techniques, encourage family and social interactions, encourage involvement in daily needs and concerns, monitor for signs and symptoms of depression, provide a caring and structured environment and routine, and use supportive words and reassurance during contact with the resident. A current, 3/30/22, care plan indicated the resident had a history of making negative statements, i.e., stating she wished to disappear, wanted to harm herself (but then stated she just wanted God to kill her), wished she were dead, and wanted to die because her stomach hurt. She indicated she was Catholic and would never harm herself. She often had those ideations during times of pain or when requesting more pain medications. Interventions included assessing the resident for pain, assisting the resident to call her family members, medications as ordered for depression, observe any changes in mood, appetite, change in sleep patterns, or any increased verbalizations of being depressed or blue, and provide reflective listening and reassurance to the resident.			

	A current, 3/30/22, care plan indicated the resident exhibited anxious verbalizations, i.e., yelling out continuously, even with redirection, and crying out loudly that she was dying. Interventions included introducing the resident to peers with similar interests, offer a small conversation to help calm and reassure the resident, and offer a back rub or repositioning. A current, 9/28/22, care plan indicated the resident had impaired cognitive function or impaired thought processes related to a dementia diagnosis. The resident needed supervision with all decision making. Interventions included keeping her routine consistent and provide consistent care givers as much as possible, in order to decrease confusion. A current, 9/28/22, care plan indicated the resident had a diagnosis of alcohol and sedative/hypnotic/anxiolytic dependence. Interventions included offering validation, empathy, and listening techniques, identifying triggers that led to urges of alcohol use, observe and report to the physician any changes in mood (withdrawal) or urges to use alcohol. A current, 7/17/23, care plan indicated the resident had a diagnosis of psychosis. She took antipsychotic medications related to the following behaviors - pain, constipation, multiple health conditions, money, yelling out, statements that she was dying because her stomach hurt, uncontrollable sobbing, calling 911 frequently, and verbal aggression towards the staff and her roommate. Interventions included			

	GDRs as ordered, medications as ordered, observe for signs and symptoms of adverse reactions to medications as listed on the behavior/intervention monthly flow record, observe for side effects of medications and notify physician of any concerns, and psych services as ordered. A behavior note, dated 4/13/24 at 5:24 p.m., indicated the resident had been walking around the building with her roommate. During resident care, she told the nurse she needed her pain pill. The nurse explained it was not yet time for the pill. The nurse offered acetaminophen instead. The resident argued that it was time for her pain pill. The nurse tried to explain why the pain pill could not be given but the resident continued to argue with the nurse. The behavior assessment indicated the resident was "irritated". A behavior note, dated 5/10/24 at 10:21 a.m., indicated the resident refused to get out of bed. A nursing progress note, dated 12/1/24 at 11:49 a.m., indicated the resident requested pain medication. She wanted to go to the emergency room to get some "good meds". The resident yelled that she wanted to die. She had no plans to hurt herself. She was placed on 15 minute checks at that time. A social service progress note, dated 1/14/25 at 9:11 a.m., indicated the resident was on buspirone two times and day for anxiety and quetiapine 25 mg once daily at bedtime for depression. The resident had no behaviors since 5/10/24. A physician's progress note, dated			

	1/29/25 at 2:36 p.m., indicated the resident was seen to follow up on hip pain. The resident had complained of pain in her right hip and threatened to call 911. She wanted to go to the hospital. The pain radiated from her right hip into her leg. The pain medication was not helping. The resident was repositioned at that time. A nursing progress note, dated 2/5/25 at 2:36 p.m., indicated the resident was upset because her pain medication was not helping her pain. The nurse practitioner discontinued her narcotic pain medication at that time and started the resident on acetaminophen (Tylenol) 1000 mg, three times a day and tramadol 50 mg, three times a day as needed. A behavior progress note, dated 2/11/25 at 9:40 a.m., indicated the resident refused to go to a doctor's appointment. She had been sick all night and did not want to go to the appointment. Her behavior was described as upset and anxious. A physician's progress note, dated 2/11/25 at 3:43 p.m., indicated the resident was not feeling well and stated she was "a ball of nerves". She denied having concerns about anything in particular. She refused to go to an outside doctor's appointment that day and denied having any pain. The resident's buspirone was increased to three times a day. During an interview with CNA 14, on 2/17/25 at 11:19 a.m., she indicated Resident 15 would often have her call light going off every few minutes, complaining of pain. Even when told she was not due for a medication, she would continue to ask the nurse for pain			

medication. She would follow the nurse around, sometimes into other resident's rooms.
During an interview with the Activities Assistant (AA), on 2/17/25 at 11:22 a.m., she indicated the resident cried sometimes because she was lonely or did not feel well. No hallucinations or delusions were observed by the AA. The resident often complained of pain.
During an interview with QMA 15, on 2/17/25 at 11:24 a.m., she indicated the resident had good and bad days. Interventions were implemented but did not always work. When interventions were unsuccessful, the staff would document the behavior. Most often, the behavior was related to pain. The resident had never said anything about hearing voices or seeing things that were not there.
During an interview with the Director of Nursing (DON), on 2/17/25 at 4:42 p.m., she indicated most of Resident 15's behaviors were complaints of pain. She would sometimes say she felt like she was losing her mind. The resident had a long history of addiction.
A summary of the black box warning for quetiapine, retrieved from https://www.nami.org/about-mental-illness/treatments/mental-health-medications/types-of-medication/quetiapine-seroquel/ on 2/18/25 at 12:08 p.m., indicated the following: "...Increased Mortality in Elderly Patients with Dementia Related Psychosis - When used for dementia related psychosis in elderly patients, both first generation (typical) and second

generation (atypical) antipsychotics are associated with an increased risk of mortality...."
A current facility policy, with a revision date of 10/2022, and titled "Psychotropic Medication Policy", was provided by the Administrator on 2/17/25 at 1:30 p.m. The policy indicated the following:
"...Behavioral interventions are individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial well-being...Expressions or indications of distress refers to a person's attempt to communicate unmet needs, discomfort, or thoughts that he or she may not be able to articulate. The expressions may present as crying, apathy, or withdrawal, or as verbal or physical actions such as pacing, cursing, hitting, kicking, pushing, scratching, tearing things, or grabbing others...Medication Management:...The facility will ensure to the extent possible that the following are met regarding medication management...Selection of medications(s) based on assessing relative benefits and risks to the individual resident...Evaluation of a resident's physical, behavioral, mental, and psychosocial signs and symptoms, to identify the underlying cause(s), including adverse consequences of medications...The facility will

	ensure each resident's clinical record contains the following: 1) Indication and clinical need for medication...Additionally, the facility will ensure when administering psychotropic medication, the following is met: Giving psychotropic medications only when necessary to treat a specific diagnosed and documented condition...Residents must not receive any medications which are not clinically indicated to treat a specific condition. The medical record must show documentation of the diagnosed condition for which a psychotropic medication is prescribed...Facility shall not use these types of brain altering medications...unless there is documented clinical indication for the use...The facility will use extreme caution in utilizing antipsychotic medications in the elderly. The following will be considered prior to initiation of antipsychotic medication: Behavioral symptoms present a danger to the resident or others...." 3.1-48(a)(4)			
F 0880 SS = D	Infection Prevention & Control 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** One resident was found to have	03/07/2025

	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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;		been affected by the deficient practice. Both staff members were educated immediately on proper PPE for droplet precautions. All staff were provided education at the All Staff inservice on 2/25/25. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**: All residents have the potential to be affected by this deficient practice. Both staff members were educated immediately on proper PPE for droplet precautions. All staff were re-educated at the All Staff inservice on 2/25/25 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Signage for droplet precaution have been updated with reminders of what PPE will be indicated. When a resident is in	

	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure staff implemented transmission based precautions for 2 of 8 residents reviewed for		droplet precautions, the Unit manager will audit and observe at least one nursing staff member and one non-nursing staff member daily (M-F) for appropriate PPE. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place**: When a resident is in droplet precautions, the Unit manager will audit and observe at least one nursing staff member and one non-nursing staff member daily (M-F) for appropriate PPE. Results from this audit will be discussed in QAPI. After one quarter or when 100% compliance is reached, the QAPI team may review audit for reduction of audit or potential for discontinuation.	

infection control. (Residents D and Resident 62)
Findings include:
Resident 62's clinical record was reviewed on 2/10/25 at 1:38 p.m. Diagnoses included osteomyelitis of vertebra, thoracic region, cerebral infarction, COVID-19, depression, and cognitive communication deficit.
Physician orders, dated 2/5/25 at 2:00 p.m., indicated transmission based (droplet) precautions were to be observed for 9 days for COVID-19. All services were to be received in his room.
On 2/10/25 at 10:47 a.m., a sign on Resident 62's door indicated the resident was on droplet precautions. The Certified Occupational Therapy Assistant (COTA) exited the room wearing a surgical mask and glasses. The COTA indicated she would remove personal protective equipment (PPE) when exiting a room. She would replace the N-95 mask with a surgical mask. Her personal glasses were not covered by protective eyewear because she was not able to see well with goggles over her glasses.
Resident D's clinical record was reviewed on 2/10/25 at 2:18 p.m. Diagnoses included hypothyroidism, anxiety, chronic combined systolic and diastolic heart failure, and bipolar disorder.
Physician orders, dated 2/3/25 at 10:00 p.m., indicated droplet precautions were to observed for 10 days. The resident tested positive for COVID-19. All services were to be received in her room.
On 2/11/25 at 10:40 a.m., an Activities Assistant was observed entering Resident D's room. A sign

	on the door indicated the resident was on droplet precautions. The Activities Assistant donned a gown and a surgical mask. She did not don gloves or protective eyewear. During an interview, at the time of the observation, the Activities Assistant indicated staff should don gloves, a gown, an N-95 mask, and protective eyewear. She forgot to wear the goggles. During an interview with Nurse Assistant 5, on 2/11/25 at 10:59 a.m., she indicated staff should wear a gown, mask, and protective eyewear when entering the room of a resident diagnosed with COVID-19. During an interview with the Certified Nursing Assistant Coordinator, on 2/11/25 at 11:03 a.m., she indicated staff should wear protective eyewear, a mask, an N-95 mask, gloves, and gown when entering the room of a resident diagnosed with COVID-19. Even if staff wore glasses, they should put protective eyewear over the glasses. During an interview with CNA 7, on 2/11/25 at 11:07 a.m., she indicated staff should wear gloves, a gown, an N-95 mask, and protective eyewear when entering the room of a resident diagnosed with COVID-19. Staff wearing glasses should also don protective eyewear over them. During an interview with LPN 10 on 2/11/25 at 1:34 p.m., she indicated staff should wear a gown, an N-95 mask, protective eyewear, and gloves when entering the room of a resident diagnosed with COVID-19. Goggles should be worn over eyeglasses. A current 7/5/21 facility policy, titled			

	"Transmission Based Precautions Infection Control", provided by the Administrator on 2/17/25 at 4:35 p.m., indicated the following: "...It is the policy of (the facility) to take appropriate precautions to prevent transmission of infectious agents. Transmission based precautions are for resident's who are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. These precautions are to be used in adjunct with standard precautions..."Droplet Precautions" ...a) Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (respiratory droplets that are generated by a resident who is coughing, sneezing, talking, or singing)...d) Healthcare personnel must wear a mask (surgical, N-95, approved KN95, or respirator when appropriate)...." 3.1-18(a)			
F 0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ 483.90(i) §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	F 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D's countertop was replaced on 2/12/25. Resident C's room was painted on 2/14/25. 311 was repaired and	03/07/2025

	interview, the facility failed to provide a safe and comfortable environment for 3 of 4 residents reviewed for homelike environment. (Resident C, Resident D and Resident 42) Findings include: Resident D's clinical record was reviewed on 2/12/25 at 10:38 a.m. Diagnoses included type 2 diabetes mellitus, chronic kidney disease, muscle weakness, and abnormality of gait and mobility. During an interview, on 2/12/25 at 12:09 p.m., Resident D indicated maintenance would be replacing her countertop. She used the countertop to help herself balance during transfers. They had not fixed the countertop at that time, as they had to order a new one. During a room observation, on 2/12/25 at 12:17 p.m., Room 316's bathroom countertop was pulling away from the wall. It had a small gap between the backsplash and the wall. The countertop moved downward when pressure was placed on top of it. During an interview, on 2/12/25 at 1:17 p.m., Resident D indicated she went to get up from the toilet, twisted her knee wrong and was able to lower herself down to the floor. She used the loose countertop to get herself off the floor. She always transferred on her own. An Interdisciplinary Team (IDT) progress note, dated 2/10/24 at 1:29 p.m., indicated Resident D reported she attempted a self-transfer from the toilet to her wheelchair, lost her balance, and fell to one knee. The resident reported she was able to get herself back into her wheelchair		painted on 3/6/25. The area near the soiled utility on 300 hall was also repaired and painted on 3/6/25. Res 42's windowsill was replaced on 2/21/25 by Nichols Construction. **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 affected by this deficient practice. All repairs have been completed to areas indicated in report. Department heads will round on a specific segment of rooms (Buddy List-attached) weekly to check for any needed repairs. Rounding lists will be turned into the Administrator to log. Administrator will give a list of needed repairs to the Maintenance Director. Administrator will audit concerns for weekly for completion of repairs.	

	and was not injured. Her bathroom was assessed and non-skid strips were in front of the toilet, there was a grab bar on the right-hand side of toilet, and a toilet seat riser. Her countertop was beginning to deteriorate and was loose when pressure was applied to the top of the counter. Resident D reported that she used the countertop to balance herself during transfers and felt that movement may have contributed to her fall. A maintenance request was put in for her countertop to be replaced. During an interview, on 2/12/25 at 1:22 p.m., the Maintenance Supervisor indicated he had Resident D's bathroom countertop in his office since Monday, it was just a matter of getting the time to install it. The countertop needed the hole cut out for the sink to drop in. He felt it was late last week when he was notified that her bathroom countertop was loose. He was unable to restructure/brace the existing countertop due to ADA guidelines. 2. During an interview, on 2/11/25 at 10:32 a.m., Resident C indicated she had paint missing from her walls where she and her roommate's bed were rubbing up against the wall, causing it to scrape into the drywall. She had complained to the maintenance department regarding wanting her room fixed and repainted. It had been like that for the last four months. During an observation, at the time as the interview, Resident C's room had numerous areas just above the bed, where the bed frame had scrapped into the drywall causing small holes and paint to be missing.		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Once weekly rounding will be completed by the Department Heads for their assigned segment of rooms. Any repairs required will be turned into the Administrator. The Administrator will log concern and give a list to the Maintenance Director. Maintenance Director may assign small repairs to Maintenance Assistant so that he may focus on all other work orders, preventative maintenance and TELS. An Employee Concern Form was also created and all staff was in-serviced on its use on 2/25/25. Staff may report any concerns on these forms as well as a Work Order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place**: All repairs and Employee Concern Forms (related to environmental concerns) will be	

	During an interview, on 2/12/25 at 1:22 p.m., the Maintenance Supervisor indicated Resident C had asked previously when her walls would be fixed. He spoke with Resident C weekly regarding painting her walls. He wasn't able to put a timeframe on when it would be fixed, as he has other issue that need fixed with a higher level of severity. A random observation of the 300 hall, on 2/12/25 at 11:09 a.m., indicated the following: Room 311 had missing paint and gouges of missing drywall, above the resident's bed. A large area, approximately the size of an index cared, of missing paint and the top layer of drywall was missing around the door frame of the soiled utility room. 3. During an observation, on 2/17/25 at 1:56 p.m., Resident 42's window sill behind her bed's headboard had a hole approximately the size of an index card and approximately one inch deep. It was covered with plastic and paper tape that was peeling off. During an interview, on 2/17/25 at 1:58 p.m., QMA 11 indicated the area had been there since January 2025. She had not reported it to maintenance, and she was unsure if anyone else had reported it. During an interview, on 2/17/25 at 1:59 p.m., LPN 12 indicated the area in Resident 42's window sill had been there for at least a month. She was uncertain if it had been reported to maintenance. During an interview, on 2/17/25 at 2:04 p.m., the Maintenance Supervisor indicated he was just notified on Friday regarding the		discussed at QAPI to ensure compliance. Audit will continue one time weekly for one quarter. If concerns with completion are noted, audit will continue for another quarter. Once 100% compliance is reached, The Maintenance Director may request the QAPI team reduce this audit or consider it for discontinuation.	

	residents window sill. He thought he had a board to fix it but needed to get a bigger board. During an interview, on 2/17/25 at 2:23 p.m., the Administrator indicated they did not have a facility policy regarding environment. This citation relates to Complaints IN00449079, IN00449973, and IN00452205. 3.1-19(e)			
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey and the Investigation of Complaint IN00450475. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00449079, IN00449973, IN00450517, and IN00452205. Complaint IN00450475 - No deficiencies related to the allegations are cited. Complaint IN00450517 - No deficiencies related to the allegations are cited. Complaint IN00449079 - Federal/State deficiencies related to the allegations are cited at F584 and F921. Complaint IN00449973 - Federal/State deficiencies related to the allegations are cited at F584 and F921. Complaint IN00452205 - Federal/State deficiencies related to the allegations are cited at F584 and F921. Survey dates: February 10, 11, 12, 13, 14, and 17, 2025	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegations in the survey report are accurate or reflect accurately the provisions of care and services to the residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegation of compliance.	

	Facility number: 000372 Residential Census: 16 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 26, 2025.			
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, record review, and interview, the facility failed to have the most recent State Survey results readily available to residents and the public. This deficiency had the potential to affect 16 of 16 residents residing in the facility. Finding includes: During an observation, on 2/17/25 at 11:56 a.m., a State Survey results binder was setting on a table in an activity lounge near an entrance door to the facility. A review of the binder's contents, completed at the time of the observation, indicated the binder lacked survey results after the annual survey completed 4/8/2022. During an interview, on 2/17/25 at 12:22 p.m., LPN 3, after reviewing the State Survey results binder indicated the binder lacked survey results after the 4/2022 annual	R 0042	What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice? A copy of the current survey was added to the Survey Binder at the Assisted Living. All 16 residents could have been affected by this deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All resident's at the Assisted living had the potential to be affected by this deficient practice. A copy of the current survey was added to the Survey Binder at the AL. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: AL Wellness nurse will request a copy of any survey to ensure this	03/07/2025

	survey. She was uncertain who was responsible for updating the binder. During an interview, on 2/17/25 at 12:29 p.m., the Administrator indicated she was responsible for updating the binder, and the updated survey results had been placed in the skilled facility building binder instead of the assisted living building binder. A current facility policy, dated 10/2017, provided by the DON on 2/17/25 at 3:20 p.m., titled "Availability of Survey Results," indicated the following: " ...A readable copy or our company's most recent federal and/or state survey report and plan of correction for any identified deficiencies is maintained in a 3-ring loose-leaf binder ...a representative of management is assigned the responsibility of making weekly inspections of the "survey binder" to ensure that the binder contains current information, is located in its designated area(s), and is readily accessible without one having to ask staff members for the information ...." Based on observation, record review, and interview, the facility failed to have the most recent State Survey results readily available to residents and the public. This deficiency had the potential to affect 16 of 16 residents residing in the facility. Finding includes: During an observation, on 2/17/25 at 11:56 a.m., a State Survey results binder was setting on a table in an activity lounge near an entrance door to the facility. A review of the binder's contents,		material is put in Survey Binder. AL Wellness nurse will audit binder once a quarter to ensure copies of all surveys are present. How the corrective action(s) will be monitored to ensure the deficient practice will not recur IE, what quality assurance program will be put into place: AL Wellness nurse will request a copy of any survey to ensure this material is put in Survey Binder. AL Wellness nurse will audit binder once a quarter to ensure copies of all surveys are present. AL Wellness nurse will bring results of this audit to QAPI. Once one quarter of compliance has been reached, AL Wellness Nurse may request for audit to be reduced or to be considered for discontinuation.	

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During an interview, on 2/17/25 at 12:22 p.m., LPN 3, after reviewing the State Survey results binder indicated the binder lacked survey results after the 4/2022 annual survey. She was uncertain who was responsible for updating the binder.
During an interview, on 2/17/25 at 12:29 p.m., the Administrator indicated she was responsible for updating the binder, and the updated survey results had been placed in the skilled facility building binder instead of the assisted living building binder.
A current facility policy, dated 10/2017, provided by the DON on 2/17/25 at 3:20 p.m., titled "Availability of Survey Results," indicated the following: " ...A readable copy or our company's most recent federal and/or state survey report and plan of correction for any identified deficiencies is maintained in a 3-ring loose-leaf binder ...a representative of management is assigned the responsibility of making weekly inspections of the "survey binder" to ensure that the binder contains current information, is located in its designated area(s), and is readily accessible without one having to ask staff members for the information ...."

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR	TITLE	(X6) DATE

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		